Tanzania

Country Operational Plan

COP 2018

Strategic Direction Summary

April 17, 2018

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1.0 Goal Statement

The 2016-2017 Tanzania HIV/AIDS Impact Survey (THIS), a national representative, population-based survey was successfully conducted country-wide, was released in December 2017 and demonstrated that Tanzania is far from reaching epidemic control. The THIS identified that only 52% of Tanzanians who are HIV-positive know their status. This realization caused the U.S. President's Emergency Plan for AIDS Relief in Tanzania (PEPFAR/T) team to work closely with the Government of the United Republic of Tanzania (GOT), implementing partners (IPs), multilateral representatives and civil society to reassess Tanzania's HIV response, identifying required course corrections, and policy changes to reach epidemic control. The unified goal across all stakeholders is to rapidly close the HIV case finding gap to reach 95/95/95 targets before 2020.

PEPFAR/T developed the 2018 Country Operational Plan (COP 2018) in this context. The strategy for COP 2018 is based on thorough review of both program data and THIS data. The THIS data demonstrate that Tanzania's greatest gap is in HIV case finding, and that case finding gaps are large across all age and sex sub-groups and all geographic areas. The THIS data additionally demonstrate that while identification is poor broadly, the gap is even larger among some sub-populations, especially men. Furthermore, early infant diagnosis (EID) and viral suppression in pediatric patients continues to be very low. Program data suggest that HIV testing yields have been falling over the past several quarters, suggesting a need for more evidence-based targeting of interventions. The THIS provided evidence about the geographic burden of disease that differed from prior available data, allowing PEPFAR/T to shift investments to better align them with gaps in coverage. Finally, evidence from this increased the sense of urgency across all stakeholders to accelerate progress, and this urgency has resulted in more rapid movement on key policy priorities.

For COP 2018, major shifts that PEPFAR/T will implement to address the broad gaps in coverage include three key aspects of HIV case finding: index testing, provider-initiated testing and counseling (PITC), and community-based testing. The proportion of positive results coming from index testing increased from 1% in FY2017 Q1 to 17% in FY2017 Q4. PEPFAR/T will increase the scale-up of testing with a focus on sexual and needle-sharing partners to ensure high fidelity. Through this PEPFAR/T estimates that 30% of all HIV-positive people are identified through index testing. Index testing will accelerate progress broadly but will especially help to close the gap in men, since most HIV-positive clients are currently women.

For PITC, PEPFAR/T will scale-up the Bukoba Combination Prevention approach for PITC to facilities with both high numbers of HIV-positive test results and high yield to ensure that PEPFAR/T maximizes the value from this investment. In lower-yield areas and facilities (including outpatient departments) PEPFAR/T will implement screening before testing to focus testing on persons with risk or medical symptoms. The result of this effort will be to increase yield for PITC, compared to Q4 2017 and Q1 2018.

For community testing, PEPFAR/T will focus on high burden areas within sub-national units (SNUs), as well as areas with large concentrations of key populations. PEPFAR/T will also use the risk and symptom-based screening approach to focus testing on higher-risk persons. The result of this will be increased yield and decreased testing. This package of three core interventions will be implemented across all regions of Tanzania. It will help not only with closing broad case finding

gaps, but also specifically with case-finding in men, since index testing and community interventions are both high yield for men. PEPFAR/T will also continue to scale-up voluntary medical male circumcision (VMMC) in areas where coverage is low and improve targeting of men aged 25-29.

Added to these three general strategies are specific strategies that are tailored to address key gaps and challenges specific to different regions. PEPFAR/T's combination prevention activities in COP 2018 will focus on key populations (female sex workers, men who have sex with men, and injecting drug users), adolescent girls and young women (AGYW), and adult men. Adolescent friendly health services will be integrated into this standard package across all councils to encourage service utilization among young men and women. PEPFAR/T will also continue to support core services for orphans and vulnerable children (OVC) in scale-up councils.

Following the release of the 2016-2017 THIS, the GOT initiated substantial policy revisions to move Tanzania closer to epidemic control. Pre-exposure prophylaxis (PrEP) for key populations and other high-risk groups began in March 2018 without the prolonged pilot that had previously been planned. Self-testing in Tanzania is also to be initiated following a planned revision in the HIV/AIDS laws by Parliament in April 2018. The task sharing plan that allows community healthcare workers (CHW) to provide HIV testing will be implemented by July 2018. COP 2018 supports HIV testing training and salary support for a number of these staff. GOT has recently expanded multi-month scripting to allow for three months between antiretroviral therapy (ART) refills. PEPFAR/T will work to scale that up during COP 2017 and 2018, building on successful implementation of two-month multi-month scripting from COP 2017. Following the PEPFAR COP Regional Planning Meeting (RPM), GOT immediately distributed an email to all Regional Management Officers and their deputies, informing and authorizing them to implement outreach ART services to those who need these services. Substantial evidence had demonstrated increased linkage with this strategy, but confusion about the policy had led to inconsistent implementation.

PEPFAR/T plans to accelerate implementation of all these activities with high fidelity through expanded use of quality improvement partners, and through an expanded interagency partner management process. Our quality improvement (QI) partners will focus on scale-up of the priority activities throughout the country and will aid sites in measurement of progress. QI IPs will also participate on site improvement through monitoring system (SIMS) visits and clinical partner management meetings to aid with continuous improvement. This enhanced QI approach will be coupled with more intensive partner management, including monthly monitoring of key indicators by PEPFAR/T as an interagency group, rapid identification and scale up of successful models, and quarterly discussions on evidence-based achievements and challenges with external stakeholders. This external stakeholder engagement (i.e. UN agencies, GOT, and other development partners), as well as the inclusion of civil society organizations (CSOs) as part of the process, will help to ensure that we are optimizing approaches for key populations, implementing patient-focused services, and addressing stigma.

Finally, above site investments focus on supporting all of these priorities through support of human resources for health that will facilitate implementation of these priorities, systems for rapid access to and use of high quality data that will facilitate immediate use of data for improvement, laboratory investments that ensure high quality testing and viral load monitoring, and institutional strengthening that will continue steps towards sustainability.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

According to THIS 2016-2017[1] the prevalence of HIV among adults aged 15- 64 years in Tanzania is 5.0 percent (6.5 percent among females and 3.5 percent among males). This corresponds to approximately 1.4 million people living with HIV (PLHIV) ages 15-64 years in Tanzania out of a total population of 54,199,163,[2] with regional HIV prevalence ranging from 0.3% (Kusini Pemba, Zanzibar) to 11.4% (Njombe).[3] The prevalence of viral load suppression (VLS) among HIV-positive adults aged 15-64 years in Tanzania is 52.0 percent (57.5 percent among females and 41.2 percent among males). The prevalence of HIV among children aged 0-14 years is low (0.3%), but the proportion of children with HIV who are virally suppressed is also low (18.4%). The annual incidence of HIV among adult ages 15 to 64 years in Tanzania is 0.29 percent (0.40 percent among females and 0.17 percent among males).[4] This corresponds to approximately 81,000 new cases of HIV annually among adults age 15 to 64 years in Tanzania. THIS 2016-17 shows that 74% of men aged 15-49 years, have a CD4 count less than 500 cells/μL compared to 60% of the same age group in women.

Though the gaps are considerable, the recent survey does show some areas of important progress. The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) from 2011/2012 showed HIV prevalence among adults aged 15-49 years was 5.1% [CI: 4.6-5.6] while the recent THIS 2016-17showed an HIV prevalence of 4.7% [CI: 4.3-5.0]. Projections from the United Nations Joint Program on HIV/AIDS (UNAIDS) Spectrum model show that, the number of new HIV infections have been declining steadily over the years, from 63,925 to 60,769 between 2015 and 2016; and in 2017, it was estimated to be 52,039. This has led to the decrease on the estimated HIV incidence per 1000, from 1.38 to 1.27 between 2015 and 2016, and in 2017 it was estimated to be 1.06. Furthermore, the estimated total annual deaths among PLHIV has been progressively decreasing from 42,881 in 2015 to 30,666 in 2017.

THIS 2016-17 showed that only 52% of people with HIV in Tanzania self-reported knowledge of HIV status. Of these, 91% self-reported current use of ART and 88% of those on ART are virally suppressed. Key populations (KPs) also play a critical role in HIV transmission dynamics. Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. Studies in Dar es Salaam estimate that HIV prevalence is 36% among people who inject drugs (PWID), 26% among sex workers (SWs), and 25% for men who have sex with men (MSM).[5] Based on program data, 98% of pregnant women had HIV testing in at least one antenatal care (ANC) visit. The national coverage of male circumcision is 70%, although more needs to be done to increase coverage among adults aged 25-29 years and sustain high coverage through early infant male circumcision (EIMC) and continued circumcisions in children aged 10-14 years. In addition, COP 2018 coverage for key and vulnerable populations (KVP) include expanding coverage of adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and PWID to 30%; 95%; 80%; and 75% respectively.

[1] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[2] National Population Projection, Feb 2018
[3] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[4] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[5] *Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.*

THIS 2016-17 data also showed that HIV prevalence varies by population in Tanzania. HIV prevalence is highest among females aged 45 to 49 years, at 12% compared to a peak of 8.4 percent among males aged 40 to 44 years. Prevalence among adults aged 15 to 24 years is 1.4% (2.1% among females and 0.6% among males), while prevalence among children aged 0-14 years is 0.4%. The disparity in HIV prevalence between males and females is highest among younger adults, with women in age groups 15-19, 20-24, 25-29, 30-34 and 35-39 years having prevalence more than double that of males in the same age groups.

The burden of HIV infection also varies geographically across Tanzania, ranging from 11.4% in Njombe to less than one percent (<1%) in Zanzibar. HIV prevalence also varied between urban (6.0%) and rural (4.2%) areas. THIS 2016-17 results show a higher estimated number of PLHIV in Kagera, Iringa, Tanga, Dodoma, and Mwanza compared to the 2016-17 Spectrum data. In Kagera, for example, there was a 122% increase in the estimated number of PLHIV from approximately 54,000 to 120,000. The table below highlights the regions with the largest increases in the estimated number of PLHIV from the 2016/17 Spectrum to the THIS 2016/17.

Change in estimated number of PLHIV aged 15-49 by region: Regions with largest increase

Region	COP16/17 SPECTRUM		THIS 2016		DIFFERENCE	
	PLHIV	HIV Prevalence	PLHIV	HIV Prevalence	PLHIV	HIV Prevalence
Mwanza	55,435	3.9%	108,316	7.2%	52,881	3.3%
Tanga	23,149	2.3%	54,609	5.0%	31,460	2.7%
Kagera	53,664	4.5%	120,971	6.5%	67,307	2.0%
Dodoma	27,407	2.7%	54,333	5.0%	26,926	2.3%
Iringa	42,212	8.5%	60,191	11.3%	17,979	2.8%

Likewise, the estimated number of PLHIV decreased in Dar es Salaam, Mtwara, Arusha, and Njombe. In Dar es Salaam, for example, THIS 2016-17 results showed a 28.3% decrease in the estimated number of PLHIV from approximately 193,000 to 138,400. The table below highlights the regions with the largest decreases in the estimated number of PLHIV from the 2016/17 Spectrum to THIS 2016/17.

Change in estimated number of PLHIV aged 15-49 by region: Regions with largest decrease

Region	COP16/17 SPECTRUM		THIS 2016/17		DIFFERENCE	
	PLHIV	HIV Prevalence	PLHIV	HIV Prevalence	PLHIV	HIV Prevalence
Dar es Salaam	192,811	6.5%	133,971	4.7%	(58,840)	-1.8%
Mtwara	24,979	3.8%	13,377	2.0%	(11,602)	-1.8%
Arusha	28,235	3.0%	18,734	1.9%	(9,501)	-1.1%
Njombe	50,665	13.9%	44,999	11.4%	(5,666)	-2.5%

PEPFAR/T is in the process of adjusting the breadth and scope of current activities based on these findings to ensure that activities are concentrated in regions with the highest estimated number of PLHIV and are focused on reaching those most at risk.

In terms of implementation of key policies, GOT has initiated substantial policy revisions to move Tanzania closer to epidemic control. In March 2018, PrEP for key populations and discordant couples started to roll out. The government is working on addressing the legal barriers to self-testing so that it's integrated into a planned revision in the HIV/AIDS laws, which is anticipated in April 2018. For the differentiated Service Delivery Models (SDM) and Revised Treatment Guidelines, scale-up of same-day ART initiation has seen substantial progress in scope, scale, and fidelity in COP 2017 and will continue in COP 2018.

Scale-up of multi-month scripting with two-month ART prescription durations has been wide-spread. GOT has recently approved expansion of this to 3-month prescription durations, and that will scale-up be starting now and continue in COP 2018. To address gaps in human resources for health (HRH), the roll out of nurse initiated and managed antiretroviral therapy (NIMART) and SDM initiatives will be a focus for COP 2018 through implementation of the task sharing policy guided by the task sharing implementation plan 2017 which includes pre-service and in-service training through distance and blended learning approaches. Since the NIMART handbook was approved by the MoHCDGEC in March of 2018, preparatory work is ongoing during COP 2017 to allow for full roll-out in COP 2018 with the goal of ensuring that quality of patient care is maintained when nurses formally initiate ART. This includes the development of nursing NIMART CPD training modules, along with a training plan that will be used systematically to train nurses and midwives.

The major programmatic and system gaps and barriers to achieve epidemic control were assessed using the Sustainability Index Dashboard (SID), which is discussed in more detail in section 2.3. The findings from the 2017 SID shows that within the four critical domains (Governance, Leadership, and Accountability; National Health System and Service Delivery; Strategic Investments, Efficiency, and Sustainable Financing; and Strategic Information) 14 out of the 15 sub-elements scored yellow, while one scored red.

Tanzania's gross national income (GNI) per capita in 2016 was $900, which indicates limited income to accommodate health expenditures. Tanzania's total health expenditure (THE) was 5.2% of gross domestic product (GDP) and 12.3% of government spending in 2014, less than the Abuja declaration target of 15%. These indicators show the need for more funds to provide health services in Tanzania as both government and household spending on health is relatively low.[6]

[6] World Bank development indicator

Standard Table 2.1.1: Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	54,199,163	100	11,777,141	22	11,890,526	22	5,384,319	10	5,291,201	*10*	10,527,608	19	9,328,368	17	National Population Projections, Feb 2018
HIV Prevalence (%)		5.0		0.5		0.3		2.1		0.6		Not available		Not available	THIS 2016-2017
AIDS Deaths (per year)	33,822		2,956		3,091		1,329		1,322		8,859		16,265		UNAIDS Spectrum Estimates, 2017
# PLHIV	1,494,324		53,166		52,619		92,004		57,634		747,563		491,334		UNAIDS Spectrum Estimates, 2017
Incidence Rate (Yr)		0.29		Not available		Not available		0.29		0.14		Not available		Not available	THIS 2016-2017 and UNAIDS Spectrum Estimates, 2017
New Infections (Yr)	81,000														THIS 2016-2017
Annual births	2,017,606	Not available													National Population Projections, Feb 2018
% of Pregnant Women with at least one ANC visit	Not available	98	Not available	Not available			Not available	98.5			Not available	98			THIS 2016-2017
Pregnant women needing ARVs	97,876	Not available													UNAIDS Spectrum Estimates, 2017
Orphans (maternal, paternal, double)	2,303,582		Not available		Not available		Not available		Not available		Not available		Not available		THIS 2016-2017
Notified TB cases (Yr)	65,505		2,930		3,424		3,819		3,184		18,929		32,764		The National Tuberculosis and leprosy Programme__The 2016 Annual Report
% of TB cases that are HIV infected	21,627	100	806	4	884	4	837	4	678	3	8,298	38	10,124	47	The National Tuberculosis and leprosy Programme__The 2016 Annual Report
% of Males Circumcised	Not available	72			Not available	Not available			Not available	70			Not available	72	THMIS 2011-2012
Estimated Population Size of MSM*	49,700	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence	Not available	25													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated Population Size of FSW	155,450	N/A													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
FSW HIV Prevalence	Not available	26					Not available	Not available			Not available	Not available			Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated Population Size of PWID	30,000	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
PWID HIV	Not available	36													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July

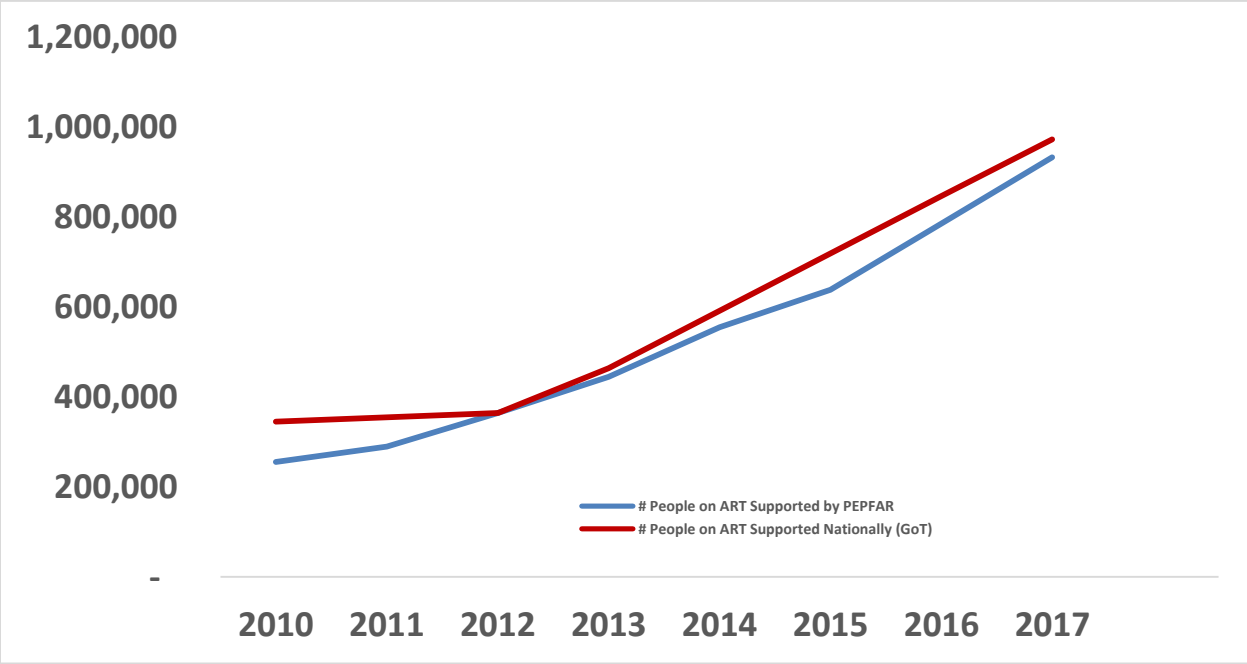
Prevalence															2014
Estimated Size of Priority Populations (Adolescent Girls and Young Women)	6,211,713	11.4													Calculations based on NBS (2018) projections
Estimated Size of Priority Populations Prevalence (Military Community)	61,632														Calculations based PEPFAR program data and partner information, FY 2017
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Standard Table 2.1.2: 95-95-95 Cascade: HIV Diagnosis, Treatment, and Viral Suppression

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year (2017)**		
	Total Population Size Estimate[7] (#)	**HIV Prevalence[8] (%)**	**Estimated Total PLHIV[9] (#)**	**PLHIV diagnosed[10] (#)**	**On ART[11] (#)**	**ART Coverage (%)**	**Viral Suppression[12] (%)**	**Tested for HIV[13] (#)**	**Diagnosed HIV Positive[14] (#)**	**Initiated on ART[15] (#)**
Total population	54,199,163	4.7	1,494,324	913,422	913,422	61%	84.0%	8,609,387	318,271	246,518
Population <15 years	23,667,667	Not available	105,789	54,837	54,837	52%	63.4%	1,590,979	15,075	12,769
Men 15-24 years	5,291,201	0.6	57,634	14,308	14,308	25%	66.1%	910,553	12,498	5,585
Men 25+ years	9,328,368	Not available	491,334	253,832	253,832	52%	85.0%	1,976,599	97,764	74,692
Women 15-24 years	6,211,713	2.1	92,004	46,641	46,641	51%	76.4%	1,457,358	41,029	25,718
Women 25+ years	10,527,608	Not available	747,563	543,804	543,804	73%	86.6%	2,673,898	151,905	127,754
MSM	49,700[16]	25%[17]	Not available	Not available	Not available	Not available	Not available	6,288	655	154
FSW	155,450[18]	26%[19]	Not available	Not available	Not available	Not available	Not available	161,796	16,128	12,667
PWID	30,000	Not available	Not available	Not available	Not available	Not available	Not available	5,512	119	54
Priority Pop (Military Community))	61,632	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

[7] National Population Projection, Feb 2018
[8] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[9] Spectrum estimates 2017 & Data pack COP18
[10] PEPFAR Program Data FY17
[11] PEPFAR Program Data FY17
[12] PEPFAR Program Data FY17
[13] PEPFAR Program Data FY17
[14] PEPFAR Program Data FY17
[15] PEPFAR Program Data FY17
[16] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
[17] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
[18] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
[19] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



2.2 Investment Profile

Tanzania's national HIV program is donor dependent. PEPFAR/T and the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM) are the two largest donors, contributing 98.8% of all public financing, according to the 2013-2014 Public Expenditure Review (2015) for HIV and AIDS. Moreover, the share of health sector (all areas of health) budget as a proportion of the total GOT budget has declined from 10.5% in 2010/11 to approximately 7% in 2017/18. The downward trend in proportion of the GOT budget going to health is concerning; the lack of funding for service delivery, HRH, and information systems could negatively affect the country's ability to achieve and sustain epidemic control. PEPFAR/T's investments in short term solutions, such as HRH remuneration, as well as longer term solutions outlined in Table 6, will enable Tanzania to overcome these challenges and will ensure continued movement toward epidemic control. The United Nations (UN) and World Bank provide a small proportion of additional funding. There are currently no other bilateral donors anticipated in FY 2019.

The total budget for HIV/AIDS for the COP 2017 implementation period was $707,544,743, which includes PEPFAR/T, GFATM, GOT and "other" funds, comprising 73.8%, 17.1%, 7.8%, and 1.3% of the budget, respectively. It remains to be seen how much of this total budget will be executed. In 2016/17, 13% of the funds budgeted for the arrears owed to the Medical Stores Department (MSD) were disbursed to MSD, and 20% of the planned budget was executed for ongoing procurement and supply chain management expenses. Notably, no domestic disbursements were made for the purchase of antiretroviral drugs (ARVs) in 2016/17, despite the GOT budgeting TZS 10 billion.

PEPFAR/T is currently working with the GOT to effectively implement its funding allocation for HIV. This collaboration will continue through FY 2019 as part of the ongoing strategy to increase the effectiveness and efficiency in the national response to HIV and AIDS. Health financing

activities in PEPFAR/T's above-site budget include working with the GOT to enable both good financial controls and "buying the right thing" to better match payment to priority services and increase efficiency.

The indicative allocation for HIV/AIDS from the GFATM for implementation in Tanzania from 2018-2020 is $408,487,081, which is inclusive of cross-cutting support for resilient and sustainable systems for health (~10%). Tanzania's funding request to the GFATM was effectively harmonized within COP 2017 and the GOT budgeting process.

PEPFAR/T, together with the GFATM will cover most of the funding needs for commodity procurement through FY 2019. In addition to ART (which is discussed in more detail in Section 4.4), this includes central funds to procure more than 13 million public sector condoms, as well as funding for 10 million condoms for a local social marketing organization to brand and distribute. This is complemented by the GOT, where $1.2 million has been budgeted for condoms in the current fiscal year. Furthermore, the GOT will continue to help finance the cost of commodity logistics in country. The GFATM will support $3 million in funding for condoms per year during the duration of their new year three.

The GOT supports most health worker salaries and other personnel emoluments for the delivery of HIV services. Despite this, Tanzania is experiencing a severe health worker shortage, impacting the ability of service delivery points to provide HIV and AIDS services. To ensure continued movement toward epidemic control PEPFAR/T fully funds the salaries of over 3,000 health workers, with Table 6 HRH activities focusing on long-term sustainable solutions. Based on a 2016 study of current practice in HIV service delivery, 47% of worker's time is devoted to HIV testing services (HTS), 27% to ART, and 24% to laboratory.

Recognizing the funding limitations in the context of a growing HIV care and treatment program, Tanzania's national strategic plans and funding proposal for HIV and AIDS have followed the UNAIDS investment approach, which prioritizes specific activities, populations, and geographies for maximum impact. The National Multi-Sectoral Framework (NMSF III), for example, prioritizes investments by intervention category, while the GFATM HIV and tuberculosis (TB) Concept Note prioritizes prevention activities for key and priority populations in the top ten high-prevalence regions. PEPFAR/T support prioritizes high-impact service delivery in the highest volume sites. Even in the context of prioritization for highest impact, as the number of PLHIV on treatment continues to grow, domestic resources will need to increase substantially to reach the Fast Track Goal by 2020. PEPFAR/T has reviewed a scale-up plan with Ministry of Health, Community Development, Gender, Elderly, and Children (MOHCDGEC) to achieve the Fast Track Goal and will continue to plan with the GOT, including the President's Office for Regional and Local Government (PO-RALG), and GFATM to determine resource needs based on this scale-up plan. In addition, PEPFAR/T is ensuring that goals are reached for specific sex and age disaggregation bands of targeted populations.

Standard Table 2.2.1: Annual Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area[20]

[20] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

Program Area	Total Budget	% PEPFAR (01 Oct 2017 – 30 Sept 2018)	% GF (01 Jan – 31 Dec 2018)	% Host Country (1 July 2017 – 30 June 2018)	% Other
Clinical care, treatment and support	$273,977,624	75.1%	21.7%	3.1%	0.1%
Community-based care, treatment, and support	$15,401,291	83.3%	3.1%	13.6	0%
PMTCT	$20,652,918	73.9%	0%	26.1%	0%
HTS	$40,962,599	92.5%	5.5%	0%	0%
VMMC	$56,156,748	100%	0%	0%	0%
Priority population prevention	$32,662,104	43.4%	21.1%	5.6%	7.1%
AGYW Prevention			22.8%		
Key population prevention	$14,797,753	53.5%	22.3%	24.2%	0%
OVC	$36,513,500	90.8%	0%	0%	9.2%
Laboratory	$29,619,939	28.0%	72.0%	0%	0%
SI, Surveys and Surveillance	$14,785,042	91.2%	8.8%	0%	0%
HSS	$41,666,235	74.7%	13.4%	3.7%	8.2%
Other	$130,358,990	66.5%	9.0%	24.5%	0%
Total	$707,544,743	73.8%	17.1%	7.8%	1.3%

Standard Table 2.2.2: Annual Procurement Profile for Key Commodities

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Budget	% PEPFAR	% GF	% Host Country	% Other
ARVs	$109,295,438	68.0%	32.0%	0%	0%
Rapid test kits	$11,249,508	81.3%	18.7%	0%	0%
Other drugs	$5,671,206	49.7%	50.3%	0%	0%
Lab reagents	$6,420,007	1.6%	98.4%	0%	0%
Condoms	$9,246,416	10%*	35%	50%	5%
Viral Load commodities	$9,957,305	39.3%	60.7%	0%	0%
VMMC kits	$5,527,564	100%	0%	0%	0%
MAT	$371,000	100%	0%	0%	0%
Other commodities	$21,825,838	22.5%	77.5%	0%	0%
Total	$179,564,282	56.3%	40.4%	3.3%	0%

* The PEPFAR/T COP contribution for condoms is coming from Central Funds, and is , therefore, not reflected in the COP 2018 budget

Standard Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives/Comments**
USAID MCH	$14,917,661	$3,142,222	5	$19,698,779	These activities are Boresha Afya – Deloitte, GHSC – PWC, PS3- Abt, RBF – WB and Tulonge Afya – FHI360
USAID TB	$4,813,860	$4,613,860	7	$26,173,043	These activities are RBF-WB, Tulonge Afya – FHI360,BIPAI-Baylor,Boresha Afya – EGPAF,Boresha Afya-Deloitte,Challenge TB-KNCV,GHSC-PWC.
USAID Malaria	$42,920,765	$5,215,200	6	$16,106,835	These activities are Boresha Afya –Deloitte,GHSC TA- PWC, Measure-UNC,Shops plus – Abt, RBF – WB, Tulonge Afya – FHI360.
USAID Family Planning	$25,581,180	$13,000,000	8	$58,985,110	These activities are Boresha Afya – EGPAF,Boresha Afya – Deloitte, GHSC TA– PWC, PS3- Abt, Sauti – JHPIEGO, Shops plus – Abt, RBF – WB and Tulonge Afya – FHI360
CDC (Global Health Security)	$2,000,000	$585,000	2	$500,000	Co-funding is for FELTP
USAID (Global Health Security)	$6,225,000	0	0	0	No co-funding
Peace Corps	2,663,333*	0	0	0	*Appropriated funds - $ 2,433,333 SPA funds - $30,000 Food Security/Feed the Future - $ 200,000
Total	**$99,121,799**	**$26,556,282**	**12**	**$121,463,767**	

Standard Table 2.2.4: Annual PEPFAR Non-COP Resources, Central Initiatives, PP, HOP

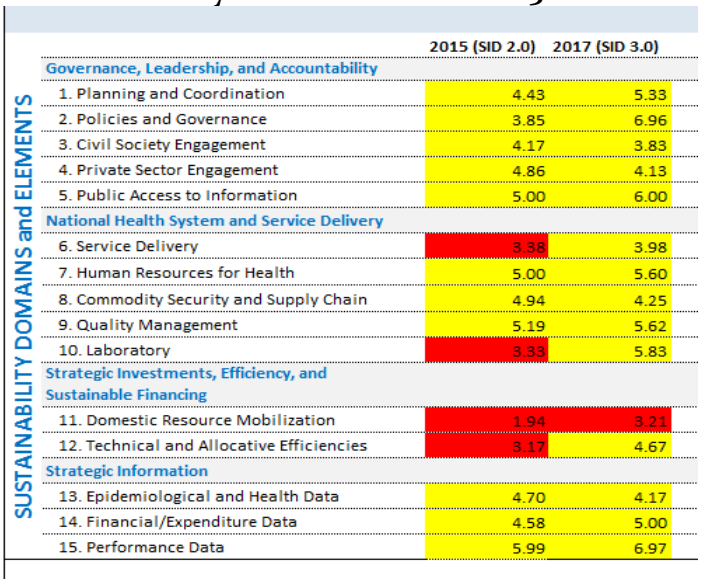
Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP*						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
DREAMS Innovation	$0	$0	$0	$0	$0	
VMMC – Central Funds	$0	$0	$0	$0	$0	
Other PEPFAR Central Initiatives	$0	$0	$0	$0	$0	
Other Public Private Partnership	$0	$0	$0	$0	$0	
Total	$0	$0	$0	$0	$0	

*** All headquarters funding is expected to be completed before the COP 2018 implementation period.**

2.3 National Sustainability Profile Update

The HIV/AIDS Sustainability Index and Dashboard (SID) is completed every two years by PEPFAR teams and partner stakeholders. The aim is to sharpen country-level understanding of the sustainability landscape and to guide informed HIV/AIDS investment decisions. The SID assesses the current state of sustainability of the national HIV/AIDS response across 5 domains that contain 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information as noted in Figure 2.3.1 below. As the SID is completed over time, it allows PEPFAR/T and stakeholders to track progress and gaps across these key components of sustainability. The SID 3.0 remains the guiding analytical document for assessing above-site level budgeting priorities in COP 2018.

Figure2.3.1: Changes in sustainability from SID 2.0 and SID 3.0



The SID 3.0 process was led by PEPFAR and UNAIDS but included participation from GOT representative agencies including the MOHCDGEC, the Tanzania Commission for AIDS

(TACAIDS), Ministry of Finance and Planning (MOFP), and National AIDS Control Programme (NACP). Other stakeholders who contributed included the CSOs, PLHIV representatives, private sector, and PEPFAR implementing partners. The composition of the stakeholders was tailored to enable in-depth discussions to occur in groups according to the four SID domains. In the stakeholders' dialogue it was agreed that SID 3.0 should be used by the various stakeholders to plan and make decisions on the country's future investments and should be reviewed on a more regular basis to update on our progress.

Sustainability Strengths:
The sustainability landscape in Tanzania, as demonstrated by both the SID 2.0 and SID 3.0 assessment findings, reveals several strong elements. Tanzania has demonstrated substantial progress in *Governance, Leadership and Accountability*, *National Health System and Service Delivery*, and *Strategic Information*. These areas directly reflect PEPFAR/T investments in COP 2016 and COP 2017 in the above site activities outlined in Table 6.

The *Policies and Governance* element within the *Governance, Leadership and Accountability* domain demonstrated the greatest improvement, largely resulting from the adoption of key policies and guidelines, such as the National Guidelines for the Management of HIV and AIDS (2017), the National Guidelines for Comprehensive Package for HIV Interventions for Key and Vulnerable Populations (2017); National Policies on Test and Start that streamlined same-day ART initiation; as well as emerging policies on self-testing and task shifting (2016). PEPFAR/T has worked closely with the GOT to develop implementation plans to implement these policies. Some critical areas under this domain that require increased efforts and attention will be described in detail under the section 6.4.

Another area that made substantial improvements compared to the previous SID is the element on *Laboratory Services* under the *National Health System and Service Delivery* domain. The laboratory element displayed tremendous gains due to implementation of the National Health Laboratory Strategic Plan II: 2016-2021. A National Health Laboratory Policy and a National Standards for Medical Laboratories Policy were also drafted. In FY 2016 and early 2017, there were insufficient laboratories and equipment to support the growing VL testing demand leading to inadequate VL testing capacity to meet targets. Despite initial obstacles, by the beginning of mid FY 2017, PEPFAR/T worked with the GOT to increase VL testing capacity from 475,000 tests per year (with 8 labs and 15 machines) to 2.2 million tests per year (with 17 labs and 30 machines). This expansion of laboratory services to support viral suppression is adequate to meet PEPFAR FY 2018 and 2019 targets. Highlighted in Section 6.3, in COP 2018 PEPFAR/T will continue to strengthen in-country laboratory capacity for viral load and EID testing as well as an efficient sample referral/transport and result feedback system. PEPFAR/T will also focus on supporting the establishment of linkage of viral load/EID testing laboratories to the Central Lab database including ensuring all VL testing laboratories have Laboratory Information System (LIS).

Under the *Strategic Information* domain, *Performance Data* and *Financial/Expenditure Data* elements demonstrated marked improvements, which are aligned to increased GOT efforts to strengthen information systems for data use and decision making. PEPFAR/T supported the implementation of the care and treatment center (CTC)3 database that assisted in deduplication, using the CTC2 identification (ID) without using personal identifiers at national level. The CTC3 database system will also act as a platform to support PEPFAR/T plans to incorporate HIV recency testing using point of care recency tests (POC-RT) into our routine HIV program activities by

quarter 3 of the current fiscal year. This will be rolled out country wide during COP 2018. This data system will ultimately improve the efficiency of the monitoring and evaluation (M&E) component of the program.

PEPFAR/T will be creating a system that enables utilization of patient level data in a real time to inform policy recommendations and resource prioritization to MOHCDGEC leadership. PEPFAR/T will work with MOH through the Registration Insolvency and Trusteeship Agency (RITA) to strengthen birth and death registration within the unique identification efforts in health care services, as part of the coordinating activities on national HIV implementation.

From the SID findings, the scores in the elements of *epidemiological and health data* under the domain of *Strategic Information* fell from 4.70 to 4.17, with a modest incremental rise in the remaining elements. PEPFAR/T will therefore use the Data Use Strategy and establish national systems and standard practice to improve dissemination products, feedback, district profiles to support use of data to inform HIV service planning. This will include M&E and health management information systems (HMIS) strengthening to improve data quality and MOHCDGEC leadership to incorporate new features to support integrated GOT and PEPFAR data systems. The purpose is to ensure synchronization of PEPFAR and GOT information systems to improve data sharing and use for decision making as well as improve data quality and MOHCDGEC leadership to incorporate new features to support integrated GOT and PEPFAR data systems.

Sustainability Vulnerabilities:
The *Sustainability Index Tool* employs a scoring system that generates responses to the specific questions under each domain and element, with a possible maximum of 10 points. The strongest scores are coded dark green (8.5- 10 points) and represent sustainability strength, while the next category is light green (7.0- 8.49), moving to yellow scores (3.50-6.49), and finally to the weakest score (less than 3.5 points). The lower scores demonstrate areas of vulnerability that require continued investments, while the higher scores (light and dark green) demonstrate areas of improving sustainability- this requiring limited investment.

Over the past 2 years (2015-2017), Tanzania has not been able to score within the green color range (7-10 points) across the four critical domains. There are several yellow scores representing areas of emerging sustainability and key vulnerabilities. While marginal improvements have been made in the domain related to *Strategic Investments, Efficiency* and *Sustainable Financing*, this was the weakest scoring domain across the sustainability landscape**.** National budgets do include funding for HIV/AIDS, but the overall ability to ensure that sufficient resources are committed to meet the needs in Tanzania remains a continual challenge**.** Only a small percentage of the national HIV response is financed with domestic resources. Data on government resources allocated to highest burden geographic areas is unavailable, and the latest HIV/AIDS Public Expenditures Review (PER) has not been updated, since it was last conducted in 2013/14. The ARV benchmark pricing is not applied by the government because of total dependence on the United States Government (USG) and GFATM for ARV procurement.

The fiscal environment, together with the elements of *Domestic Resource Mobilization* and *Technical and Allocative Efficiencies***,** is currently unsustainable, meaning that Tanzania does not adequately generate the necessary financial resources for HIV and AIDS, ensure sufficient resource commitments, and use data to strategically allocate funding and maximize investments.

Highlighted in Section 6.5, in COP 2018, PEPFAR/T will continue to support GOT efforts to roll out a national health insurance program. To improve efficiencies, PEPFAR/T will assist GOT to shift to output based payments to the facility level, ensuring LGAs receive timely disbursements from MOFP to enable HIV service delivery

Private sector engagement within the *Governance, Leadership and Accountability* domain witnessed a significant drop. While there is reasonable engagement with private health service providers and private training institutes, employers and the commercial sector have not been forthcoming in supporting HIV and AIDS efforts, as there have been fewer incentives for private sector to be engaged for the needed support. Highlighted in Section 6.4, PEPFAR/T activities proposed for COP 2018 will renew direct engagement with a broad range of commercial companies to find ways in which they can support increased testing among men in their workforce and to explore ways in which PEPFAR-funded IPs and private health providers can be linked to these companies. Small private pharmacies, Accredited Drug Dispensing Outlets (ADDOs), which are often the first source for medicines for people in rural and underserved areas, will be supported in the dispensing of multi-month ARV prescriptions and providing assisted self-testing upon the government's change in policy.

The *Commodity Security and Supply Chain* element also exhibited a decline over the two years of assessment. However, critical efforts during the past two years, such as the holistic supply chain review, (a joint collaboration with the GFATM), the development of a National HIV Supply Plan, and direct support to the Logistics Management Unit within the MOHCDGEC yielded positive results. Nevertheless, the review revealed weaknesses not previously identified which lowered the score for supply chain maturity. There continues to be unsustainable dependence on the USG and GFATM for supply chain and commodities financing. Highlighted in Section 6.6, in COP 2018 PEPFAR/T will continue to provide technical assistance (TA) to strengthening supply chain performance management in facilities providing HIV services, as well as national level institutions. Prior support has produced a significant increase in the availability of products at the MSD, councils, and facilities. PEPFAR/T will continue to support restructuring the supply chain system design that will enhance supply chain data analytics to both improve performance and streamline distribution. PEPFAR/T will also assist the Pharmaceutical Services Unit (PSU) to work with performance metrics, to be used to hold MSD and facilities accountable to a minimum standard of service.

The *Civil Society Engagement* element under the *Governance, Leadership, and Accountability* domain has also seen marked decreased from SID 2.0 to 3.0. Civil society engagement has been limited, especially in relation to their roles in bridging the gap between the community and service providers, which can help address quality of service delivery, stigma and discrimination. These limitations have been due to a lack of proper coordination, collaboration, involvement and proper documentation between the various GOT and community structures. Nonetheless engagement is critical to ensure the voices and contribution of the community, including PLHIV are heard, channeled and included during various GOT planning and budgeting. CSOs also have a vital role to substantively impact policy, programming, and budget decisions related to HIV/AIDS through dissemination of information, through policy briefs and advocacy using various media outlets and forums. In COP 2018 PEPFAR/T will strengthen the capacity of local CSOs as agents for change in service delivery provision, advocacy, and as a key stakeholder to inform the national HIV/AIDS programing and response. PEPFAR/T will build capacity of CSOs in data driven advocacy for health services and to ensure there is an enabling policy environment

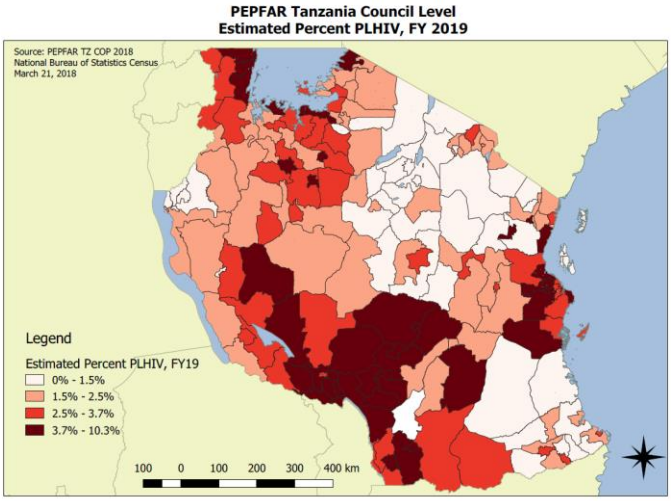
to govern HIV/AIDS service delivery which are inclusive. PEPFAR/T will also continue to work with CSOs in the reduction of stigma and discrimination, which acts as a barrier for PLHIV to access HIV care and treatment that is important for sustainability purposes.

Although it's SID 3.0 score improved, HRH remains a vulnerability. PEPFAR/T has developed an HRH Sustainability Plan to map current and future investments for sustainability and shared responsibility for HRH by the GOT. Funding for health care workers (HCW) supports epidemic control by ensuring appropriate levels of human resources across the HIV care continuum, particularly at the community level in scale-up councils. Highlighted in Section 6.2, in COP 2018, PEPFAR/T will strengthen retention mechanisms to ensure HCWs are motivated, to decrease the constant flux of HCWs. PEPFAR/T is supporting the implementation of the Task Sharing policy, in conjunction with the differentiated HIV SDM. In COP 2018, PEPFAR/T will improve the efficiency of HRH allocation through Workload Indicators for Staffing Needs (WISN), Prioritization & Optimization Analysis (POA), and Workforce Allocation Optimization (WAO) tools. The continued implementation of the task sharing policy guided by the task sharing implementation plan 2017, full roll out of NIMART and SDM initiatives, will be a focus for COP 2018, including pre-service and in-service training through distance and blended learning approaches.

2.4 Alignment of PEPFAR investments geographically to disease burden

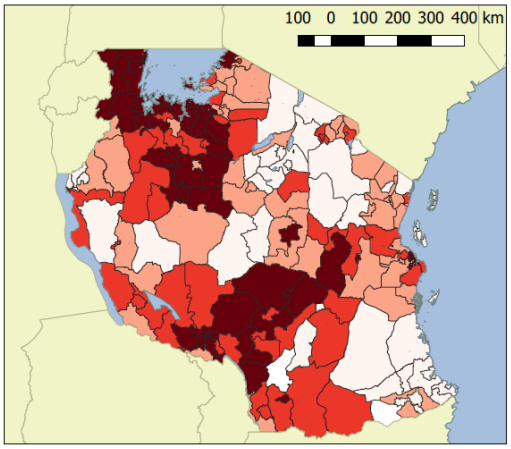
As noted in section 2.1, PEPFAR/T is using THIS results on regional estimates of PLHIV to adjust geographic focus of both clinical and prevention activities in the current fiscal year. To further guide these geographic and programmatic strategy revisions, planned COP 2018 spending was matched with PLHIV across the planned expenditures positively align with the estimated PLHIV by council. As displayed in Map 1, a higher number of PLHIV are found in the Lake Zone and Southern Highlands, and higher amount of COP 2018 planned expenditures will be invested in corresponding geographic areas. Maps 2 and 3 compare the number of PLHIV by council as compared to the planned COP 2018 expenditures by council to demonstrate that program funds and activities will be channeled to areas with the highest HIV burden.

Map 1:



Tanzania: Alignment of PEPFAR Investments Geographically to Disease Burden

Map 2: Number of People Living with HIV (PLHIV) by Council

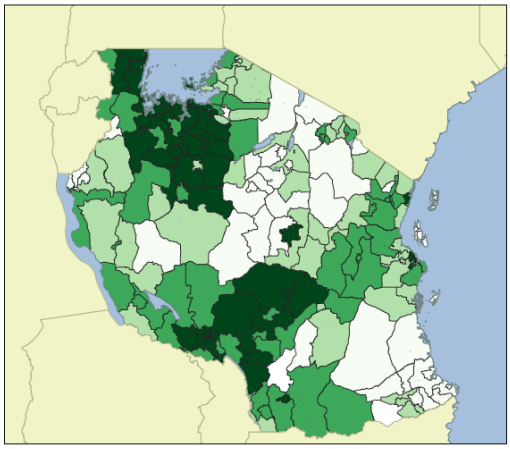


Legend

Estimated Number of PLHIV, FY19 [193]

- 299 - 3,221 [48]
- 3,221 - 5,888 [48]
- 5,888 - 9,872 [47]
- 9,872 - 48,935 [48]

Map 3: Total COP18 Planned Expenditures by Council



Legend

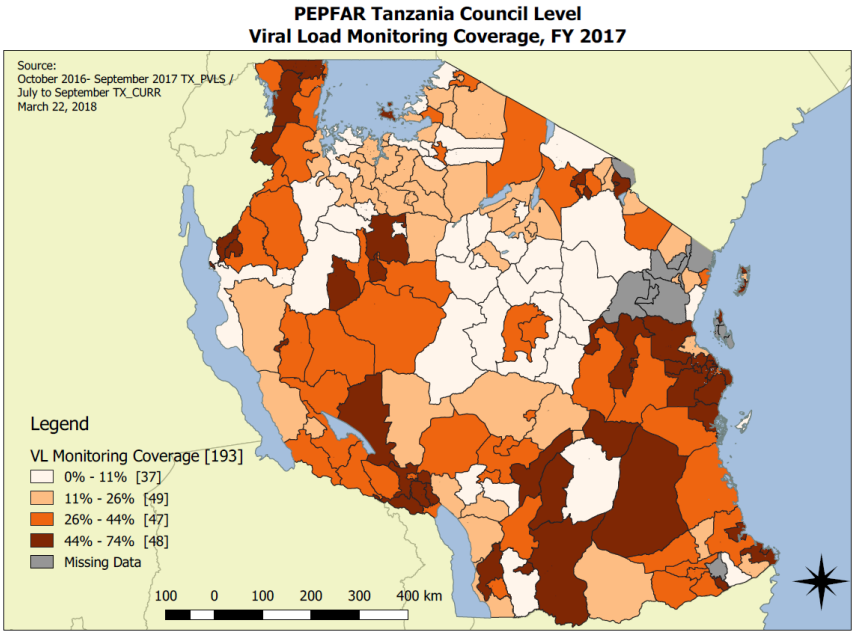
COP18 Planned Expenditures [193]

- $34,323 - $424,804 [48]
- $424,804 - $910,996 [48]
- $910,996 - $1,825,262 [47]
- $1,825,262 - $10,800,000 [48]

Source: PEPFAR TZ COP 2018
March 19, 2018

Map 4 below portrays viral load coverage at the council level. PEPFAR/T has worked hard over the last year to scale-up viral load capacity. Continued emphasis will be on ensuring that sample transport systems that are aligned with HIV burden.

Map 4:



2.5 Stakeholder Engagement

Engagement with external stakeholders to develop COP 2018 began in December 2017 when PEPFAR/T held a quarterly meeting with implementing partners, CSO representatives, development partners, UN agencies, and GOT representatives. THIS 2016/2017 results were presented and discussed along with anticipated ramifications on COP 2018 planning and priorities. Shortly thereafter, the draft COP 2018 Guidelines were shared, and these stakeholders were encouraged to provide feedback to the Office of the U.S. Global AIDS Coordinator (OGAC) through the designated channels.

In early January PEPFAR/T led a workshop alongside the National Bureau of Statistics on small area estimation to extrapolate national PLHIV estimates to the regional and council level. GOT, UNAIDS, and PEPFAR staff participated in the exercise. This was followed by participation in UNAIDS' Spectrum workshop (which incorporated THIS findings) to come to consensus on the PLHIV estimates which would be used for target setting for COP 2018.

The week of January 29th, PEPFAR/T held a COP 2018 Strategic Planning Workshop during which COP priorities were shared and the various COP inputs and tools were discussed. Representatives from the GOT, bilateral and multilateral development partners, including GFATM and civil society were integrated with the PEPFAR/T headquarter and Tanzania-based technical teams throughout this process. Attention was paid to building consensus around the strategic objectives and approaches to be used in the funding allocation to strategy tool (FAST). Focus was

also given to reviewing and discussing THIS findings, program data, and identifying key gaps and challenges for programmatic focus.

Focused engagement with CSOs took place after the forming of a CSO consortium that was dedicated to COP 2018. The PEPFAR Coordination Office attended their kick-off meeting and was able to present COP 2018 priorities as outlined in the COP Planning Letter. CSOs subsequently went through a democratic process to elect three representatives to attend the COP 2018 RPM in Johannesburg. Representatives from UNAIDS and the PEPFAR Coordination Office worked with these representatives through a series of meetings to help ensure that they understood the COP priorities. Since the RPM, the CSOs shared draft language on their priorities for integration into the strategic direction summary (SDS) and convened to debrief on the meeting and to review the SDS and provide input. PEPFAR was represented at this meeting to answer questions and to continue to discuss CSO priorities and their role in helping to support COP 2018 implementation.

In preparation for COP 2018, two of the major private health sector associations – the Association of Private Health Facilities of Tanzania (APHTA) representing for-profit private health facilities, and the Christian Social Services Commission, representing the majority of faith-based health facilities in Tanzania – were consulted individually to ascertain their perceptions of HIV/AIDS work in Tanzania. Their considerations were integrated into COP 2018 strategies. Furthermore, in both the kick-off meeting and the follow-up meeting, the informal sector, which is a component of the private sector, was present and involved. Specifically, a representative from the Tanzania Informal Economy Network on AIDS Initiatives (TIENAI) was vocal in offering suggestions about working with the informal sector, especially to reach men. TIENAI also provided formal feedback on the draft SDS sent to stakeholders for input.

The GOT selected three representatives to attend the RPM, one of whom was from TACAIDS, one from NACP, and one was the Honorable Deputy Minister of Health himself. Several pre-meetings were held with the Government to discuss policy and program issues that would be at the forefront of RPM discussions. PEPFAR/T will continue to engage CSOs, GOT, UN Agencies, and other stakeholders in quarterly meetings to examine data and progress on policy implementation and program activities to identify priority action items and seek out best practices to bring to scale. Since the RPM, PEPFAR has continued to engage regularly with the GOT in both high-level and technical settings and has seen movement in key policy areas as discussed throughout this document. A monthly meeting between the U.S. Embassy Front Office and the MOHCDGEC Front Office has been planned to share and review monthly PEPFAR data, review policy adoption and implementation, and review program implementation.

The GFTAM was also involved in the Johannesburg RPM. PEPFAR continues to regularly engage with GFTAM to coordinate commodity procurement and supply chain as well as to ensure that program activities are complementary.

3.0 Geographic and Population Prioritization

Based on information for the THIS, Tanzania revised council classification from seven councils achieving attained status to 11. This represents 11% of the national HIV burden, up from 3% in 2017. There has also been an increase of scale up councils from 81 in 2017 to 94 representing

70.4% of national burden. There are now 87 Sustained Councils representing 18.4% of the national HIV burden.

PEPFAR/T is currently operational in 199 councils in the country, with a passive enrollment approach in 87 Sustained Councils. PEPFAR/T has realigned its investments to better correspond with the epidemiology and recent THIS data, and has prioritized investments to increase identification, yield and ART coverage, as well as adherence and retention on ART. The THIS demonstrates that there are large gaps across all age and sex groups, and throughout all regions of the country. To address broad gaps, PEPFAR/T will scale up a package of interventions described in detail in the next section. Additionally, the THIS did find that important gaps that require specific focus. In 2018, PEPFAR Tanzania is prioritizing men, adolescent girls and young women, pregnant and breastfeeding women. In addition, the program will focus on key and priority populations to address the unmet need to achieve epidemic control in the councils with the highest HIV, including four metropolitan cities. PEPFAR/T reviewed epidemiologic data and burden of disease at the council level, including population density and total number of PLHIV and unmet need for ART. PEPFAR/T also took into consideration the location of key and priority population and hot spots. Given the need to balance the joint goals of accelerating the elimination of mother-to-child transmission of HIV and attaining sustained epidemic control in scale-up councils, PEPFAR/T also prioritized diagnosis and rapid/same day ART initiation for all male and female clients found to be HIV-positive across all population and age groups including pregnant women and infants identified through EID. COP 2018 builds on the programmatic shifts operationalized in COPs 2015, 2016 and 2017 and uses the new THIS results to focus efforts on the councils with the highest HIV burden to get maximum impact per dollar.

PEPFAR/Tanzania continues to prioritize VMMC in councils with low male circumcision coverage and high HIV prevalence including the DREAMS districts. The COP 2018 strategy is to maintain high coverage among 10-29-year-old males in councils where circumcision coverage already exceeds 80% and achieve 80% coverage in councils where circumcision coverage is lower. By the end of FY 2018, PEPFAR/Tanzania will have supported 3,380,984 circumcisions and by end of FY 2019 the cumulative number of VMMC performed is expected to be 4,129,834. In COP 2018, PEPFAR/T will expand VMMC coverage in 25-29-year-old men – where there has been a programmatic gap - through focused demand creation that addresses structural and accessibility challenges for that age group. This is described in more detail later in the document. In addition, PEPFAR/T will expand EIMC in key sites in all priority councils. Working with UNICEF, sustainability models for both adult and early infant VMMC programs are being implemented to provide a long term approach to service provision.

Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP 2018**	**# Current on ART (FY 2018)**	**# of SNU COP 2017 (FY 2018)**	**# of SNU COP 2018 (FY 2019)**
Attained	164,540 (11.0%)	42,721	7	11
Scale-up Saturation	1,055.646 (70.4%)	665,757	81	94
Scale-up Aggressive				
Sustained	276,350 (18.4%)	169,591	86	87
Central Support				
N/A		59,098	16	

4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

The THIS data demonstrate that gaps in case finding are large across all age and sex sub-groups and all geographic areas. In 2017, 248,549 people were newly initiated on ART, of the 319,168 clients who tested HIV positive. The THIS data show that while identification is poor broadly, the gap is even larger among some sub-populations, especially men. Program and THIS data demonstrate that EID and viral suppression in pediatric patients continues to be very low. Finally, program data suggest that HIV testing yields have been falling over the past several quarters, suggesting a need for more evidence-based targeting of interventions.

This section will highlight the key strategies that are employed by PEPFAR/T to address gaps and challenges across the populations with unmet needs.

4.1 Finding the missing, getting them on treatment, and retaining them

In FY 2019, PEPFAR/T aims to identify 308,176 new patients, enroll 283,259 on treatment and provide 1,316,609 patients with ART. This represents an increase in national ART coverage to nearly 90% of all PLHIV and contributes to the 90% adult and 90% children ART coverage targets by end of 2018 in the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III). Based on these targets, the prioritized scale-up to saturation councils should at least reach 90% coverage of PLHIV by annual program report (APR) 2019. After incorporating new geographical data based on the THIS, there are 27 SNUs out of 86 that have been moved from sustained to scale-up with a an estimated 100,000 PLHIV not on ART. PEPFAR/T employed a cascade approach to setting HIV testing targets and considered several critical program streams to most efficiently identify HIV-positive individuals and effectively link them to care and treatment. For COP 2018, PEPFAR/T will address the broad gaps in coverage across age and sex bands through enhanced, evidence-based implementation of 3 key aspects of HIV case finding: index testing, PITC, and community-based testing. The proportion of positive results coming from index testing increased from 1% in FY 2017 Q1 to 17% in FY 2017 Q4. PEPFAR/T will continue to increase coverage and fidelity of index testing to achieve at least 30% of all HIV-positive people being identified through index testing modalities in FY 2019. Specifically, partners will scale-up assisted partner notification to support index client testing. A national training curricula and materials for index testing will be developed and rolled-out and will include HIV self-testing and linkages to care. PLHIV peer navigators will be deployed to facilitate index testing as part of linkage case management services. Epidemiologic outbreak and contact tracing approaches will be adapted to identify sexual partners of new PLHIV as identified.

Index testing will accelerate progress broadly but will especially help to close the gap in men, since most HIV positive results are currently among women. For PITC, PEPFAR/T will scale-up the Bukoba Combination Prevention Evaluation (BCPE) approach for PITC to facilities with both high numbers of HIV positive test results and high yield to ensure that PEPFAR/T maximize the value from this investment.

Bukoba Combination Prevention Evaluation

BCPE is a provider-initiated HIV testing and counseling intervention implemented in the outpatient department and at reproductive and child health clinics. Expert clients are used to provide information and screen patients to refer those who are high-risk for testing. Counselors provide the testing, but the expert clients handle linkage and case management services. There is also a peer delivered component for persons diagnosed in community-settings.

This approach uses a more rigorous, centralized process within the facility to minimize the number of people who are missed by the various HIV testing points in the facility. In lower-yield facilities and venues, PEPFAR/T will implement screening before testing to focus testing on persons with HIV risk or medical symptoms. The result of this effort will be to increase yield for PITC, which have had quarter on quarter declines for at least 5 quarters, compared to Q4 2017 and Q1 of 2018.

Furthermore, PEPFAR/T will target community testing in high-risk areas informed by mapping of KP hotspots and concentrations of PLHIV. For community testing, PEPFAR/T will focus on areas with high HIV burden within SNUs, as well as areas with large numbers of key populations. PEPFAR/T will also use the risk and symptom-based screening approach to focus testing on higher-risk persons. The result of these interventions will increase yield and decreased testing in low burden areas. Data from PEPFAR/T community activities in COP 2016 and COP 2017 demonstrate that this strategy is higher-yield for men than is facility testing. So, while this approach will have broad benefit in closing HIV case finding gaps, it is especially important in finding men.

In addition, to effectively target community-based HTS activities, PEPFAR/T will integrate night time and moonlight testing activities to better reach key populations and communities surrounding KP hot spots. Deploying a multi-disease approach by providing concurrent STI, FP, cervical cancer screening, and primary health care services alongside HTS will help reduce stigma in accessing HTS services at the community level. Mobile clinic trucks providing comprehensive HIV services, including clinical and lab services, will help ensure services can be accessed in hard-to-reach communities. Targeting key and priority populations using a social network approach will help strengthen community support systems for testing, linkage, and retention. Biometric finger print scanners will be introduced to minimize double-counting of people who frequently re-test. Finally, HTS providers will conduct competency assessments of non-laboratory HIV rapid testers in community settings as part of the national certification program to ensure the quality of HIV rapid testing.

PEPFAR/T aims at scaling-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV. PEPFAR/T will also strengthen and support PLHIV support groups and networks to improve overall quality of services to increase retention and achieve viral suppression for both adults and children living with HIV. Given the high burden of TB/HIV co-infection in Tanzania, high rates of tuberculosis (TB)-related mortality in PLHIV, and the accessibility of these patients through existing PEPFAR-supported care programs and TB clinics, PEPFAR/T has committed to increase comprehensive TB-HIV services with focus on scaling up fidelity of TB screening for improved TB case detection, treatment of co-infected individuals, and providing isoniazid preventive therapy (IPT) to all eligible clients. To achieve this, PEPFAR/T will address challenges at multiple levels including Isoniazid supply chain, laboratory diagnostics with GenXpert, and site-level tools to support implementation.

4.1.1 Adult men

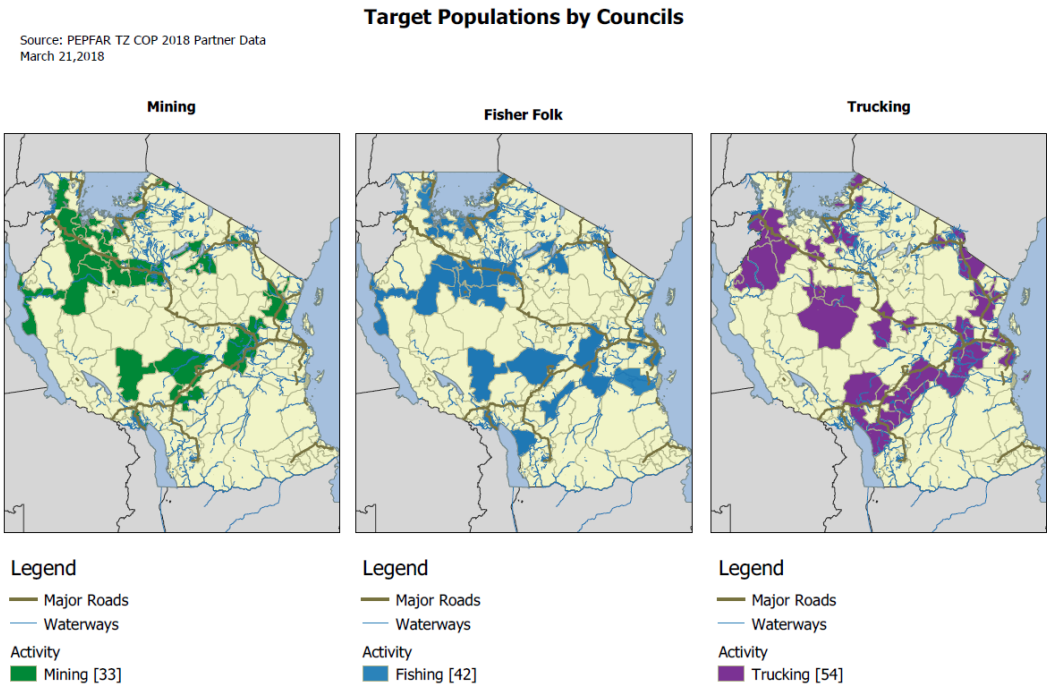
Based on the program and THIS 2016-17 data, PEPFAR/T continues to struggle with identification of HIV-positive men and initiating these men on treatment. Also, the findings from the THIS data show a high HIV burden in metropolitan municipalities. Young adult and adolescent males are a

population that has been least reached by PEPFAR/T programs as of FY 2017, despite relative success in VMMC. Index testing is an approach PEPFAR/T will employ to increase identification of males. In the context of observed declines in scale and fidelity of index testing overall in Q1 of 2018, PEPFAR/T has examples of favorable trends from some partners who have demonstrated a 3 to 4-fold increase in number of index clients tested while also showing increasing yield. Data shows a very high yield on testing men after working hours ("moonlight") through clinics and community testing, BCPE and testing of male partners of AGYW who are reached by DREAMS. PEPFAR/T will scale up these interventions. Additionally, through reaching FSW and vulnerable AGYW the program will reach and test sexual contacts and their partners as well as HIV self-testing and link them to services. Finally, targeted testing through private sector workplace programs has demonstrated success to improve HTS access among men. In collaboration with the Association of Private Health Facilities in Tanzania (APHFTA) PEPFAR/T will intensify this approach. PEPFAR/T will also explore working through the informal sector – which is a component of the private sector – to better reach men.

PEPFAR/T's FY 2017 annual report showed that viral suppression among men is low, at 66.1% and retention proportions, at 74%, need improvement. Poor retention and loss-to-follow-up among men are often due to long facility waiting times, long travel distances to facilities, facility operating hours conflicting with work schedules, and stigma in seeking health services. To improve retention, PEPFAR/T will build on COP 2017 efforts to make clinics more "male-friendly" by extending operating hours, enhancing adherence counseling, especially for men with poor viral load results, and use of peer support for close follow-up including appointment reminders to help ensure clients don't miss their appointments. Roll out of the differentiated service delivery model that includes multi-month prescriptions and ART outreach services that reach men will help eliminate the need to go to clinics monthly.

4.1.2 Focusing on cities with high burden

Based on information obtained from the THIS 2016/2017, overlaid with population density derived from census projection, program data and other key variables available during COP 2018 planning, seven metropolitan centers (Mwanza, Tanga, Geita, Tabora, Mbeya, Dar es Salaam and Njombe) were found to have high HIV burden. Four of these cities – Dar es Salaam, Mwanza, Mbeya, and Tabora – are currently the focus during FY 2018, while the remaining three cities will receive focus during FY 2019. In these cities, PEPFAR/T will scale up testing at high-yield and high-volume facilities, underserved slum areas, hotspots and in private facilities. This will also include community testing for fisher-folk, miners, 'Bodaboda' drivers and other mobile populations who play an important role in ongoing HIV transmission. The map below shows the geographic location of mining, fisher folk, and truckers along major routes. This information will help PEPFAR/T target the appropriate cities and towns to reach these at-risk, and hard-to-find groups.



4.1.2 Adult women

In the THIS, 45% of women with HIV reported not knowing their HIV status. In the context of a country with 98% of pregnant women attending their first antenatal care (ANC) visit, and a fertility rate of 5-6%, this defies expectations. However, PMTCT program data from FY 2018 Q1 shows that 346,198 pregnant women attended their first ANC visit, of whom 99% (344,069) received HIV testing. For those who tested HIV-positive, 99% (15,682/15,830) received ART for PMTCT.

PEPFAR/T considered many possible hypotheses to understand discrepancies between THIS 2016/17and programmatic data, as the above data suggests low known status in women cannot be explained by ANC1 data. The plans below therefore focus on other strategies for addressing gaps in case-finding in women, including increasing the uptake of late pregnancy and post-pregnancy HIV testing, in part through use of the DPT1 visit to identify women who should be tested. One possibility is that some women are either sero-converting or contracting HIV after their first ANC visit. This possibility is supported both by emerging data on heightened susceptibility to new HIV infection in late pregnancy and post-partum, as well as gaps identified in program data. For example, according to the Tanzania Demographic and Health Survey 2015-16, although coverage of the first ANC visit was 98%, while coverage at the fourth visit was only 51%. Furthermore, only 64% of births occur in facilities. To address ANC visit attrition rates, PEPFAR/T aims to enhance promotion of ANC attendance for subsequent visits through counseling, follow-up, and demand creation, strengthen HIV prevention messaging to pregnant women and breastfeeding mothers, and use the infant immunization platform (the DPT1 visit) to test women who were missed or those who have not been retested after a negative first test during pregnancy. This strategy will be implemented judiciously using a phased-scale-up approach to ensure that the strategy is monitored for best practices and lessons learned. This will help ensure success and minimize

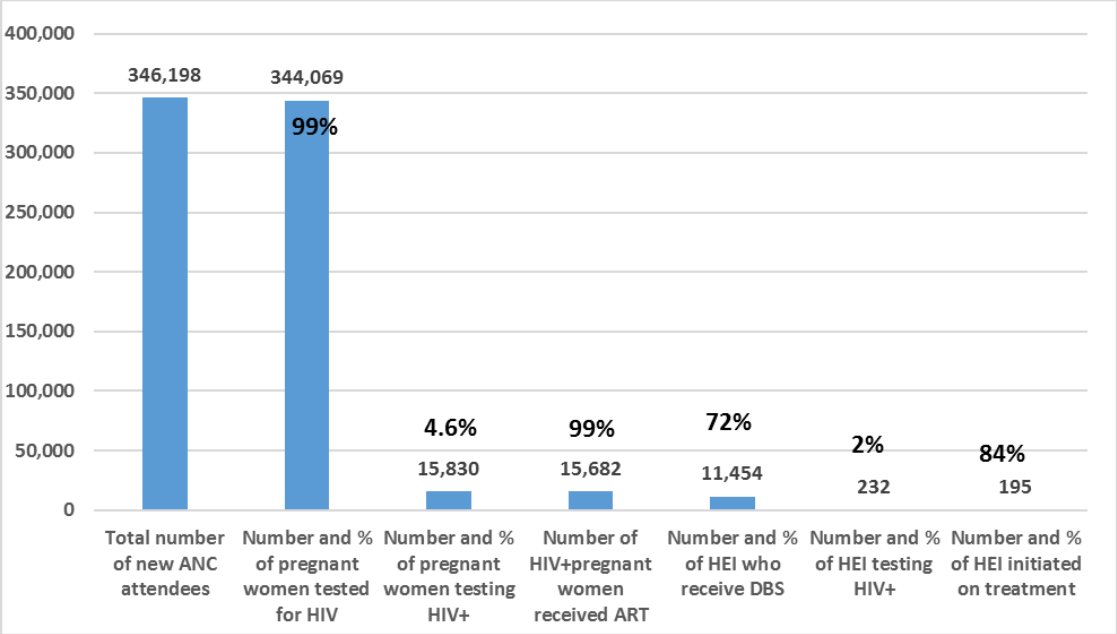
chances of disrupting the immunization program. PEPFAR/T will continue to improve counseling to promote retention in PMTCT and ultimately transition to and retention in care and treatment to achieve viral load suppression among beneficiaries of PMTCT. Furthermore, PEPFAR/T will enhance integration of family approaches, gender-based violence (GBV) services, cervical cancer screening, and index testing of male partners with HIV testing services and referrals. Lastly, PEPFAR/T will continue to closely monitor the roll-out of standard operating procedures that address data quality concerns in the PMTCT program.

4.1.3 AGYW/KP See section 4.2.4 for details

4.1.4 Pediatrics

Both program and THIS 2016-17 data shows major gaps in reaching pediatric populations, low yield of HIV testing and viral suppression. PEPFAR/T reached only 58% of the annual target for EID, with only 73% of HIV-exposed infants being tested for HIV. Based on FY 2018 Q1 results, the number of pregnant women testing HIV-positive was 15,830, and the number of HIV-exposed infants with DBS collected was 11,454, which is 72% of the eligible infants. Of these 232 tested HIV-positive, and 195 (83%) were initiated on ART. The figure below shows the complete PMTCT and EID cascade.

PMTCT and EID Cascade from FY 2018, quarter one



Challenges contributing to this attrition include reporting issues, skilled human resource shortages, missed opportunities to utilize immunization platforms to identify HEI who require EID services, and sub optimal use of peer mothers to track lost to follow up clients. This issue was specifically highlighted in the COP planning letter and is addressed in more detail in section 4.3.

In brief, PEPFAR/T is working to ensure EID sample collection at the first immunization visit for all HEI. We will also support LGAs and IPs to ensure that all PMTCT sites are equipped to provide EID services and using peer mothers to track lost to follow up. Furthermore, PEPFAR/T

will scale-up use of GenXpert – near point of care (POC) - for EID testing to address long turn-around time and low coverage challenges. IPs will continue to support mentorship and supervision on use of mother cohort register to improve EID data quality. Furthermore, PEPFAR/T plans to leverage OVC platform to increase HEI referrals for EID.

PEPFAR/T will scale-up with fidelity, PITC at inpatient and malnutrition wards and increase use of the Bandason screening tool already used in some outpatient wards and high-volume facilities. The tool will be modified to optimize sensitivity/specificity for local settings before being rolled-out to all sites. PEPFAR/T will strengthen pediatric and adolescent friendly services to improve retention and viral suppression.

PEPFAR/T plans to scale-up testing of biological children of people with HIV through scale-up of index testing as a core intervention. PEPFAR/T will also scale-up testing children of HIV-positive female sex workers and women who inject drugs. The OVC program will be leveraged as an entry point for identifying and testing children most at risk children through the screening tool. OVC community case managers will be used to support linkages from the community to the facility through escort referrals and track loss to follow up.

Viral suppression is another key area of focus for children and adolescents in light of the 2016-17 THIS finding that only 18% of children aged 0-14 years are virally suppressed. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T will also expand use of age/weight appropriate dosing including providing advocacy and roll-out support to the GOT during the TLD transition for children weighing >30kg. This will include site mentorship to ensure HCWs understand and are confident on ART dose adjustment. PEPFAR/T will conduct site-level cascade analyses to assess adolescents and children for early identification of non-suppressed individuals and ultimately provide enhanced adherence counseling through pediatric and adolescent friendly services to improve viral suppression.

4.1.5 Retention

As of Q4 2017, Tanzania had a high loss-to-follow-up among PLHIV, with a 12-month retention rate of 74%. Some reasons for losses to follow-up include long facility waiting times, and distance to and from facilities. In some instances, a person who appears to be lost to follow-up has not actually been lost, but instead has self-transferred to another facility or is registered at multiple facilities without program knowledge. Finally, defaulter tracing has been sub-optimal, as data on people lost-to-follow-up from partners identifies the majority of them as "lost", without further explanation.

To improve retention, PEPFAR/T plans to connect new clients to peer support for close follow-up, and to trace those who miss their appointments before they get lost. PEPFAR/T will also support scale-up of the use of SMS reminder messages to reach out to clients who miss their appointments. Multi-month scripting up to three months and block appointments will reduce service waiting times and costs for clients especially for those who live far from the facilities. Additionally, PEPFAR/T will work with GOT to strengthen documentation of transfer in and out of clients at facilities and implement unique identifier to capture clients that register at multiple facilities. We note that the planned adoption of tenofovir, lamivudine, and dolutegravier (TLD) may also improve retention due to fewer side effects.

For adolescents and children, PEPFAR/T plans to strengthen pediatric and adolescent friendly health services to address the PHIA gaps across the three 90s with regards to reaching and retaining young people in care. The expansion of adolescent friendly health services (AFHS) within select PEPFAR high volume sites will ensure that both HIV-positive and HIV-negative adolescents have access to appropriate information and quality services from testing to psychosocial support to adherence counseling to care itself. The table below highlights the scale-up councils in which AFHS will be prioritized. AFHS, including adolescent clubs and peer treatment support groups, will be strengthened to reach more adolescents for HIV prevention and risk reduction and will include components to retain ALHIV in treatment. All AFHS and priority population scale-up will be done in consultation with GFATM and other key development partners.

AFHS Scale-Up Councils		
Ilala	Dodoma MC	Mbarali
Kinondoni MC	Manyoni DC	Tunduma TC
Magu	Igunga DC	Kilombero DC
Arusha CC	Kaliua DC	Kilosa DC
Arusha DC	Tabora MC	Morogoro MC
Meru DC	Uyui DC	Mvomero DC
Moshi DC	Morogoro	Masasi
Moshi MC	Iringa MC	Newala TC
Mwanga DC	Kilolo DC	Ludewa DC
Iringa DC	Njombe TC	Iramba DC
*Temeke	*Shinyanga MC	*Shinyanga DC
Kahama	*Ushetu	*Msalala
*Kyela	*Mbeya CC	

PEPFAR investments in information systems in prior years has recently allowed for the identification of patients who are registered at multiple clinics. In preparation for COP 2018, this enabled us to more accurately know numbers of people currently on treatment for Spectrum estimates, but it also allows for more accurate data on retention. In COP 2018, PEPFAR/T will build on this success by working with MOHCDGEC to develop unique identification system for PLHIV to enable tracking in ART services. Biometric identification has already been implemented in three facilities in Zanzibar during early 2018, and this is actively being expanded.

4.1.6 TB Screening with Fidelity and Isoniazid preventive therapy Coverage

Despite high reported coverage TB screening (90%) among PLHIV program data shows low numbers of people with HIV who screen HIV-positive, and low numbers of people diagnosed with TB. To address this, PEPFAR/T plans to strengthen TB screening with fidelity for case detection by focusing on screening QI measures. PEPFAR/T will also optimize use of GeneXpert machines for TB diagnosis among PLHIV by ensuring the availability of cartridges and intensifying mentorship on the use of the machines. Additionally, high rates of screening did not translate to high coverage of TB prevention, with IPT coverage only 9% due to inadequate supply of isonicotinylhydrazide (INH). This shortage was partly due to limited IPT procurement through GFATM, which PEPFAR is working to supplement based on the coordinated procurement effort that has gained traction during COP 2017. PEPFAR/T's IPT procurement will cover 685,000 patients in the current fiscal year. The first orders have already arrived in country. PEPFAR/T is

also working to strengthen program readiness for IPT roll out by including IPT provision in the revised national guidelines for management of HIV/AIDS. PEPFAR/T is also working to improve data collection through the CTC databases to ensure IPT provision is documented and monitored.

4.2 Prevention, specifically detailing programs for priority programming:

Activities addressing key and priority populations are implemented mainly in scale-up councils. PEPFAR/T has set targets for key and priority populations in some Attained and Sustained councils with known hotspots. Hotspot mapping will be strengthened by linking POC-RT results, which will be integrated into the routine HIV program activities. Together with other routine data such as age, sex, site, council, and mode of transmission POC-RT results will be used to identify and monitor clusters of recent infections and to initiate a public health response as needed. As noted earlier, these efforts will begin in the current fiscal year, and be scaled up nationally in COP 2018. Additionally, index partner testing will be prioritized for clients that test positive for recent infections.

In scale-up councils, PEPFAR/T targets key and priority populations, including SWs, MSM, transgender women, PWID, AGYW, and at-risk individuals in these sexual networks. To accelerate epidemic control, and informed by available data, PEPFAR/T will implement programs for key and vulnerable populations on HTS, condom provision and promotion, ART, PMTCT, HIV self-testing (HIVST), PrEP, and targeted community prevention interventions, including addressing gender norms and gender-based violence. Additionally, within the context of DREAMS, through structural interventions, social asset building, and economic strengthening, interventions are layered to ensure that AGYW are reached with multiple and appropriate interventions to reduce their HIV risk.

PrEP activities are being implemented as of March of 2018 in 14 regions at selected sites and continue to be scaled in phases. The roll-out plan will include investment in multi-level communications campaigns (social media, information, education, and communication (IEC), peer to peer) that promote PrEP with messages validated by the civil society, and that place PrEP in the context of comprehensive prevention including couples testing, male and female condoms, lubricants for women and men, and treatment leading to undetectable viral load in PLHIV.

Linkage and retention to ART remains the main area of focus for those identified as KP living with HIV, with the goal of achieving and sustaining viral suppression. In COP 2018 PEPFAR/T will scale with fidelity the best practice and evidence-based community outreach ART, where facility-based providers initiate ART at the point of diagnosis in the community setting. This approach shows improved same day ART initiation and linkage for the newly diagnosed clients who are hard to reach. Priority population prevention complements the PEPFAR/T clinical portfolio targeting hotspots with concentrations of key and priority populations to facilitate effective epidemic control in the country. The portfolio has set targets in select scale-up councils where there are existing hotspots.

4.2.1 HIV prevention and risk avoidance for AGYW

In Tanzania there are 6.2 million AGYW age 15-24 and according to the THIS 2016-17, this population is at considerable risk for contracting HIV. Due to a variety of drivers including; cultural norms, lack of education and gender-based violence, adolescent girls are more than twice as likely as their male counterparts to become infected.

For COP 2018, PEPFAR/T has identified vAGYW age 15-24 as a priority population, with a target of 318,070 for PP_PREV in scale-up districts. This intervention includes the delivery of the Stepping Stones curriculum and targeted demand creation activities. To change the trajectory for those most at risk, the OVC program will also be scaling up the HURU menstruation management intervention which includes SRH and risk avoidance education as well as parenting for early adolescent girls age 9-14 in 17 councils. Other prevention strategies include community-based GBV Screening in safe spaces, escorted referrals to post-violence care services, and scaling up AFHS.

DREAMS

Since 2015 PEPFAR/T has intensified efforts to avert new infections in this population by specifically targeting them within the broader key and vulnerable populations' portfolio, and more specifically through the DREAMS initiative. DREAMS delivers a comprehensive set of evidence-based biomedical, behavioral, and structural interventions that have been proven to reduce the risk of HIV in AGYW. In FY 2018, PEPFAR/T received an additional $10million (total $18.1m) to intensify program efforts, and to reach an additional 80% of the target (beyond 55% target by end of FY 2017) vulnerable adolescent girls and young women (vAGYW population) which involved expanding and deepening coverage within the existing priority councils.

By the end of FY 2018, it is expected that through the DREAMS program 176,310 of AGYW (10-24) will have been reached with a DREAMS minimum package that includes HIV/violence prevention, sexual and reproductive health education, and links to testing, family planning and GBV screening. Approximately 60% of the total AGYW reached will have also been reached with economic strengthening and young parenting skills.

To ensure young women are identified and offered a core package across the community and facility, the DREAMS program implementation model in Tanzania leverages the capacity of three key partners: OVC, community prevention, and facility. Primary beneficiaries are targeted through both the OVC program (age 9-14) and through intensive peer and community-based outreach (age 15-24). Once identified, a vulnerability assessment (vAGYW index) is used to understand the level of risk of the beneficiary and guide the prioritization of services. Beneficiaries are split into three distinct age categories: 9-14-year-old OVCs in- and out-of-school; out-of-school and sexually active 15-19 year olds; and 20-24 year olds who have dropped out of school and engage in high risk sexual activity. Girls are maintained in the program until they meet the established graduation criteria, which typically takes about 18 months.

Up to FY 2018, DREAMS was implemented in seven SNUs (Temeke, Kahama TC, Shinyanga MC, Ushetu, Msalala, Kyela, and Mbeya CC). According to the 2016-17 THIS, the estimates of the burden of HIV were substantially lower in Temeke than had previously been projected. Therefore, in COP 2018, the new targets for Temeke, a council with a large population within a major metropolis, will be replaced with two smaller councils: Shinyanga MC in Shinyanga, and Muleba in Kagera. These councils were identified based on prevalence, GOT prioritization of the Lake Zone, and proximity to current DREAMS councils, with the aim of optimizing existing investments and program efforts. The table below highlights these adjustments.

Original DREAMS councils	Target Type	Targets (9-24 combined)

Shinyanga MC	Maintenance*+New**	11,665
Ushetu	Maintenance+New	15,113
Msalala	Maintenance+New	14,620
Kahama	Maintenance+New	12,369
Mbeya CC	Maintenance+New	19,120
Kyela	Maintenance+New	7,866
Temeke	Maintenance	8,762
Muleba	New	20,300
Shinyanga DC	New	14,391

* *Maintenance*- Beneficiaries enrolled in the program in FY 2018 and completing in FY 2019
** *New*- Newly enrolled beneficiaries for FY 2019, expected to complete in FY 2020

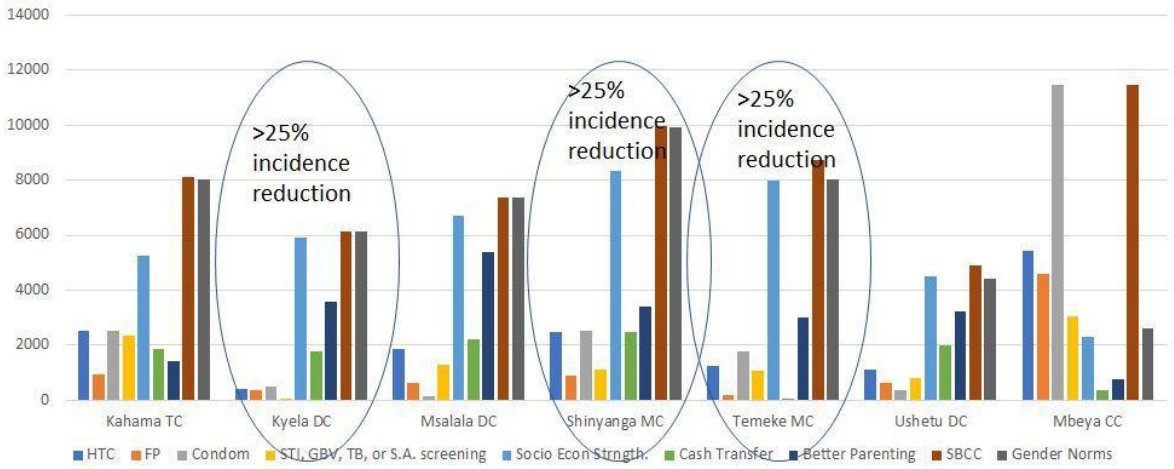
DREAMS Target Groups and Intervention Package:

Age Disag:	**9-14**	**15-19**	**20-24**
Population Description:	OVC in and out of school (priority for girls actively enrolled in school)	Sexually active, condomless sex out of school (uncompleted secondary)	Sexually active, condomless sex (priority for young mothers, girls engaged in transactional sex)
Proportion of the vulnerable population*:	70%	60-100%	60-100%
Package:	• SRH/Menstruation Management • Sexual Violence Prevention • HIV Prevention through risk avoidance • Violence Screening • Educational Subsidies • Parenting Adolescents • Household Economic Strengthening	• Economic Strengthening (young mothers training, business & financial literacy) • SRH & HIV Prevention • Targeted HTS • FP Method Mix • AFHS • GBV/TB/Drug/Alcohol Screening, escorted referrals & post violence care • OVC Program Core Package	• Economic Strengthening (young mothers training, business & financial literacy) • SRH & HIV Prevention • Targeted HTS • FP Method Mix • AFHS • GBV/TB/Drug/Alcohol Screening, escorted referrals & post violence care

*Based on PHIA estimates of vulnerability, proportions reflect the combination of new and maintenance targets for FY 2019

In COP 2018, DREAMS will continue to target 69,168 (55,038 maintenance) vAGYW and their sex partners, however also more broadly there will be enhanced focus on reaching and improving access to services for both men and women under 30 with 69,168 men and community members being reached through gender norms change interventions. Through male characterization, the team will identify men who likely to influence AGYW to be involved into sexual behavior and reach them with prevention services including HIV testing.

In addition to reaching AGYW, PEPFAR/T has maximized efficiencies through the tracking of service layering using an SMS/App-based platform entitled the DREAMS Auxiliary Monitoring and Evaluation (D.A.M.E.S.). This dashboard, visually displays the real time layering and reach of the DREAMS cohort across key community services (www.dames.co.tz). On average, both AGYW 15-19 and 20-24 receive 5 services. The top three services accessed include Stepping Stones, economic strengthening, and gender norms education. Access to community based mobile health units also are high and provide a one-stop suite of services including HIV Testing, family planning (FP), gender-based violence (GBV)/TB/substance/alcohol screening and escorted GBV referrals. Layering data also reveals a need to improve FP commodities procurement at the local levels to ensure AGYW have access to the information and the commodities in a timely manner.



DREAMS has also served as a platform for working with LGA to coordinate adolescent health activities at the council level across the key sectors (HIV, reproductive and child health (RCH), education etc.) for improved service uptake and health outcomes. In the 8 councils with new DREAMS targets, PEPFAR /T will work with PO-RALG to identify key priority indicators (i.e. teen pregnancy and child marriage rates) that will be tracked to help councils and PEPFAR/T measure progress.

In Tanzania, 27% of girls have begun child bearing (TDHS 2015/2016). These statistics are even higher in some regions where DREAMS is being implemented such as Shinyanga (34%) and Mbeya (33%). Harmful gender norms and lack of SRH knowledge are just two of many factors that contribute to such high rates. Tanzania's DHS further indicates that knowledge on family planning is inadequate with 43% of young women aged 15-24 unaware of any contraceptive methods. For those who have not completed primary school, knowledge is even more limited, which results in only 9% uptake of modern contraception in this group. Tanzania also has one of the highest child marriage prevalence rates in the world. On average, almost two out of five girls will be married before their 18th birthday (TDHS 2015/16). While the Law of the Child is in place, stating that a child is a child until 18, the customary marriage law enables a young woman to be married at 15.

DREAMS addresses some of the key drivers to teen pregnancy and early marriage through behavioral and structural interventions including: opportunities to continue education; teaching

young women about their bodies; SRH services and education; family planning services and education; how to protect themselves from sexual violence; and sensitizing parents and community members on harmful gender norms and their effects.

While the DHS has regional data on teen pregnancy and early marriage, there is not currently a systematic routine way to collect district level data on these indicators. As a result, there have been ad hoc requests by the government to schools to conduct physical examinations to understand the extent of teen pregnancy and to dismiss those who are found to be pregnant. In COP18, PEPFAR/T will work with MoHCDGE and PO-RALG to identify constructive and sustainable ways to track these key statistics within the current data collection modalities. Political support will be critical to address the legal and cultural barriers to reduce pregnancy and early marriage. It is important to note, however, that the current political environment criminalizes AGYW who become pregnant and systematically blocks them from accessing opportunities to pursue formal studies, thus limiting PEPFAR/T's impact.

4.2.2 OVC

Tanzania has 2.3 million OVC affected by HIV/AIDS (Measure Evaluation, 2018). The goal of the OVC program is to improve OVC and family wellbeing through HIV/AIDS impact mitigation, ensuring that OVC know their HIV status, are linked to treatment, receive services to reduce HIV risks, prevent new HIV infection and receive protection from GBV and child abuse. The OVC National Costed Plan of Action (NCPA) and National Action Plan to End Violence against Women and Children 2017-2022 guide the implementation of OVC programs in Tanzania.

PEPFAR/T will serve 595,697 OVC less than 18 years (32% of estimated number of OVC) in the scale-up saturation councils. About 8% of OVC (47,656) are expected to graduate from the OVC program resulting in 548,041 active OVC in the program. In FY 2017, about 49% of OVC reported their HIV status. PEPFAR/T will also reach 195,436 OVC caregivers. PEPFAR/T will ensure 100% of OVC active in the program report their HIV status and have their HIV status documented on files. The use of OVC HIV risk assessment tool has proven to be effective in targeting children at risk of HIV. PEPFAR/T will conduct HIV risk assessments for all OVC with undocumented HIV status and document whether risk is not indicated or refer those at risk for HTS (providing accompaniment by case workers as needed). OVC targeting will prioritize HEI, children living with HIV (CLHIV), adolescents living with HIV (ALHIV), children of people living with HIV, children of FSW and women who inject drugs, children and young women aged 10-17 years living or working in the streets, and children from mining communities, and children and adolescents aged 10-17 experiencing violence. This will be accomplished through facility based OVC identification and enrollment through PMTCT (including mother-baby pair follow up), first postnatal visit to identify HIV exposed and positive OVC missed at facilities. Community-based case identification will prioritize OVC and adolescents who are highly vulnerable to HIV infection particularly adolescent girls.

OVC program implementation will complement and be integrated with DREAMS. The program will implement activities related to risk avoidance, risk reduction, and community prevention and respond to GBV and child abuse. Activities include parenting and sexual reproductive education for adolescent' girls aged 15-17 that aims to foster open communication on HIV and sexuality issues between adolescents and their caregivers. The program will provide education subsidies to

ensure that adolescent girls aged 9-14 at risk of HIV complete primary and transition to secondary and receive HURU kits for menstrual period management. DREAMS and the OVC program will deliver a set of interventions to prevent sexual violence and risk among girls 9-14 years; this includes SASA!, violence risk screening, educational support, parenting, household economic strengthening (HES) and community prevention and response.

In FY 2017, 1028 of OVC who were assessed for HIV risk, 63% were at risk of HIV, 4.6% were identified as HIV-positive and 95% of those at risk were referred for HTS services. Also, about 20% of OVC (802 out of 3,785) identified as HIV-positive were not on treatment and were linked to treatment. In order to improve the pediatric continuum of care and prevention of new infections among children, the program will scale best practices, learn, and adapt. Effective interventions to improve outcomes among OVC and adolescents include flexible clinical hours, peer support and adherence clubs, adherence monitoring, family disclosure support. Memorandum of Understanding (MOUs) between PEPFAR care and PEPFAR treatment partners designate the roles of facility healthcare workers and community case workers and have demonstrated effectiveness in tracking HIV- exposed and positive children who are lost or missed at facilities and linking them back to care and treatment. In addition, active referrals such as accompaniment by case workers to HTS and ART sites have been critical to improving referral to service completion by over 90%. PEPFAR/T will scale-up these proven interventions across the OVC scale-up SNUs by 92%.

The OVC IPs will collaborate with demand creation programs to create demand and uptake of HIV services among ALHIV. To sustain the OVC response, community ownership will continue to play a critical role; therefore, caregiver strengthening will continue to be important component of the OVC service package. Other key activities to strengthen OVC service delivery and bi-directional linkage will include community case manager training, capacity strengthening of local government authority (LGAs) and community child protection committees. Continuous robust partner management, program monitoring, quality improvement, learning, adaptation and operational research to advance the evidence based on HIV risk and reduction among underserved OVC sub-populations will also be key activities.

4.2.3 Children and Adolescents

HIV prevention for children and adolescents includes prevention of perinatal transmission though comprehensive PMTCT programming, DREAMS integration and VMMC. APR 2017 revealed mother to child transmission rate at two-month of age to be 2% with EID coverage of 58% of HEI. With a goal of lowering transmission to <1%, PEPFAR/T will support the national PMTCT program through support for comprehensive PMTCT services with a goal of attaining virtual elimination of mother-to-child transmission (eMTCT). The program will support the efforts to reach all pregnant and breastfeeding women with HIV testing, and those identified as HIV-positive with lifelong ART and viral load monitoring.

THIS has revealed low self-reported knowledge of HIV status among females of reproductive age, suggesting challenges with the national PMTCT coverage. Specific programmatic challenges in PMTCT and EID include quality assurance of HIV rapid testing within RCH is low, data quality concerns for PMTCT, shortage of skilled HCWs in EID, loss to follow up of mother-infants pair, and missed opportunities for screening of mothers and infants at neonatal immunization platforms. Strategies that will be implemented in COP 2018 to address the challenges include

improve patient literacy to increase ANC/PMTCT service utilization and retention in services, support provision of condoms and prevention messages to reduce the risk of sexual HIV acquisition, implement standard procedures in immunization clinics to retest mothers who missed retesting in 3rd trimester or at labor and delivery (L&D) and test all HIV-exposed infants, and use of mother support groups and community health workers for follow up of mother-infants pairs. PEPFAR sites will also be supported for quality assurance for HIV rapid testing to ensure that national standards for HIV testing is maintained. In addition to that data quality will be improved by disseminating SOPs and mentorship for health care workers to improve reporting on PMTCT and EID indicators. Enhanced adherence counseling will be prioritized for pregnant women with high viral load results.

DREAMS integration for prevention in adolescents is described in section 4.2.1 above, and VMMC is described in section 4.2.5 below.

4.2.4 Key Populations

Support for targeted interventions for key and priority populations include those for SWs, MSM, transgender women, and PWID as well as at-risk individuals in these sexual networks. Activities addressing key populations are implemented in all scale-up, 11 attained councils, and seven selected sustained SNUs with known hotspots. In COP 2018, these councils account for 60%, 36% and, 4% of KP_PREV targets, respectively.

Following release of the revised National Guideline for Comprehensive Package of HIV interventions for Key and Vulnerable Populations(KVP) in April 2017, a notable increase in uptake of services among KPs was observed, resulting in IPs meeting their targets for both testing and KP_PREV targets. FY 2017 Q4data indicate that 92,218 (99% of the target) KPs were reached with core intervention packages. For those KPs reached, 89,451 (97%) were tested for HIV during the implementation period, 8,299 (9%) were identified positive, and 6,455 (78%) were linked to ART.

Another success in KP programming is the revived commitment by GOT to provide a comprehensive prevention, care and treatment package for KVPs, recently including full roll out of PrEP and planned roll out of HIV self-testing (as soon as the law is changed, targeting April 2018) as well as identifying facilities with KP friendly services. PrEP will have a prevention benefit while HIVST will help with the identification of KPs and sexual partners of female sex workers that are reluctant to go for services because of stigma. Despite the good progress above, high levels of stigma and discrimination still exist as an important implementation barrier. To accelerate epidemic control, and informed by available evidence, PEPFAR/T will continue supporting programs that improve interpersonal communications and structural barriers to make services friendly and accessible to Key and Vulnerable populations. PEPFAR/T will continue supporting comprehensive service delivery including HTS, condom provision and promotion, ART, PMTCT, HIVST, and targeted community prevention interventions, including addressing gender norms and gender-based violence. Pre-Exposure Prophylaxis (PrEP) will target high risk HIV-negative KPs and sero-discordant sexual partners. Additionally, PEPFAR/T will guide IPs to conduct mapping of local civil society organizations that work with KP especially MSM and identify collaboration areas to accelerate geographic expansion. Through this approach, peers/seeds will be selected as key contacts personnel to enable reach with convenience to KPs including MSM to access the services such as HTS and linking to ART services.

Based on FY 2017 data it was observed low linkage into ART services for HIV-positive KP in some councils especially in councils which did not implement community ART. Partner data in the month of December 2017, indicates linkage of 81% in Kagera and Tanga and 20% in Dar es Salaam and Kigoma, these are councils with community ART and the other with no community ART respectively. A clarification of the community ART policy was sent out to all regions by the National AIDS Control Program immediately after the Johannesburg RPM, stating that this policy should be implemented. Community ART initiation has proven effective linkage and will be scaled-up in COP 2018. With MOH guidance, PEPFAR/T will support roll-out of this best practice to all councils to as an important addition to the community-based KP package of services. In COP 2018, PEPFAR/T will scale with fidelity the best practice and evidence-based BCPE model to facilitate early linkage and retention to HIV care for the newly diagnosed KP/PP clients.

In Tanzania's COP 2018, PEPFAR will include financial and technical support for implementation of a coordinated set of initiatives designed to monitor key and vulnerable populations. Specifically, COP 2018 will fund the implementation of stigma and discrimination sensitization programming for healthcare workers and law enforcement. PEPFAR will engage with key population groups in design and implementation of these programs and will work with Government of Tanzania to develop a system for documenting and remediating instances in which policy and/or persistent stigma adversely impacts access to HIV testing, linkage, treatment and prevention. PEPFAR will further encourage implementing partners in Tanzania to utilize Safety and Security Toolkits for key populations, and to adequately consult indigenous organizations for all programming and the monitoring of effectiveness of stigma and discrimination programming.

In efforts to identify more PLHIV, IPs will be required to focus on reaching sexual contacts/ partners of all female workers reached including partner notification from sex workers identified as HIV-positive. PEPFAR/T intends to conduct mapping of locations and facilities with high numbers of PLHIV and focus implementation on key population programs in those areas to identify high yield. Engagement with CSOs has helped us to understand that current KP size estimates used in programming might be an underestimate of actual KP size. It is important to note that the current KP size estimates that Tanzania is using are outdated. In COP 2018, PEPFAR/TZ will conduct a bio-behavioral survey and population size estimate among FSW, MSM, and PWID in Dar, Arusha, Mwanza, Mbeya, Tanga, and Dodoma. The PEPFAR/T team is working with the GOT to safely roll out the national KP M&E system and unique identifier system that will facilitate case-based monitoring to allow confidential tracking of beneficiaries across the continuum of HIV prevention and care services without jeopardizing their anonymity and, ultimately, their safety. In COP 2018, PEPFAR will also map and tailor engagement strategies with health services for organizations serving transgender people. Working closely and diligently with these organizations will enhance reach and scale-up of services to transgender people.

In COP 2018, PEPFAR/T will support the GOT to adopt the total market approach for condoms, including complementary support to meet the needs beyond GFATM support for the procurement of supplemental supply of male and female condoms, for both socially marketed and free public-sector condoms. Support for condom programming will remain national in scope, yet condom promotion activities will be limited to scale-up councils where targets are set for comprehensive prevention interventions.

The PEPFAR/T team will continue to advise the GOT on key population policies with a guide to ensure safe and appropriate access to services for key populations that adhere to international standards.

4.2.5 VMMC

In Tanzania, the VMMC program is a priority in councils with low male circumcision coverage and high HIV prevalence, including the DREAMS districts. The program continues being priority to HIV prevention as highlighted in the Tanzania National Country Operational Plan for VMMC (2015). Tanzania's priority VMMC age is 10-29yrs. Selection of the priority age band was based on the impact model (Avenir Health, FY 2016) that informs us on the immediacy and VMMC impact. The model considers the age-structure of the population, and HIV incidence, among other factors. The Decision-Makers' Program Planning Toolkit, Version 2 (DMPPT 2) is a monitoring and planning tool that generates coverage estimates, target and impact projections for the VMMC program down to the district-level, disaggregated by five-year age bands.

Thanks to PEPFAR's technical and financial support, the male circumcision (MC) rate in Tanzania has risen from a national overall average of 72% (THMIS 2012) to 80% in 15-29yrs (THIS, 2017). However, there remain pockets of low coverage in the country. The coverage in 10-14yrs is still low (59.3%, THIS 2017) and program data continue highlighting the coverage gap in men older than 24years, and in highly mobile men and communities in which men's occupation is characterized by seasonality (such as men working in agricultural and mining sectors, as well as fisher folk). The high coverage for older age band justifies the continuation of VMMC mop-up campaigns in the younger age band who age-in (10-14yr olds) in order to maintain the high coverage.

By end of FY 2018, PEPFAR/T will have supported 3,380,984 circumcisions and by end of FY 2019 the cumulative number of VMMC performed is expected to be 4,129,834. Building on efforts from COP 2017, in COP 2018, PEPFAR/T will continue to focus on scaling up VMMC services among older males aged 25-29 by addressing key barriers to seeking VMMC services. The barriers include physical, economic constraints, emotional reservations, service delivery convenience, and traditional and cultural elements. PEPFAR/T's demand creation efforts use client-centered approaches, such as age-specific SMS messages and integrated voice response (IVR) systems such as helpline services to target this group with relevant information and support. Efforts also include a focus on reaching female spouses and sexual partners. VMMC services are also being tailored to ensure privacy for older men, to allow for separation of older men from younger men, to include extended hours and moonlight services, and to increase the use of male service providers. In addition, IPs will focus on seasonal preferences for older clients (i.e. May – August), and will scale-up provision of VMMC services during this time.

COP 2018 strategy is to maintain high coverage among 10-29 years in councils where circumcision coverage already exceeds 80% and achieve 80% coverage in councils where circumcision coverage is lower. Scale-up of VMMC will continue in FY 2019 to reach and maintain saturation in all strategic councils (i.e. 9 attained, 55 scale-up, and 9 sustained SNUs), targeting 748,735 boys and men.

Summary of VMMC Strategy and Direction in COP 2018

SNU Category	For > 80% coverage among 10-29 years	Introduce/expand EIMC	Total
Scale Up Sat	54	54	520,905
Sustained	9	9	143,875
Attained	9	9	68,933
Total SNUs	72	72	72
Total target	730,307	18,428	748,735*

* Total includes military

In COP 2018, PEPFAR/T will also strengthen data quality, coordination and improve sustainability of the VMMC program. While PEPFAR/T has made considerable progress toward MC saturation, the VMMC program continues to need technical support, including strengthening its data quality, partnerships and quality of both adolescent/adult program and early infant circumcision (EIMC). PEPFAR/T supports the National AIDS NACP to monitor the implementation of standardized VMMC minimum package including HIV prevention, sexually transmitted infection (STI) screening, HTS testing and linkage to care services among VMMC clients including youth and adolescent groups. PEPFAR/T will support the integration of VMMC and youth and adolescent basic minimum package of HIV/AIDS prevention including SRH counseling, condom promotion and counseling, STI management/referrals, ART services, psychosocial services and others.

4.3 Additional country-specific priorities listed in the planning level letter

The COP Planning Letter included six items under the "FY 2017 Tanzania Challenges" section. Our approach for each of these is addressed here. Working in collaboration with implementing partners and the GOT, PEPFAR/T will closely monitor all of these issues throughout the current fiscal year (through regular reviews of data and performance), tracking to ensure that progress is made.

1) "PEPFAR/T achievement only reached 68% of the annual target for EID, testing only 73% of HIV-exposed infants for HIV." PEPFAR/T has assessed this issue carefully. The primary issues identified are as follows: first, only about 60% of PEPFAR-supported facilities currently provide EID on-site. Women and children seen at those sites without EID were referred to sites with EID services, which at times were far away and oftentimes the patients did not complete the referral. Second, the routine immunization visits have not been systematically used to identify children who need EID testing. Third, a new "cohort mother-child" register was implemented in 2016. That register was complex, and as a result, under-reporting of EID testing was common. PEPFAR/T has already made important changes to address these gaps and will continue in COP 2018. PEPFAR/T is working with partners to expand sites that can offer on-site EID testing. The goal is for all PEPFAR-supported facilities is to have EID services in place by October 2018. PEPFAR/T is also in the process of integrating PMTCT and EID into the DPT1 routine immunization visit. The mother-child register has been revised, and is being used at six facilities to identify any problems before it is rolled-out country-wide in September 2018. With the combination of these three approaches PEPFAR/T expects there to be a favorable impact towards EID targets. Close monitoring and partner management will ensure rapid progress.

2) "The programmatic linkage rate between HIV positive individuals and those initiating treatment has improved from 70% in FY 2016 to 78% in FY 2017, however, this remains low and is lower still in select populations [males and 15-24 year olds]". The THIS found that ART initiation among people with known HIV status was high, suggesting that the linkage gaps are not as large as once thought. However, the groups mentioned above, along with some key populations, do have lower linkage rates. Program data clearly indicate that community outreach ART substantially increases linkage. This is used in community testing activities, and as such, it specifically benefits KPs and men. While successful, implementation in different regions was inconsistent due to some confusion at sub-national levels over the policy. However, following a message of clarification from the NACP to all regions immediately following the Johannesburg RPM, these barriers have mostly been overcome, and implementation is expanding. PEPFAR/T is also scaling up the linkage case management module of the BCPE, which includes expert HIV clients who provide escorts to navigate through the facility, along with counseling and retention follow-up.

3) "PEPFAR Tanzania continues to struggle with identification of HIV positive men and initiating these men on treatment." The PEPFAR/T strategy for identifying HIV-positive men and starting them on treatment begins with our core package of index testing, PITC, and community testing. While all three have broad impact, index testing and community testing both disproportionately benefit men. To those, PEPFAR/T is expanding the number of clinics that offer after-hours services, especially in urban areas, and testing of partners of DREAMS participants. PEPFAR/T is also in the process of implementing and expanding HIV testing for partners and children of sex workers. Given the large gap in reaching men, PEPFAR/T will monitor progress closely to ensure rapid progress towards goals. Additionally, PEPFAR/T will engage informal sector associations in partnership with community IPs, and large employers in urban areas in partnership with private sector programs to reach more men for identification and linkage to treatment.

4) "Although viral load (VL) monitoring improved in FY 2017, coverage remains low; rapid scale-up of VL testing will be required to reach targets for FY 2018 and beyond." In FY 2017 Q1, country-wide capacity for viral load testing was only 475,000 tests per year, whereas the need is approximately 1.5-2 million tests per year. By Q3 of 2017, in collaboration with GOT, PEPFAR/T (including support from two headquarters technical support visits) had increased capacity to 1.17 million, and by Q4, it this further increased to 2.28 million. Subsequently, the number of tests increased from approximately 50,000 in FY 2017 Q2 to 114,000 in Q3 to 134,000 in Q1 2018. In addition to the capacity limitations, there were also challenges with sample transportation and supply chain. The sample transportation challenges have been substantially improved by expanding the number of "hub" facilities from 57 to 157. These facilities receive specimens from lower facilities, process the specimen into plasma, and transfer it to a testing facility. The supply chain challenges were primarily related to delays in delivery from a new supplier, and these have now been overcome, and there is adequate buffer stock in place. Some partners had planned to close the testing gap over a 1-year period, however in the partner management meetings in January 2018, we directed them to close the gap by September 2018. PEPFAR/T is now working closely with partners to ensure that this is done.

5) "PEPFAR Tanzania should increase the current 41% rate of receipt of VMMC in 25-29-year-old men." Tanzania's success in VMMC scale-up has not been evenly distributed across all targeted age groups. In most cases, programs meet or over-achieve targets among males aged 10-24 years, but under achieve among older age groups, particularly males aged 25-29. In 2017, PEPFAR/T initiated a shift in focus to increase demand creation toward older men aged 20-29. Data demonstrate that this yielded substantial increases in men aged 20-24 but not men 25-29 years. Over the course of implementation, the challenges have become clear: adult clients do not want to be mixed with adolescents and prefer to access services in static facilities. Furthermore, men aged 25-29 are likely to be married or in stable relationships, so it is more difficult to convince them of the importance of circumcision for HIV prevention. In order to reach men age 25-29 years with VMMC services, PEPFAR/T is developing demand creation efforts specifically to attract the older men into testing. Demand creation efforts will also target female spouses and sexual partners to promote the benefits of VMMC. Programs will also aim to make services more attractive and accessible to men by offering weekend and extended "moonlight" services, as well as tailoring services through improved privacy, more convenient locations, and increased use of male service providers.

6) "The program's high loss-to-follow rates for persons on HIV treatment, as indicated by underperformance towards net new treatment target, need careful consideration and action." While Tanzania initiated 245,249 patients onto treatment during the course of FY 2017, we counted only 146,405 NET_NEW patients compared to the total number of patients on ART at the end of FY 2016. Not all of the 102,000 patients can be explained by non-retention. For example, nearly 30,000 patients are no longer being counted by PEPFAR as a result of the successful transition of over 1400 low burden sites to the GOT. Additionally, because of successful above-site investments in information systems, PEPFAR/T was able to determine that there is some duplication within TX_CURR, whereby some patients are registered multiple times. This already had important implications for SPECTRUM modeling this year, but we are now using this to determine if any of the differences between TX_NEW and TX_CURR are due to this. Regardless of these issues, however, improvements in this area are needed to reach TX_CURR targets for COP 2018. As described in greater detail earlier, we are scaling up the linkage and retention module of BCPE, which essentially provides expert clients as counselors and facility navigators, along with follow-up outreach and defaulter tracing. Other strategies included in the BCPE package include connecting new clients to peer support for close follow-up to immediately trace those who miss their appointments, multi-month scripting up to three months, block-appointments to reduce wait times, and extended clinic operating hours in the evenings and on weekends.

4.4 Commodities

PEPFAR/T contributes with GFATM and the GOT to the total country needs for ART, rapid test kits, EID, and viral load commodities by providing them to the central medical stores for distribution. All products, with the exception of those for VMMC and harm reduction, are distributed nationally based on historical consumption. VMMC commodities will be fully supported through COP 2018 and are provided directly to implementing partners providing VMMC services. Harm reduction supplies will be supported by PEPFAR/T through IPs who provide harm reduction services.

The GFATM contribution to the HIV program is defined in the approved grant, which includes $86 million for ART and $15 million for lab supplies. Between the GFATM and GOT commitment to condoms and opportunistic infection (OI) medicines and PEPFAR support for commodities, there is no anticipated financial gap in commodities. TLD availability will also depend on manufacturers' ability to supply the global demand.

PEPFAR/T supports the new supply chain design that focuses on increasing velocity and visibility in the supply chain. Increased velocity includes reducing the amount of stock being held in warehouses and increasing the frequency of deliveries to facilities from quarterly to monthly. The months of stock to be held in government warehouses before reaching patients will be reduced by five months. Increased visibility refers to expanding the electronic information system to manage and track supplies from district offices, as it currently is, down to the facility level. This will not only help responsible actors to see product location, but will also improve data quality on levels of stock around the country. Through GFATM, PEPFAR, and GOT support, there are no commodities gaps expected during COP 2018.

Tenofovir, Lamivudine, Efavirenz (TLE) is expected to run out around July 2019. However, Tanzania currently holds 23 months of Lamivudine, Nevirapine, Zidovudine (LNZ), which would not be out until April 2020. 14% of patients are on this regimen. The overstock is due to 1) a delay in a procurement and supply management (PSM) order, 2) the decision to push a GFATM order to before the end of the grant in December 2017, and 3) declining consumption as patients move away from this regimen. In connection to this, PEPFAR/T has initiated planning for the TLD transition, and is engaging in ongoing conversations with GFATM, headquarters, and NACP to determine the best approach to balance rapid transition with minimal waste. The TLD transition is expected to take place in two phases: Phase 1, beginning January 2019, will focus on treatment naïve patients, as well as transitioning all current patients not on a Nevirapine-based regimen including pregnant women, TB co-infected and all KPs. Phase 1 is expected to be complete by June 2020. Phase 2 will begin in January 2020 (overlapping with Phase 1) and will involve transitioning all remaining Nevirapine-based patients. This phase will also be complete by June 2020.

4.5 Collaboration, Integration and Monitoring

Strengthening Cross Technical Collaborations:

In Tanzania, the participating PEPFAR agencies have agreed to foster a culture of cooperation and collaboration and are committed to an interagency approach to achieve programmatic goals. The internal organization of PEPFAR/T is explicitly designed so that teams at all levels of decision making have representation from each relevant participating agency. Constructive dialogue and sharing experiences between agencies and technical teams stimulates innovation, enhances program standardization (especially partner management), and identifies opportunities to achieve efficiencies across the PEPFAR/T program.

PEPFAR/T has ongoing regular engagements with GOT at different levels, in additional to semi-formal engagements on an ad-hoc basis. PEPFAR personnel are members of national technical working groups that regularly convene to address program implementation and propose policy adaptations. Leadership teams have scheduled monthly meetings with the Deputy Minister for Health and other senior MOH teams to track policy and performance, starting in FY 2018 and continuing through COP 2018. PEPFAR/T withdrew support to zero- and low-volume facilities

and GOT has retained full responsibility for services and reporting for these sites. These steps to consolidate the PEPFAR portfolio allowed for GOT and other stakeholders, including GFATM, the Bill and Melinda Gates Foundation (BMGF), and the Clinton Health Access Initiative (CHAI) to easily determine where and how to allocate complementary resources and other support for the national HIV response. For COP 2018, PEPFAR/TZ has updated its site analysis based on new data. This will in turn be discussed with stakeholders once the targets have been approved.

Alignment between PEPFAR/T and the GFATM with respect to the procurement of HIV commodities has been effective for several years, and both PEPFAR/T and the GFATM work with the GOT from a common, national supply plan. With respect to the implementation of community services, including those targeting KPs, PEPFAR/T works closely with GFATM principal recipients (PRs) to geographically align partners and programs. The HIV/TB funding request for the years 2018-2020 is designed from the vantage of the PEPFAR's community, priority and key population services plan to ensure that geographic alignment is built into the design from the outset.

Strengthening Partner Management

Highly effective, timely, and standardized partner management, part of which is managed as an interagency as guided by the Quality Management for Epidemic Control (QMEC) plan, will be required to achieve COP 2018 targets and improve identified gaps. This process will be managed in four steps: 1) implementation, reporting and monitoring; 2) data analysis; 3) interpretation and decision-making; and 4) feedback and remediation. Beginning in FY 2018, PEPFAR/T is conducting all of these steps as an interagency, to ensure optimal sharing of best practices, challenges, and remediation steps across all partners.

1) Implementation, Reporting & Monitoring: PEPFAR/T will use a comprehensive set of information to assess partner performance by examining data on program achievements (through the PEPFAR Monitoring, Evaluation, and Reporting (MER)), quality (through SIMS), and financials (through outlays and budget analysis), all of which are currently available quarterly. However, to achieve the scale-up of priority interventions, select additional data that has been selected by the interagency team, will be collected monthly from implementing partners to monitor progress in real time. Specifically, data will be collected on the clinical cascade, as well as selected site-level indicators required to measure implementation of our high priority activities, including: index testing; true linkage; retention; same-day initiation; after-hours services; and multi-month scripting; and after-hours services. In addition, QI and quality assurance (QA) processes will be applied to further strengthen scale-up and fidelity of priority interventions. High-volume and low performing sites will continue to be prioritized for SIMS visits and tracking of remediation across all performance measures (program achievements, quality, and expenditure). The QMEC will be applied to define facility and community sites that are under-performing, and to improve implementation fidelity and achievement of outcomes to drive epidemic control. PEPFAR/T will use QA data to refine continuous quality improvement plans as well as to identify facilitating factors for successes that could be scaled up.
2) Data Analysis: Based on findings of focused monthly and comprehensive quarterly data reviews (which include QA and QI dashboards, financial data and MER indicators), agency activity managers will meet with partners to analyze and discuss successes, weaknesses, barriers and opportunities in program implementation for real-time course

correction. Frequency of meetings with partners will be based on analysis and performance, but not limited to quarterly meetings. At least on a quarterly basis, QI partners will be invited to meet with IPs and project officers to analyze QA & QI dashboards. Key lessons will be shared with agency leadership and through the interagency platforms as soon as they are found.

3) Interpretation & Decision Making: On a monthly and quarterly basis agency and interagency teams will assess progress being made to achieve targets overall and across sub-populations. This will include an assessment of performance against targets overall, as well as an assessment of whether actual outcomes are achieving expected results for priority interventions. The PEPFAR/T interagency team will discuss how barriers can be addressed and how opportunities should be capitalized on collectively, both for site-level and for above site activities. This information will be presented in the PEPFAR Oversight and Accountability Review (POART). Immediately following the POART, PEPFAR/T will meet with GOT, CSO and IP to discuss findings from the previous quarter and POART conclusions. Agency and Embassy Leadership will also meet monthly with the MOHCDGEC leadership to review monthly data, review policy implementation, and address any programmatic gaps. Using site level MER data and information spending, lowest performing sites will be selected for QI interventions. Targeted SIMS will be performed. As noted in the COP guidance, the targeted SIMS process entails implementation of a streamlined and tailored SIMS visit using existing tools. In contrast with Core SIMS, targeted SIMS will use 'Bellwether' core essential elements (CEEs) to determine whether all CEEs within a given set/Program Area should be assessed.
4) Feedback & Remediation: When partner performance is of concern, PEPFAR/T management teams will increase the frequency of the review of results to weekly remediation actions, utilizing frequent benchmarks to monitor progress. Lessons learned from other successful partners as well any strategic technical shifts will be included in the remediation strategy. Over-spending will neither be approved nor accepted. If spending is outpacing target achievement or monthly burn rate toward the approved annual budget, a financial remediation plan will be enacted. Formal Partner Performance Plans will be implemented in cases of prolonged underperformance. There may be situations, either epidemiological or related to partner performance that require shifting funds from one partner to another. In this case, PEPFAR/T plans to submit reprogramming requests in the hopes to make these adjustments in a timely manner.

PEPFAR will also continue to engage with CSOs – both those receiving PEPFAR funding through subawards and those not receiving PEPFAR funds – to continue to foster a grassroots network of indigenous organizations to drive more local investment. This will include quarterly meetings and implementation of a Tanzania-specific CSO strategy to be developed during COP 2017 implementation. This strategy will clearly outline PEPFAR's CSO-engagement approach and will include proposed indicators to measure the extent to which more established IPs engage with and build the capacity of grassroots, indigenous organizations with the goal of helping to position CSOs to take increasingly larger implementation roles in PEPFAR programming. PEPFAR/T will continue to prioritize engagement with PLHIV and KP communities and organizations to build on their experience carrying out peer support, outreach, awareness raising, and treatment literacy to ensure program success.

Improving Integration of Health Systems Interventions

In COP 2018, PEPFAR/T will accelerate certification and accreditation of laboratories to meet the required operational standards and while continuing to expand the HIV proficiency testing program to more HIV testing sites for continuous improved quality of HIV testing services. PEPFAR/T will strengthen the already-expanded laboratory diagnostic capacity for viral load, EID, and TB to enable widespread scale-up of services in the country. PEPFAR/T will also continue supporting the national laboratory information system by linking viral load data to the CTC3 database for timely viral load test results to improve patient management along the continuum of health care delivery. In addition, PEPFAR/T will collaborate with other stakeholders to support laboratory optimization and strengthen the sample referral/transport and results feedback system. Above-site level activities to strengthen laboratory services will include quality assurance for rapid testing at PMTCT sites and training of 212 laboratory staff and 20 trainer-of-trainers to reach a laboratory accreditation target of 80% for all PEPFAR/T supported labs.

Finally, PEPFAR/T will continue to work in a collaborative manner with MOHCDGEC and PORALG through the existing GOT platforms to ensure COP 2018 implementation reflects all relevant policies and guidelines regarding HIV/AIDS programming. Specific new policy developments that will support implementation include community outreach ART, transition to TLD, pre-exposure prophylaxis, differentiated service delivery, nurse-initiated management of ART, and deployment for community health workers for task shifting. In addition, PEPFR/T will continue to support GOT to adopt newer pediatric formulations of ARVs to improve clinical outcomes, HIV self-testing, HIV recency surveillance as part of routine program activities, community ART distribution and ART prescriptions for 3+ months.

The GOT is currently working to expand its human resources for health, both at the community and at the health facility level. PEPFAR/T will support the GOT's planned implementation of community health workers and will ensure that these workers are assigned to areas with the greatest HIV burden, and where the facilities that will supervise them are supported by PEPFAR IPs. In addition, PEPFAR/T's program to assist the GOT with rational application of human resources will support the application of new clinical staff to facilities in areas with high HIV burden where they can be trained and mentored appropriately. The GOT is currently working to expand its human resources for health, both at the community and the health facility level. PEPFAR/T will support the GOT's planned implementation of community health workers and will ensure these workers are assigned to areas of high HIV burden and in places where the supervisory facilities are supported by PEPFAR/T IPs. In addition, PEPFAR/T's program will assist the GOT with rational application of human resources to support new clinical staff to facilities in areas with high HIV burden where they can be trained and mentored appropriately. This will include training to newly appointed nurse graduates or junior nurses who will be trained on NIMART in addition to other HIV interventions. Specific indicators to measure the success of NIMART roll out (including training and mentorship) will include (but are not limited to):

- percentage of nurses trained in NIMART during the last 12 months;
- percentage of nurses having received mentorship in NIMART; and
- percentage of nurses trained or mentored in NIMART who have initiated and managed ART in the last 12 months.

<u>Improving Quality and Efficiency of Service Delivery</u>

In COP 2018, PEPFAR will continue taking same-day start, multi-month prescriptions and task-shifting to nurses to scale across sites, with ambitious targets for saturation of these interventions. By the end of COP 2018, 100% of sites will have implemented relevant interventions at scale.

PEPFAR will also continue to gather and act on information about the impact of different community service delivery approaches on performance across the treatment cascade, evaluation of community-facility outreach models, including expansion into districts that newly adopt this policy; impact of various lay cadres and peer support mechanisms on linkage, adherence and retention. Having completed the roll out of Test and Start, in COP 2018 PEPFAR/T will continue to refine and roll out the revised SDM. This will include training on differentiated service delivery models for various factions of stable patients. Additional focus will be moving from two-month to 3-month prescriptions. Additional approaches will include extending clinic hours to see young people, adolescents and men and scaling up community ART via outreach from a mother site – the dispensary - by a trained provider. The GOT has already sent broad communication to all districts approving and encouraging adoption of this community-ART approach.

Addressing existing legal barriers to HIV self-testing is a priority for both PEPFAR/T and GOT. GOT has committed to raise the relevant act for review in upcoming parliament sessions. PEPFAR/T will help address the sustainability barriers identified in the SID, including service delivery efficiency and quality of service, gaps in domestic resource mobilization, and laboratory capacity as described in section 2.3, which will help make services more accessible and efficient to clients. The GOT, GFATM, and PEPFAR/T will all review the same disaggregated cascade analyses and agree on joint solutions to reach the UNAIDS Fast-Track Goals while realizing additional budget efficiencies.

4.6 Targets for scale-up locations and populations

Standard Table 4.6.1

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY 2019) *HTS_TST*	Newly Identified Positive (APR FY 2019) *HTS_TST_POS*	Newly Initiated on ART (APR FY 2019) *TX_NEW*
Total Men	2,148,612	83,059	78,679
Total Women	3,222,919	124,589	118,018
Total Children (<15)	964,286	31,765	29,854
Adults			
TB Patients	33,250	9,543	9,543
Pregnant Women	901,270	22,415	22,184
VMMC clients	364,633	501	Not available
Key populations	*123,909*	16,969	122,282
Priority Populations	*383,247*	N/A	N/A
Other Testing	3,840,363	207,591	N/A
Pediatrics (<15)			
HIV Exposed Infants	*41,128*	1,990	1,990
Other pediatric testing	2,094,965	31,765	29,854

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Councils

SNU	Prioritization	Size estimate (10-29yrs	Target - VMMC_CIRC (10-29yrs, FY 2018)	Current coverage (end of FY 2018)	Target - VMMC_CIRC (FY 2019); 10-29yrs	EIMC (FY 2019): <1 yr.	2
Biharamulo DC	Scale-Up Sat	64,215	22,196	80%	19,038	393	
Bukoba DC	Scale-Up Sat	57,642	817	80%	935	249	
Bukombe DC	Scale-Up Sat	46,788	6,828	109%	5,149	248	
Busega DC	Scale-Up Sat	41,156	807	106%			
Chato DC	Scale-Up Sat	75,156	11,045	80%	9,665	387	
Geita DC	Scale-Up Sat	147,117	52,213	80%	44,638	779	
Geita TC	Scale-Up Sat	21,777	7,802	198%	6,669	115	
Igunga DC	Scale-Up Sat	79,824	7,239	95%	5,064	409	
Ileje DC	Scale-Up Sat	24,947	4,795	80%	4,123	95	
Iramba DC	Scale-Up Sat	47,273	17,018	80%	14,509	214	
Iringa DC	Scale-Up Sat	52,589	780	111%			
Itilima DC	Scale-Up Sat	59,974	26,050	80%	22,176	294	
Kalambo DC	Scale-Up Sat	40,494	10,095	70%	8,721	242	
Kaliua DC	Scale-Up Sat	82,111	5,996	80%	5,316	414	
Karagwe DC	Scale-Up Sat	69,236	8,900	80%	7,800	324	
Kigoma Ujiji MC	Scale-Up Sat	48,471	20,358	80%	17,290	189	
Kilolo DC	Scale-Up Sat	45,729	2,643	95%	1,838	162	
Kilombero DC	Scale-Up Sat	83,456		80%	25,537	300	
Kishapu DC	Scale-Up Sat	55,812	1040	100%			
Kwimba DC	Scale-Up Sat	81,571	3,201	80%	3,131	443	
Kyela DC	Scale-Up Sat	46,046	5,147	95%	3,908	176	
Kyerwa DC	Scale-Up Sat	65,268	29,106	80%	24,790	341	
Ludewa DC	Scale-Up Sat	27,495	2,657	119%	1,989	103	
Magu DC	Scale-Up Sat	60,666	3,168	80%	2,946	285	
Makambako TC	Scale-Up Sat	20,454	3,214	95%	2,455	70	
Makete DC	Scale-Up Sat	19,775	1,709	107%	1,290	62	
Maswa DC	Scale-Up Sat	70,459	1349	114%			
Mbarali DC	Scale-Up Sat	59,916	5,003	80%	4,481	278	
Mbeya DC	Scale-Up Sat	62,558	1001	210%			
Mbinga DC	Scale-Up Sat	74,838	1,274	80%	1,558	300	
Mbogwe DC	Scale-Up Sat	40,482	16,730	80%	14,264	211	
Mbozi DC	Scale-Up Sat	95,193	8,060	80%	7,148	378	
Meatu DC	Scale-Up Sat	58,610	19,308	80%	16,514	295	
Missenyi DC	Scale-Up Sat	42,103	6,659	80%	5,764	171	
Misungwi DC	Scale-Up Sat	70,979	4,845	80%	4,449	380	
Momba DC	Scale-Up Sat	35,883	894	118%			
Mpanda TC	Scale-Up Sat	57,507	2,534	90%	8,287	305	

Msalala DC	Scale-Up Sat	51,497	21,197	80%	18,087	282
Mufindi DC	Scale-Up Sat	55,744	1576	114%	831	209
Muleba DC	Scale-Up Sat	110,306	13,524	95%	10,244	473
Musoma DC	Scale-Up Sat	34,821	12,535	80%	10,708	178
Musoma MC	Scale-Up Sat					115
Mvomero DC	Scale-Up Sat	62,074	22,346	80%	-	264
Namtumbo DC	Scale-Up Sat	40,293	32,234	80%	19,035	179
Ngara DC	Scale-Up Sat	61,423	32,097	80%	27,256	365
Njombe DC	Scale-Up Sat	17,504	6,087	284%	27,327	63
Nkasi DC	Scale-Up Sat	54,974	2,174	83%	4,964	350
Nzega DC	Scale-Up Sat	83,716	5,298	95%	2,177	418
Rungwe DC	Scale-Up Sat	55,227	11,465	80%	3,463	155
Sengerema DC	Scale-Up Sat	137,373	5,029	80%	9,786	705
Shinyanga DC	Scale-Up Sat	66,626	5,182	89%	4,929	338
Shinyanga MC	Scale-Up Sat	36,064	1212	111%	3,556	130
Songea DC	Scale-Up Sat	35,726	15,099	80%	711	139
Sumbawanga DC	Scale-Up Sat	59,663	1390	120%		
Sumbawanga MC	Scale-Up Sat	46,674	1,178	81%	12,822	192
Tabora MC	Scale-Up Sat	51,510	4,117	80%	1,181	195
Tunduma TC	Scale-Up Sat	21,240	1,097	80%	1,019	97
Tunduru DC	Scale-Up Sat	57,800	34,211	80%	28,986	249
Ukerewe DC	Scale-Up Sat	68,829	13,713	80%	11,884	365
Urambo DC	Scale-Up Sat	41,243	1,609	109%	1,547	196
Ushetu DC	Scale-Up Sat	55,788	12,673	80%	10,950	305
Uyui DC	Scale-Up Sat	81,008	5,292	80%	4,748	304
Wanging'ombe DC	Scale-Up Sat	32,650	4,190	95%	3,249	115
Total/Average		**3,553,343**	**589,006**		**520,905**	**14,993**

Standard Table 4.6.3

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY 2018)**	**FY 2019 Target**
PP_PREV *KP_PREV* *KP_MAT*	**1,186,501** **135,869** **2,360**	**AGYW-70%** **KP (FSW85%, MSM 65%, PWID 75%)** **85%**	**261,913** **94,527** **1112**
TOTAL	**1,324,730**		**357,552**

Standard Table 4.6.4 Targets for OVC and Linkages to HIV Services

Table 4.6.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY 2019 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY 2019 Target)
Arusha CC	19,437	5,832	5,366
Arusha DC	6,822	2,455	2,259
Biharamulo DC	19,533	976	898
Buchosa DC	-	1,214	1,117
Bukoba DC	15,758	6,460	5,943
Bukoba MC	5,541		
Bukombe DC	17,566	1,405	1,293
Bunda DC	9,117	3,828	3,522
Busega DC	13,077	653	601
Chalinze DC	-	3,360	3,091
Chato DC	29,071	2,325	2,139
Dodoma MC	11,264		
Gairo DC	7,310	1,095	1,007
Geita DC	62,558	46,920	43,167
Geita TC	-	1,029	947
Igunga DC			

Ilala MC	34,471	14,478	13,320
Ileje DC	81,094	42,980	39,542
Ilemela MC	8,019	801	737
Iramba DC	18,313		
Iringa DC	6,671	2,001	1,841
Iringa MC	20,198	8,281	7,619
Itilima DC	16,202		
Kahama DC	-	841	774
Kahama TC	44,283		
Kalambo DC	19,902		
Kaliua DC	7,834	784	721
Karagwe DC	34,221	2,396	2,204
Kibaha TC	18,259	3,105	2,857
Kigamboni MC	4,846	4,850	4,462
Kigoma Ujiji MC	-	1,108	1,019
Kilolo DC	16,715	6,852	6,304
Kilombero DC	17,032	8,346	7,678
Kilosa DC	13,671	3,008	2,767
Kinondoni MC	15,669	2,351	2,163
Kishapu DC	110,777	72,005	66,245
Kondoa DC	22,029	2,203	2,027
Kongwa DC	6,552	1,311	1,206
Korogwe DC	7,688	1,537	1,414
Kwimba DC	11,344	2,270	2,088

Kyela DC	33,217	2,656	2,443
Kyerwa DC	15,529	19,211	18,379
Ludewa DC	18,631	3,727	3,429
Lushoto DC	14,999	4,950	4,554
Mafinga TC	24,604	4,921	4,527
Magu DC	5,570	1,116	1,027
Makambako TC	23,614	2,124	1,954
Makete DC	11,397	2,281	2,099
Masasi DC	9,821	5,695	5,239
Maswa DC	3,494	944	869
Mbarali DC	22,568	1,579	1,453
Mbeya CC	22,189	11,760	10,819
Mbeya DC	36,182		
Mbinga DC	21,346	12,487	11,488
Mbinga TC	20,045	11,225	10,327
Mbogwe DC	-	5,573	5,127
Mbozi DC	-	957	881
Meatu DC	32,000	22,401	20,609
Missenyi DC	20,842	4,168	3,835
Misungwi DC	10,708	2,570	2,364
Mjini	28,346	2,551	2,347
Mkuranga DC	367	366	337
Momba DC	8,467	8,466	7,789
Morogoro DC	14,218	711	654

Morogoro MC	8,728	1,745	1,605
Moshi DC	14,017		
Moshi MC	17,826	14,617	13,448
Mpanda TC	4,696		
Msalala DC	6,040	2,235	2,056
Mufindi DC	-	29,533	28,504
Muheza DC	21,656	10,828	9,962
Muleba DC	8,678	1,735	1,596
Musoma DC	29,833	38,216	37,023
Musoma MC	4,093	819	754
Mvomero DC	5,941	1,188	1,093
Namtumbo DC	10,232	2,251	2,071
Ngara DC	11,730	2,347	2,159
Njombe DC	18,316	3,663	3,370
Njombe TC	9,597	7,006	6,446
Nkasi DC	14,672		
Nyamagana MC	11,267	3,156	2,904
Nzega DC	19,148		
Rorya DC	42,487	19,120	17,590
Rungwe DC	6,355	3,303	3,039
Sengerema DC	22,033	9,695	8,919
Serengeti DC	52,550	25,225	23,207
Shinyanga DC	6,506	1,302	1,198
Shinyanga MC	27,269	25,845	25,169

	13,485	22,794	21,985
Songea DC	9,503	4,752	4,372
Songea MC	19,871		
Songwe DC	-	2,345	2,157
Sumbawanga DC	11,709	9,602	8,834
Sumbawanga MC	8,311	4,987	4,588
Tabora MC	20,449		
Tanga CC	18,991	6,267	5,766
Tarime TC	-	642	591
Temeke MC	93,214	55,369	51,640
Tunduma TC	10,003	1,801	1,657
Tunduru DC	16,238	2,435	2,240
Ubungo MC	-	2,049	1,885
Ukerewe DC	26,383	3,957	3,640
Ulanga DC	8,965	1,344	1,236
Urambo DC	17,042	2,556	2,351
Ushetu DC	-	26,284	25,564
Uvinza DC	13,100	1,965	1,808
Uyui DC	34,589	5,187	4,772
Wanging'ombe DC	17,512	4,203	3,867
	1,864,033	**753,867**	**701,954**

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 COP 2018 Programmatic Priorities

Attained councils are geographic areas that have achieved ≥90% treatment coverage in both males and females within the following prescribed age bands: <1, 1-9, 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-49, and 50+. Achievement of 90% by FY 2019 will ensure that the country gets to 95/95/95 overall. The emphasis for these Attained councils is to sustain high coverage levels and increase viral load suppression rates to achieve at least 95% suppression rate in all PLHIV on treatment. Sustained councils are districts that have a lesser HIV burden and where fewer than 20% of all PLHIV reside. In COP 2018, treatment targets in sustained and attained councils consider a passive growth of 2.5%.

PEPFAR/T calculated the expected volume of patients needing the standard package of services in these areas by council and overall (Table 5.1.1). PEPFAR/T derived the expected number tested through PMTCT sites based on the assumption that these sites would continue in FY 2019 to test 95% of pregnant women and link 95% of those identified HIV-positive to treatment, per standard of care and national guidelines. - PEPFAR/T has discontinued support to testing in zero and low- yield sites.

5.2 Targets for attained and sustained locations and populations

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts*

Attained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing (all populations)	*HTS_TST*	2,134,093	531,926
HIV-positive (all populations)	*HTS_TST_POS*	114,349	19,017
Treatment new	*TX_NEW*	96,676	20,800
Current on ART	*TX_CURR*	368,298	180,459
OVC*	*OVC_SERV*	11,341	170,091
Key populations	*KP_PREV*	54,194	18,884

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		**Expected result APR 18**	**Expected result APR 19**
HIV testing in PMTCT sites	*PMTCT_STAT*	258,384	310,938
HTS (only sustained ART sites in FY 2017)	*HTS_TST/HTS_TST_POS*	63,578	1,403,577/26,912
Current on ART	*TX_CURR*	189,060	192,428
OVC	*OVC_SERV*	22,254	7,571*

* From two councils: Chunya DC and Moshi MC

5.3 Establishing service packages to meet targets in attained and sustained districts

The 11 attained SNUs are all in densely populated urban areas. THIS data found that HIV prevalence is higher in urban areas than in rural areas that lack of knowledge of status is common, and that viral suppression is low. Program data demonstrate that people living in neighboring SNUs commonly seek care within these urban SNUs. Program data also continue to demonstrate relatively high testing yields in these SNUs. Additionally, the PEPFAR/T

strategy for COP 2018 prioritizes efforts in urban areas, recognizing that transmission of HIV in those areas could impact a large number of people quickly. Therefore, the package of services offered in the attained SNUs will be the same as that offered in scale-up SNUs, with the addition of strategies specific for high-density urban areas described earlier, including more in-depth sexual network index tracing. PEPFAR/T believes that continuing in this manner will not only limit the potential for undue transmission in densely populated areas, but that it will also contribute towards HIV case finding among persons residing in neighboring SNUs.

In sustained councils, PEPFAR/T will provide HIV testing and counseling on request or as indicated by clinical symptomology or identified risk behaviors. Standard national clinical service package will be provided for PLHIV; this will include, routine clinic visits, ARV treatment and care package. Essential laboratory services will be provided for PLHIV in terms of viral load testing to increase coverage.

In surveillance, program monitoring, and laboratory systems, PEPFAR/T will continue to monitor viral load suppression and suspected treatment failure in attained and sustained Councils. PEPFAR/T will continue to support ongoing surveillance activities to monitor new and on-going HIV infection. Surveillance will also monitor those who continue to be at risk based on surveillance and epidemiologic data. In addition, all laboratory systems in the attained councils will support clinical monitoring of patients to meet 90% viral suppression target in FY 2019. Specifically, PEPFAR/T will work with IPs in attained councils to improve lab-clinical interface and catalyze scale-up of enhanced tools to promote accuracy, reliability, and timeliness of VL testing and return of results to patients (e.g. VL facility scorecard, web-based dashboard).

In COP 2018 PEPFAR/Tanzania will support maintenance of high coverage for VMMC services among 10-29 years in councils where circumcision coverage already exceeds 80% and will achieve 80% coverage in councils where circumcision coverage is lower. Males aged 25-29 years will be targeted to reach 80%. This will contribute to the attainment of national target of excess of 4 million circumcisions. Attained and sustained councils will continue government leadership in rolling out of EIMC.

In COP 2017, the OVC program is serving 33,595 OVC in attained and sustained SNUs; while in COP 2018, the program is expected to reach 170,091 beneficiaries in attained councils, and very few 7,571 OVCs in sustained councils. The later has few beneficiaries because only two districts will be covered, Moshi MC and Chunya DC, as transitioning to the GOT is being affected. Effective IP engagement and program monitoring with council leaders and stakeholders will continue in these councils to ensure maintenance of service to this important population.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.0 Critical Systems Investments for Achieving Key Programmatic Gaps

Site-level investments on their own will not succeed in achieving epidemic control. PEPFAR/T has identified several key areas where above-site investments will address barriers to reaching epidemic control. These investments focus on: 1) improving systems for accurate, timely data for patient care and program improvement; 2) addressing human resource gaps; 3) ensuring that

laboratory services have the capacity and quality needed to reach epidemic control goals; 4) accelerating development and implementation of key policies, especially those that will improve HIV case finding and retention; 5) increasing sustainable financing; 6) improving commodities and the supply chain; and 7) ensuring systems for quality assurance and improvement. This section will complement Table 6 by describing the key epidemic control or systems barriers that we are aiming to address, specific examples of investments that we have already made, along with the impact of those investments to date, and plans for COP 2018 to continue to address key barriers.

PEPFAR Tanzania's investments in systems over the past three years have been informed by analysis conducted in COP 2016 that identified core about seven systems barriers to meet critical programmatic gaps.

6.1 System Barriers: Information Systems and Data Use

Access to accurate, timely information about key aspects of program performance is essential to making the rapid progress that Tanzania must make to achieve epidemic control targets. Likewise, appropriate information systems can improve patient-level care. For these reasons, information systems and data use have been critical areas of above-site investment for PEPFAR/T and remain so for COP 2018.

The table below highlights specific examples from Table 6 of key above-site investments in information systems and data use, the epidemic control or systems (MER/SIMS/SID) barrier that was identified, key selected activities and benchmarks, and the current status of what has been achieved with above-site investments to date.

Epidemic Control Barrier or Systems Gap Identified	Key selected activities and benchmarks	Current status (value from investment to date)
Efforts to use data within planning and resource allocation hindered by lack of evidence from **surveys, surveillance and evaluations**	Fully functioning case-based surveillance system consisting of testing data, care & treatment sentinel events, and facility-based HIV mortality data SRE activities completed and results disseminated to inform planning.	Case Based Surveillance Strategy documented to leverage existing Patient Monitoring System. Data available for care and treatment, systems being updated to capture testing data, sentinel events and mortality data. THIS (PHIA), completed and used to inform planning, 2018 PLHIV estimates developed, regional spectrum files updated, costing studies for PMTCT and HTC completed and disseminated, and evaluation of TB services completed and disseminated
Client level data systems need to scale and adapt to support service delivery models, service level follow up on retention, improve quality of routine data and linkages across service delivery points.	Tracking and linkage across HIV Services supported via electronic systems for 40% of HIV-positive people identified and 90% of clients on treatment by 2019. 50% coverage for SMS IEC or automated appointment reminders	As of Dec 2017, Tracking and linkage across HIV services supported via electronic systems for approximately 5% of HIV-positive people identified and >75% of clients on treatment. Plans in place to achieve 2019 goal. PMCTCT clients receiving SMS IEC.

	for clients of PMTCT, HTS and HTX services by 2020 Increased number of clients registered within patient level data systems for remote check in or alternative refill site for less frequent clinic visits.	Automated appointment reminders to be introduced in 2018. Pilot for remote check ongoing.
HIS Registries, Services and Infrastructure required to link or integrate data across services and sites.	By 2019 all 'Stable' PEPFAR reporting requirements sourced from GOT data systems and stakeholders using single data set for decision making. National HIS infrastructure supports integrated service delivery	Data Alignment completed to synchronize DHIS, DATIM and CTC with Health Facility Register (HFR). Majority of IPs sourcing PEPFAR reporting from GOT data systems. Common set of data for current on treatment used for decision making Health Information Mediator customization ongoing Client Identification Standard and requirements for Client Register reviewed and approved by Care Delivery TWG
Data Access and Data Use impeding effective monitoring of new interventions, planning and resource allocation	At least 90% of scale-up councils have systems that facilitate use of Multisector profile data for decision making At least 90% of CHMTs in scale-up LGAs implement data-driven planning and accountability approaches when developing Comprehensive Council Health Plans and monitoring their implementation	Service statistics (DHIS), patient records, and logistics data (eLMIS) dashboard developed to facilitate stakeholder review across information systems by 2019. Redesigned PlanRep/EpicoR is used by all 195 Councils.

6.1.1 Information Systems and Data Achievements to date:
Surveys, Surveillance and Evaluations are addressed in a separate section 6.8.

As described in the table above, substantial progress has been made in the data and information systems domain in achieving goals needed to facilitate epidemic control. The percentage of clients captured in national care and treatment database increased from 15% in Q3 2017, to >60% in Q4 2017 and is now over 75% as of FY 2018 Q1. Tanzania is on track to meet 90% target for 2019 and working towards 95% coverage by 2020. These data allowed PEPFAR/T to look at age disaggregation not available within routine aggregate reporting, but which is now requested by PEPFAR. Additionally, it enabled the team to assess the extent to which clients were attending more than one clinic with the same registration ID. This was essential for the new SPECTRUM estimates used for COP 2018 planning. Successes in strengthening client level data systems are being leveraged to monitor fidelity of scale-up for key interventions including test and start and multi-month testing, providing both aggregate and site-level data, and facilitating access to data far more frequently than quarterly.

Tanzania recently completed pilot testing of new HTS extension for CTC2 and plans are underway to scale-up this system to large sites. During FY 2017, we implemented a biometric system in majority of HIV care and treatment clinics in Zanzibar. The biometric system provides linkage between HTS and care and treatment databases, which have patients' level identifiers, and information, and this can help to build the platform for case-based surveillance (in both Mainland and Zanzibar). Expansion to mainland Tanzania is planned for 2018 and COP 2018.

Concurrent to this effort, PEPFAR/T has supported the development of new GOT Integrated electronic Health Facility Management System (IeHFMS) with EMR and hospital management capabilities. By APR 18, Tanzania expects to complete testing of system in 8 facilities and start deploying to large facilities. The IeHFMS supports capture of HIV testing client level data from all service delivery points including RCH, TB, OPD, IPD, Immunization, etc. GOT has applied for $3 Million of GF catalytic funding for IeHFMS roll out to regional referral hospitals. Targeting large hospitals is seen as a key first step since 50% of all HIV-positive people are identified in the largest 400 health facilities. Strong client level data for HIV testing is vital to be able to accurately monitor scale-up of index testing and other targeted testing interventions.

Tanzania is working to adapt facility level electronic reporting systems to support service delivery and quality of services. Within FY 2018, a remote check in service, automated appointment reminders, viral load results integration and IEC SMS messaging are all being integrated and tested.

PEPFAR/T has been working to triangulate results from SIMS assessment visits with program and financial results to inform partner and program management strategies. In addition, over 75% of scale-up councils have developed multi-sectoral reports with HIV data triangulation for use within their annual planning.

PEPFAR supported development of new versions of PlanRep and EpicoR, GOT planning and budgeting data systems used at the LGA levels which are not in use at 100% of LGAs. In July 2017, the requirement to use the redesigned PlanRep for LGA planning and budgeting was incorporated into the official national planning and budgeting guideline.

6.1.2. Information Systems and Data Priorities and COP 2018 Activities

PEPFAR/T will continue supporting automated aggregate reporting from facility level systems to the HMIS/DHIS2 and continuous improvements in quality and use of electronic medical records to support the full HIV cascade. This includes evolving the system to support program data requirements and moving towards automated reporting from site level, to CTC, to DHIS and into the PEPFAR DATIM. In collaboration with GOT, PEPFAR will support the training of a cadre of well-trained M&E professionals to improve the culture of data use, strategic decision making, and data quality in Tanzania.

One focus area for investigating data quality is PMTCT Data as DQA suggests there may be over reporting. Additionally, the THIS highlighted a potential discrepancy between number of women being tested during pregnancy, high fertility rates and high number HIV-positive women who do not know their status. While DQA efforts can help address data quality, the IeHFMS is expected to support data collection that from efforts to introduce HIV testing for women and their children when they come for DPT1 vaccination that is linked to PMTCT records.

At the service delivery level, and to improve retention, PEPFAR/T will strengthen the use of appointment and tracking registers, with special emphasis on early tracking of missed appointments. PEPFAR/T will use mobile technology by expanding the use of text message reminders to follow up clients and electronic self-triaging systems. PEPFAR/T will support the development and improvement of an integrated electronic Health Facility Management System (IeHFMS) that can ensure HIV data needs are integrated across health services including support for additional service delivery points to capture HIV testing, improve quality of reporting and monitor repeat testing.

As continued leverage of the private sector, PEPFAR/T will continue to expand the mHealth Public Private Partnership activity. This initiative under the leadership of NACP facilitates the implementation and expansion of Fast Track ARV refills (FASTA) schemes for differentiated service delivery models.

PEPFAR/T will continue to strengthen the national Health Information System infrastructure for improved data use, exchange and management. COP 2018 will support scale-up of integration of facility systems with national Client Register (CR) to support linkage and deduplication of reported data, Shared Health Record (SHR) to strengthen capture of HIV service data and customization of Health Information Mediator (HIM) to support data exchange across systems.

6.2. System Barrier 2: Human Resources for health

HRH are a critical factor for health service delivery, and the provision of quality HIV services to beneficiaries. While this remains a major challenge for Tanzania, some important progress has been made. This section will describe the efforts by PEPFAR/ T to increase the availability of competent and skilled workforce to meet the unique needs of the program. The table below highlights specific barriers and related outcomes that have guided implementation over the past three years with an added emphasis on the technical priorities that are the focus of COP 2018 implementation.

Epidemic Control Barrier or Systems Gap Identified	**Key selected activities and benchmarks**	**Current status (value from investment to date)**
Technical Priority: HIV Testing Services: Expand targeted testing approaches to increase identification of PLWHA		
Limited use of targeted approaches to increase testing yield and improve linkage. Inadequate use of community structures, including community health workers, to support targeted HTS interventions.	• Increased yield for all HTS tests increased to 7% by 2020. • Increased support for CHW deployment by GOT to each village within scale-up districts	• PEPFAR will support the MOH to utilize CHW for testing. • CHW training packages and Scopes of Practice (SOP) developed • Process to formalize CHW cadre launched in 2018 • 280 health care workers in Field Epidemiology

		and Laboratory management • HR mentors deployed in 13 target regions
Technical Priority- Treatment: Finding the people the program has missed, getting them on treatment and retaining them		
Shortage of skilled service providers in scale-up LGAs Inefficient HRH allocation and distributions processes; and poor rational use of health workforce.	At least 75% of approved permits are filled in scale-up councils, disaggregated by cadre. Available health workers are efficiency allocated to facilities of highest need, based on treatment and retention needs.	• 33,00 HCW supported • 280 health care workers in Field Epidemiology and Laboratory management • Improved HRH recruitment, deployment, and retention process by introducing WISN, POA and WOA • HRH sustainability plan developed • HR mentors deployed in 13 target regions
Technical Priority: ARV commodities and transition to new regimen's (includes TLD optimization)		
• Limited capacity for supply chain management at the subnational levels,	• Pro-active management of facility level supply chains done by the RHMTs and the CHMTs	• 280 health care workers trained in Field Epidemiology and Laboratory management
Technical Priority: Differentiated Service Delivery Models		
• Shortage of skilled service providers in scale-up LGAs • Inefficient HRH allocation and distributions processes; and poor rational use of health workforce.	• High quality services per new HIV/AIDS protocols, updated DSDM guidelines, NIMART and task sharing policies • Available health workers are efficiency allocated to facilities of highest need, based on treatment and retention needs.	• 33,000 HCW supported • 280 health care workers in Field Epidemiology and Laboratory management • Improved HRH recruitment, deployment, and retention process by introducing WISN, POA and WOA • HRH sustainability plan developed • HR mentors deployed in 13 target regions

6.2.1 Human Resources for Health Achievements to date:

Staffing shortages in the health sector have undermined Tanzania's efforts to achieve HIV epidemic control. Since 2016 PEPFAR/T has invested in HRH to address this critical barrier. In FY 2016, PEPFAR Tanzania supported nearly 33,000 health workers through a combination of salaries; stipends; financial and non-financial benefits; and professional development. PEPFAR's financial support to the Tanzanian workforce reached approximately 10,000 clinical and managerial workers and 23,000 community health workers.

Through COP 2016 activities CHW training packages and Scopes of Practice (SOP) were developed. However, the recruitment of CHWs was delayed due to a GOT hiring freeze. The MOHCDGEC launched consultations to formalize the CHW cadre in February 2018. Specific PEPFAR/T plans to increase the role of CHW in HIV service delivery are described in detail in the COP 2018 Activities section below.

According to the MOHCDGEC it is estimated that Tanzania requires 225 epidemiologists. However most trained epidemiologists are located at the national level, leaving approximately 55% of required positions unfilled. This gap contributes directly to the inability to effectively monitor and evaluate ongoing HIV/AIDS programs or detect other priority diseases. Since the inception of the Tanzania Field Epidemiology and Laboratory Training Program (FELTP) program in 2008, the program has managed to produce public health leaders in technical areas such as medicines and technologies, information systems and HRH. Graduates have supported HIV testing, quality assurance in HIV testing, validation of HIV laboratory tests/kits, and the coordination HIV proficiency testing. To date, the FELTP program has trained 280 health care workers in Field Epidemiology and Laboratory management.

In COP 2016, PEPFAR/T successfully redesigned the HRH recruitment, deployment, and retention process to use information on disease burden and various evidence tools such as the Workload Indicators for Staffing Needs (WISN), the Prioritization & Optimization Analysis (POA) and Workforce Allocation Optimization (WAO). This redesign improved workforce allocation and distribution considerably. In collaboration with the GOT, HR mentors were also deployed to facilitate workforce retention in 13 target regions. In early 2018, the MOHCDGEC has committed to create another 11,000 permits and these tools will be used to ensure the rational distribution of the workforce in priority scale-up councils to deliver quality HIV services. The success of Tanzania in this area has been identified for inclusion in the PEPFAR Solutions Platforms.

The adoption of the differentiated SDM has helped to significantly decongest clinics. PEPFAR/T has worked closely with the GOT to develop the implementation plan for task sharing and revise the Scopes of Practice (SOP) for nurses and other mid-level cadres in order to implement the SDM and Test and Start policy. The SDM policy standard operating procedures, guidelines and job aides were finalized as of 2017, with full roll out expected to continue in FY 2018. PEPFAR/T is working with the GOT through the MOHCDGEC, PORALG and the Tanzania People Defense Forces (TPDF) to accommodate a more streamlined and standard SDM aiming to decongest clinics, improve quality of care, support distribution points to decentralize ARV pick up that are closer to beneficiaries in their communities. Nursing, clinical officer, pharmacy, and CHW cadres will continue to provide high quality services per the Task Sharing policy in 100% of scale-up councils and the GOT plans to deploy between 1 to 2 CHWs to each village within scale-up councils.

As part of the sustainability landscape, human resources for health scored yellow under the *Health System and Service Delivery* domain, representing an area for continued investment. In order to map the current and future investments for sustainability and shared responsibility for HRH by the Government of Tanzania. PEPFAR/T has developed a HRH Sustainability Plan. Funding for health care workers HCW supports epidemic control through ensuring appropriate levels of human resources across the HIV care continuum, particularly at the community level in scale-up councils.

6.2.2. Human Resources for Health Priorities and COP 2018 Activities

Based on the current COP 2018 priorities and the status of key HSS benchmarks and outcomes, PEPFAR/T will focus on host country institutional development for HRH leadership and governance and management through COP 2018 activities. PEPFAR/T will ensure that at least 75% of HCW are retained for 1 year. To assure this retention rate, PEPFAR/T will employ a combination of approaches to ensure a decrease in vacancy rates through the various components of the HRH value chain. For example, PEPFAR/T will ensure that recruitment best practices are in place to ensure the right staff with the right qualifications are identified to fill vacancies, and are allocated to the locations with the highest need. To support staff retention, PEPFAR/T will promote the utilization of evidence-based HRH tools such as the WAO and WISN-POA tool. Facilities will develop retention plans which will include key HR metrics to assist in measuring performance on attrition rates, staff turnover, and absenteeism PEPFAR will continue to build on successful HRH interventions that support deployment and distribution of critical staff efficiently within LGAs to ensure health workers are allocated to scale-up councils and to facilities of the highest need.

PEPFAR/T will assist the GOT to effectively allocate new graduates from Health Training Institutes through the approved permits and existing health care workers, to assist in the HRH cycle of recruitment, deployment, retention and redistribution. This will include working closely with the different stakeholders across key ministries that include MOHCDGEC, PORALG, and Presidents Office- Public Service Management (PO-PSM), and the integration of the existing tools to the national Human Resource Information Systems HRHIS. These initiatives and approaches will strengthen the existing relations between PEPFAR/T and GOT to ensure integration and sustainability of HRH investments.

PEPFAR/T will strengthen host capacity institutions across different levels, including at the local council and facility level, to ensure that service providers meet HIV program needs across the continuum of care. Capacity building approaches will focus on both facility health care workers and lay worker providers at the community level to monitor and follow up on retention and support decision makers. Programs will ensure that HCW are available and well equipped with the essential skills to provide quality treatment in the new service delivery models

COP 2018 will see continued support to mid and lower-level cadres practicing task sharing through various methods including Continuous Professional Development (CPD) through the respective professional associations/bodies, LGAs, and designated professional councils to regulate the quality of task sharing. PEPFAR/T will also focus on most at risk OVC who will be identified through KP focused social services initiatives In addition, PEPFAR/T will track the practice of task sharing to inform future strategy on HRH investments through the HRH Sustainability Plan.

In COP 2018 PEPFAR/T will provide financial support for the new formal CHW cadre to increase the coverage of community level interventions. Community and social welfare workers and community health volunteers will support identification of PLWHV and targeting of specific populations like FSW and AGWY who will also be encouraged to bring in their children for testing. PEPFAR/T will work with the GOT to coordinate between the new CHWs and the existing program community health volunteers to increase community-based HIV activities-including testing, prevention, care and treatment.

PEPFAR/T will support health care workers for specific HIV program management actions including monitoring and follow up on retention and support. To increase pediatric retention, PEPFAR/T will strengthen the tracking system for children, especially adolescents, and vulnerable children. For all hard-to-reach populations, PEPFAR/T will strengthen the use of appointment and tracking registers, with special emphasis on early tracking of missed appointments. PEPFAR/T will use mobile technology to facilitate client follow up through text message reminders, electronic self-triaging systems and designing family centered clinic appointments.

PEPFAR/T will support the continued utilization and roll out of the Tanzania Nursing and Midwives Information System (TNMIS) and the development of the TNMIS Sustainability Plan for the MOHCDGEC. The plan is part of the transition process to guide the TNMIS system's gradual hand over to the MOHCDGEC. This will be used by the Directorate of Nursing and Midwifery Services (DNMS) and the Tanzania Nursing and Midwifery Council (TNMC), to monitor registration and licensing of nurses and midwives. The sustainability plan will also provide a framework for development of additional service level indicators during the implementation of NIMART, as a CQI process. This will further assist in the institutionalization of the planned 12 NIMART indicators during implementation of task sharing and elaborate the contribution of nurses to specific services like HTS conducted by nurses and clients initiated on treatment. In addition, this will ensure availability of quality patient-level data from the community and facility service delivery, across selected scale-up districts.

PEPFAR/T will continue to provide TA to the Centre for Distance Education (CDE) under the Ministry of Health, to strengthen distance education and e-learning platform by conducting ECHO (telehealth) sessions for health care workers delivering HIV care in all regions. PEPFAR/T in COP 2018 will continue to work with FELTP, NACP, and other development partners to further identify and align with the HRH priority areas. The trainees of the FELTP will focus PEPFAR technical issues, programmatic challenges and shifts. This approach in the past has resulted in an increased number of HIV and TB related research studies generated and published to date.

In COP 2018 PEPFAR/T will strengthen the supply chain by include equipping the RHMTs, CHMTs and the Pharmaceutical Services Unit to proactively manage the supply chain. As part of long-term sustainability, PEPFAR/T is transitioning efforts from the PEPFAR/T supply chain implementing partner to GOT through a phased approach that leverages USG, Global Fund and GOT resources towards a complete handover of all Logistical Management Unit staff to the GOT by 2020. Improved dashboards for supply chain using newly standardized supply chain key performance indicators will equip the councils with the tools they need to ensure availability of HIV products. To improve data accuracy, supply chain needs will be included in new data quality assessments done by the councils. PEPFAR/T will also support the process to update the Electronic Logistics Information System and expand data entry down to the facility level and in line with EMR services.

The support of HRH will significantly increase in COP 2018 to assist Tanzania to achieve its ambitious targets. PEPFAR does not have a breakdown of cadres for COP 2017 because this data is collected retrospectively. Therefore, comparisons are best made with figures from COP 2016. These HRH projections for COP 2018 may shift depending on the actual needs identified by implementing partners and NACP for each facility and community site during COP 2018 implementation. COP 2018 projections reflect approximately a four-fold increase from COP 2016 indicating PEPFPAR/T's commitment to scaling-up human resource capacity. The table below highlights the proposed increases in PEPFAR/T support for HRH by cadre from COP 2016 to COP 2018.

Number of PEPFAR Supported Staff by HRH Category from COP 2016 to COP 2018

HRH Category	Number of Staff	
	COP 2016	COP 2018
Clinical Service Care Provider (clinical sites) including Lab	2,474	6,836
Community Health Worker	4,561	17,851
Managerial and Support Staff (non-clinical, clinical service sites)	1,099	1,209
Managerial and Support Staff (non-clinical, government sites)	89	98

6.3. System Barrier 3: Laboratory systems

The network of laboratory services in Tanzania is comprised of a National HIV reference laboratory, five zonal referral hospital laboratories, 24 regional laboratories, and 93 district laboratories, as well as 583 larger health centers with laboratory facilities and 5525 dispensaries that can perform simple diagnostic procedures. Of all these, PEPFAR/T currently supports 2380 facilities with the capacity to perform clinical laboratory testing, including 839 laboratories and 1541 Point-of-Care (POC) testing sites.

Historically, the country has not had enough laboratories and machines to support the growing VL testing demand which has resulted in inadequate VL testing capacity to meet targets. Above-site investments in laboratory services have aimed to increase capacity to the level needed for patient care, successfully achieve target VL coverage, ensure that test results are returned in accordance with an appropriate turn-around time, and assure the quality of laboratory services, including HIV testing and VL testing.

The table below highlights specific examples from table 6 of key above-site investments in laboratory services, the epidemic control or systems (MER/SIMS/SID) barrier that was identified, key selected activities and benchmarks, and the current status of what has been achieved with above-site investments to date.

Epidemic Control Barrier or Systems Gap Identified	Key selected activities and benchmarks	Current status (value from investment to date)
Increasing the scale of viral load testing		
• Low viral load coverage because of inadequate viral load capacity	• All patients on ART eligible for VL testing received at least one VL test per year.	• Viral load capacity increased from 475,000 to 2.2M during 2017. Increase from 96,000

• High turn-around time (TAT) for lab results due to inadequate number of "hub" facilities capable of receiving, processing, and transporting specimens	• All 309 sample collection hubs are fully functional and VL lab results TAT is within the national set time of 14 days.	tests in 2016 to 327,000 in 2017. • The number of hub facilities increased from 57 to 157 in 2017. TAT decreased from 60 to 30 days (with TAT of 10 in places with hub and spoke model in place)
Improving the quality of laboratory services		
• Healthcare workers have limited knowledge and skills on implementation of Rapid Test Continuous Quality Improvement (RTCQI). • Few facilities participated in Proficiency Testing / EQA for rapid HIV testing and those participating, had low passing scores. • Only 6 labs doing VL testing, of which 5 of 6 accredited	• All HIV Rapid testers are certified to be competent on RTCQI. • All facilities (5,310 sites) participate in and 90% of participating sites pass PT/EQA • Expand to 17 VL testing laboratories, and all should be fully accredited to International Standards ISO 15189	• For RTCQI, the certification framework was developed. Certification was begun in 2018, so no results to date. • 4,596 sites (87%) are participating in PT/EQA. Of those, 2,460 (54%) passed. • Expansion to 17 VL labs complete. Still only 5 ISO accredited, but 3 have 3 star WHO rating and have applied for ISO accreditation assessment.

6.3.1 Laboratory systems Achievements to date:
As noted in the table, above-site investments in laboratory services led to a quadrupling of VL testing capacity in 2017, more than a 3-fold increase in the number of VL tests conducted, an increase in the number of hub facilities and concomitant decrease in TAT, and improved quality of testing.

6.3.2. Laboratory systems priorities and COP 2018 Activities
While substantial progress was made in scaling up capacity in 2017, quality gaps were noted and will be a key focus for the remainder of 2018 and through COP 2018. PEPFAR/T will focus on addressing the remaining gaps to accelerate viral load testing and early infant diagnosis through laboratory accreditation and quality improvement, strengthening sample transportation systems and supporting of the critical human resource shortages for HIV testing. The new focus will address inefficiencies in sample referral networks leading to long results turn-around time and supply chain challenges related to the timely supply of reagents.

During COP 2018, PEPFAR/T will work in collaboration with the Department of Quality Assurance of the NACP and the MOHCDGEC Laboratory and Diagnostic Unit and the National Laboratory to improve the quality of HIV services in country to accelerate the QMEC. PEPFAR/T supports HIV Proficiency Test (PT) program with human resource, technical assistance and

equipment. By APR 2017, 4,448 HIV testing sites were enrolled into the PT program. Expansion to recruit more testing sites will continue during COP 2018. PEPFAR/T will also support External Quality Assurance of the CD4 and HIV viral load machines through support from CDC Atlanta. The country team will continue the collaboration with GOT to implement its QMEC using the existing CQI structure.

Lab standardization and optimization has been identified as an essential area to ensure lab supply availability and further strengthen the viral load program. Building on the lab standardization exercise supported by GFATM in FY 2018, PEPFAR/T will use LabEquip optimization software to examine the hub and spoke model and optimize lab and hub locations. This exercise will also assess laboratory system capacity factoring in the potential opportunity of GenXpert machines for EID while ensuring sufficient testing capacity is maintained for Tuberculosis testing, aiming for integration of POC platforms into current conventional laboratory network.

For laboratory systems, most commodities come from GFATM, and most HR needs are filled by GOT. In both cases, PEPFAR/T supplements to fill gaps. Otherwise, the laboratory expansion and quality efforts are funded by PEPFAR. GOT capacity has been built to oversee quality management.

6.4. System Barrier 4: Policies and Governance

Policies that are critical to reaching the country's targets include HIV self-testing and PrEP, differentiated service delivery models (DSDM), same day ART initiation and multi-month scripting of ART. These gaps are consistent with contents described in the WHO Guidelines and the PEPFAR/T COP Guidance and are relevant across the national, sub-national, and site levels. These have been significant areas of focus for system investments over the past three years as described in the table below:

Epidemic Control Barrier or Systems Gap Identified	Key selected activities and benchmarks	Current status (value from investment to date)
Policies to support increased HIV Case Finding		
Current Policy guidelines and operating procedures on self-testing, CHW testing, repeat testing, certification of testers/sites and anonymous HTS limit effective HTS interventions to maximize yield.	Adoption of critical HIV policies, on self-testing, index testing and development of operational guidelines for service delivery at different levels of care Engagement of community health workers in service delivery	Index testing increased from 1% to 17% of HTS_POS from Q1 to Q4 2017. Self-testing endorsed but requires law change, which is being tabled in April 2018 in parliament. CHW policies approved, MoH plans to hire (with partial PEPFAR support) during 2018. Community outreach ART supported by NACP, rolled out broadly, though some progress still needed in selected regions
Policies to decongest clinics and improve linkage and retention		

Congested clinics and sub-optimal retention	Scale-up of differentiated service delivery models with multi-month scripting	Multi-month scripting scaled up broadly, but only for 2 month ART refills for now.

6.4.1. Policies and Governance achievements to date:
As discussed in Section 2.1, the GOT has made great strides on policy revisions and this domain was one of the stronger scores on the SID 3.0. Following the release of the THIS, the GOT redoubled efforts to adopt new policies to increase identification, linkage, and retention. PEPFAR/T has worked closely with the GOT to develop implementation plan for the various policies above. In addition to the above policies, PrEP has also been approved and is slated to be implemented this month (March 2018), the KP policy was approved in 2017, and Nurse Initiated Management of Antiretroviral Therapy (NIMART) guidelines have been approved.

6.4.2. Policies and Governance priorities and COP 2018 activities
PEPFAR/T will work closely with the GOT to build on recent momentum in policy progress. We have scheduled monthly meetings with the senior levels of the Ministry to track progress in policy development and implementation, along with other key epidemic control priorities. PEPFAR/T will continue support for policy implementation and has identified key approaches that include *policy and governance, host institutional capacity development,* and *development of technical area guidelines and tools*. In COP 2018, PEPFAR/T continues to support sub-national structures including the RHMTs and CHMTs in translating policy guidelines into annual operational plans and provides continuous monitoring support for effective implementation. Strengthened governance structures at both PO-RALG and MOHCDGEC will facilitate the implementation of key policies and guidelines to improve the coverage of high impact interventions.

Focused IEC approaches will be developed to increase awareness and understanding of key policies, benefits of knowing one's HIV status among priority sub-populations, to address stigma in community and facilities, and to promote index testing among the clients and children of KP and PP. Advocacy actions support will be undertaken to leverage differences an increased population reach. In addition, community-based interventions using community structures and local community-based organizations (CBOs) will be used to integrate and promote HIV testing, including index testing. This approach will expand the reach of index testing beyond the "traditional partners" of positive pregnant women.

PEPFAR/T will facilitate increased collaboration between government and non-state actors and the private sector. ADDOs, which are often the first source for medicines for populations in rural and underserved areas, will be supported in the dispensing of multi-month ARV prescriptions and provide assisted self-testing upon the government's change in policy. The recent change in GOT policy on renewed emphasis on the role of the formal community health worker cadre will support these efforts.

The SDM policy has been rolled out, but a priority for the remainder of 2018 and COP 2018 is to improve its implementation, such that longer durations of ART refills are allowed. COP 2018 will see continued support to mid and lower-level cadres practicing task sharing and SDM in the form of Continuous Professional Development (CPD) (through the respective professional associations/bodies and LGAs), strengthened monitoring and supportive supervision (through the

National Supportive Supervision Guidelines (NSSG)), and strengthening of designated professional councils to regulate the quality of task sharing. In addition, PEPFAR/T will track the practice of task sharing to inform future strategy on HRH investments. In addition, PEPFAR/T will support at least 2,000 of the planned 11,000 CHWs who can support HIV testing as part of COP 2018 interventions to accelerate HIV case finding.

The PEPFAR/T team has developed specific measurable outcomes that address barriers associated with the implementation of these policies for future HRH programming.

PEPFAR/T will strengthen functional formal channels for diverse civil society groups and the private sector to engage, advocate for and provide feedback on the implementation of HIV/AIDS policies, programs, and services. PEPFAR/T will strengthen and support CSO coalitions to advocate and engage policy implementation. Effective CSO coalitions and advocacy will spearhead reduction of policy barriers, engagement in policy development and implementation for as active partners in the national HIV/AIDS response. PEPFAR/T will also continue to support LGAs to have functional channels to receive and give feedback for planning and decision making to the community, private sector, and civil society organizations. As key to policy implementation, strong engagement with PO-RALG is prioritized to fulfill its designated role of rolling out and implementing key programmatic policies.

PEPFAR/T leverages investments from GOT and other sources by working closely with GOT staff on policy issues. Staff in the Ministry of Health and TACAIDS are GOT-funded and lead policy development and translation. Staff in PO-RALG are GOT funded and support policy implementation down to the site-level. In all cases, PEPFAR/T engages with these portions of GOT to accelerate progress, in collaboration with multilaterals, including UNAIDS and WHO.

6.5. System Barrier 5: Financing

Sustainable financing for the HIV response in Tanzania continues to remain a major systems barrier. As demonstrated in the PEPFAR/T SID 3.0, and described in the sustainability profile section 2.2, sustainable financing scored poorly. The national budgets do have explicit funding for HIV/AIDS, but the overall ability to ensure that sufficient resources are committed to and allocated to meet the HIV disease burden remains a continual challenge**.** Only a small percentage of the national HIV response is financed with domestic resources. The table below summarizes some of the key activities and related outcomes in addressing this system gap. While some achievements have been made, significant needs and gaps remain and will continue as areas of PEPFAR/T support in COP 2018.

Table 6.5.1 Overview of outcomes defined for investments in Financing

Epidemic Control Barrier or Systems Gap	Key selected activities and benchmarks	Current status (value from investment to date)
Inefficient GOT systems for disbursement, management and use of funds budgeted for	Increased proportion of facility own revenue in targeted LGAs deposited in facility bank accounts and	LGAs nationwide utilizing PlanRep to plan budgets, request funds, and receive them from the central level.

HIV across all levels of government results in reduced GOT investment in HIV.	expended.	
	Facilities in scale-up LGAs receive timely disbursements of funds from the central level.	Improved planning system and direct to facility funding system is ensuring equitable distribution of resources to over 6,000 health facilities in the country and allows Tanzania to program funds to the highest priority services. These funds can also then be tracked so the public sector can be held accountable for delivering on its commitments. Health facilities have the autonomy to develop and monitor their own plans and budgets including prioritizing services tailored to their clients and communities, thus maximizing the use of existing resources to improve service delivery and outcomes.
	Scale-up LGAs increase allocation of domestic funds for HIV services by 10% in CCHP.	The proportion of facility revenue in scale-up councils deposited in facility bank accounts and expended has increased, and facilities in scale-up councils are receiving more timely disbursements of funds from the central level.
Insufficient leverage of the private sector to co-finance HIV program activities and services.	Commercial insurers develop complementary health insurance packages for customers available to pay.	Preliminary commercial supply chain analyses have been initiated.
	Total Market approaches used to decrease costs of HIV prevention commodities.	PEPFAR/T has worked with GFATM to build consensus and understanding on the need for a total market approach.
Financing gap between ARV commodities and viral load needs and GOT/PEPFAR/GFATM allocation.	Coordinated procurement plan for commodities developed and implemented on annual basis.	PEPFAR/T, GFATM, and NACP complete joint annual quantifications of HIV commodity needs with twice yearly reviews to update costed procurement plans.
	Increased domestic and external financing for HIV commodities and distribution identified in annual coordinated procurement plan.	For the first time, the government included a line item in its annual budget (FY 2016/17) specifically for procurement of ARVs
	GOT increase in funding of in-country	The GOT has started incremental repayments to this outstanding debt to the Medical Store

	distribution costs for all donated products including HIV-related donated product.	Department (MSD).

6.5.1. Financing achievements to date:
For the past two years, PEPFAR/T has provided TA and contributed to specific health financing reforms in the country that have an impact on the resource commitments and expenditures for HIV. Extensive policy dialogue, in collaboration with health basket fund (HBF) donors resulted in strategic purchasing agreement that would shift direct facility financing (DFF) for HBF from input-based to output-based payments. This increases the allocation of the domestic funds for HIV services in council level health plans. TA support at the national level also designed to improve the predictability and flow of funds from central to the sub-national levels.

In addition, PEPFAR/T has also supported key actions to ensure more efficient GOT systems for the disbursement, management and use of funds budgeted for HIV at all levels. As part of strengthening for public financial management (PFM) systems, PEPFAR/T has supported the design, deployment and launch of new and improved financial accounting and reporting systems at the health facility level. At the sub-national levels this facilitates better management of resources by the CHMTs to support HIV program activities.

As highlighted under the sub-section on information systems, PEPFAR/T supported TA and capacity building at the LGA level for expenditure and financial data system improvements. This included the redesign and implementation of the LGA level planning and budgeting system (PlanRep) which now includes service provider codes to track value for money and link expenditures to HIV service outputs.

Overall, as a result of these interventions, the proportion of facility revenue in scale-up councils deposited in facility bank accounts and expended has increased, and facilities in scale-up councils are receiving more timely disbursements of funds from the central level. As country-wide implementation is realized, scale-up councils will have an increased allocation of domestic funds for HIV services and budget execution rates should increase. All these efforts enhance local government's capacity to support HIV service delivery priorities in response to local needs and demands.

PEPFAR/T also supported strategic advocacy efforts with key stakeholders for supply chain targeted fund allocation in the GOT budget to mitigate challenges associated with ARV and commodity distribution. In COP 2016, the GOT significantly increased its contribution to the purchase and distribution of essential medicines and commodities. For the first time, the government included a line item in its annual budget (FY 2016/17) specifically for procurement of antiretroviral drugs (ARVs). That first stage of progress catalyzed increased advocacy through CSOs and PEPFAR IPs for effective budget execution and increased allocations for procurement or ARV, supply chain and repayment of MSD debt.

6.5.2 Financing priorities and COP 2018 activities
Strategic Objective: *Increased commitments, expenditures and efficient use of resources from government and the private sector to meet the HIV response in the country*

PEPFAR/T continues to support activities that will improve efficiency in HIV spending, including policy dialogue and capacity development with critical stakeholders at the MOFP, PO-RALG and MOHCDGEC, to support rolling out a national health insurance program that offers a comprehensive minimum benefit package that includes HIV/AIDS services. In addition, PEPFAR/T will provide support to ensure that the system allowing LGAs receive on-time disbursements of allocated resources from MOFP to enable HIV service delivery is running smoothly through its second year of implementation.

In response to the SID 3.0 assessment that revealed weak scores for private sector engagement, activities will be implemented with FY 2018 funds to expand and leverage private sector resources for the HIV response. PEPFAR/T will provide TA to health insurers (National Health Insurance Fund, Jubilee Insurance, and AAR Insurance) to assess feasibility of affordable HIV/AIDS care insurance packages for customers who are able to pay, based on commercial costs of HIV basic commodities and services. The expected outcome is for the NHIF and commercial insurers to develop complementary health insurance packages for customers able and willing to pay for HIV/AIDS services.

PEPFAR/T will revitalize employer/corporate engagement in HIV/AIDS and develop innovative solutions in collaboration with PEPFAR-funded IPs in priority areas outside of Dar es Salaam in male dominated industries such as transportation, security, minerals and mining, cement manufacturing, and bottling. These private sector platforms that increase collaboration between commercial firms and the more traditional PEPFAR-funded IPs present innovative solutions that will contribute to targeted and focused testing and treatment programs for special populations.

The National Health Insurance Fund, which is to become GOT's single health insurance provider, and commercial health insurance firms, such AAR and Jubilee Insurance, have committed to collaborate in developing complementary HIV/AIDS packages as a way of segmenting the market. As the first step, PEPFAR/T will collect cost data and information about regulatory barriers in using a commercial supply chain for providing commodities and services to complement the current donor dependent model.

PEPFAR/T will engage government, social marketing organizations, and private companies supplying condoms to coordinate marketing and distribution strategies so that people, such as those living in rural and poor areas, receive free and subsidized condoms, while those who are able to pay, such as those living in urban and more prosperous areas, can opt to purchase commercially available condoms. This total market approach to procure and distribute HIV prevention commodities is aligned with GOT's desire to mobilize domestic resources for increased self-reliance.

6.6. System Barrier 6. Supply Chain and Commodity Management

The availability and accessibility of life-saving commodities are the cornerstones of epidemic control and achieving the 90-90-90 goals. This is a major area of investment for PEPFAR/T especially this year as the program implements TLD optimization, which presents new challenges for increased commodity needs and effective transition of regimens. While supply chain gaps and barriers have been addressed and approaches described under different system gaps, this section provides an overview of specific logistics and commodity management approaches and activities that are essential for achieving sustained epidemic control in Tanzania.

Epidemic Control Barrier or Systems Gap Identified	Key selected activities and benchmarks	Current status (value from investment to date)
Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS		
Inefficient system for distribution of commodities under new service delivery platform	Average in-country distribution costs for health commodities reduced from 20% to 15% by 2019.	New supply chain design proposes to reduce holding stock by five months and increase reporting and delivery to monthly.
Financing gap between ARV and viral load needs and GOT/PEPFAR/GFATM allocation	GOT funds the full amount of in-country distribution costs for all donated products including HIV-related donated product	Funds for in-country distribution of donated products were, for the first time, its own line item in the GOT budget for FY 2017-2018 Disbursements for essential medicines, including opportunistic infection medicines, were 100% of the budgeted amount.

6.6.1. Achievements to date:
The last two years of investments in supply chain have led to a program that is increasingly cost efficient and responsive. In coordination with the Global Fund, Tanzania conducted a holistic review of its health supply chain. The resulting new design will, beginning July 2018, increase reporting frequency from quarterly to monthly. Similarly, deliveries to hospitals will increase from quarterly to monthly and while health clinics and dispensaries will be bi-monthly. The exercise and additional advocacy to increase data use has led to significantly more engagement from stakeholders such as the LGAs and the Chief Pharmacist's office to more proactively manage the supply chain. Funds for in-country distribution of donated products were, for the first time ever, its own line item in the GOT budget for FY 2017-2018 and MOFP disbursements for essential medicines, including opportunistic infection medicines, was for the first time in recent memory 100% of the budgeted amount.

6.6.2. Supply Chain and Commodities Management Priorities and COP 2018 Activities
Strategic Approach: Improved security, reliability and distribution of key products for prevention, diagnosis and treatment of HIV/AIDS

Tanzania's adoption of new treatment guideline policies, including a transition to TLD and ambitious treatment targets, is expected to increase the number of clients and demand for more ARVs and commodities. PEPFAR/T is committed to working with the GOT to meet the projected commodity demands and address the barriers to ARV and commodity availability. PEPFAR/T is

planning to support ARV refill distribution points outside the clinics using trained community health workers, and to decentralize ARV pick up at designated village dispensaries.

PEPFAR/T team has developed specific measurable outcomes while addressing the barriers associated with ARV and commodity management – including TLD. It will develop and implement a coordinated procurement plan for commodities on an annual basis with sufficient financing for HIV commodities defined in that procurement plan. The new, efficient supply chain design will be rolled out nationwide, making the system more responsive to changes in consumption and provide increased visibility of stock around the country.

PEPFAR/T is committed to assist GOT to transition to Dolutegravir based regimens through a rapid but responsible plan which balances the need to provide patients with a better product with minimizing wastage of existing stock in country. PEPFAR/T will work with the GOT, GFATM, and other external stakeholders to meet the projected commodity demands and address the barriers to ARV and commodity availability including TLD and viral load testing supplies. As part of the transition to TLD, PEPFAR IPs will engage with local civil society and PLHIV networks representing different segments of the population (women, men, young people) to support and revitalize treatment literacy focused both on the rationale for TLD transition and on broader retention, adherence, and stigma issues among PLHIV.

Because TLD offers a pack size that lasts three months, the transition to TLD provides an opportunity to expand multi-month prescribing for stable patients from two to three or possibly six months. During COP 2018, barriers for TLD transition include the ability of global supply to meet demand for TLD. Should planned shipments for Tanzania's transition be delayed, the start date for Phase 1 of the TLD transition will be one month after the initial TLD shipment has cleared customs in Tanzania. PEPFAR/T is also working closely with stakeholders to ensure that the planned transition factors legacy stock into the timing of the transition to minimize wastage. PEPFAR/T IPs along with the GOT will monitor stock levels of existing product carefully to responsibly plan the transition.

6.7. System Barrier 7: QA and QI

Systems investment to institutionalize QA and QI as a complement to site level QA and QI initiatives remains an area of focus for PEPFAR/T. Tanzania has progressed in introducing a new Star Rating System that incorporates QI and QA techniques. Different disease programs have distinct QI approaches, but critical gaps exist in coordinating these approaches.

The table below highlights specific examples from table 6 of key above-site investments in QA and QI, the epidemic control or systems (MER/SIMS/SID) barrier that was identified, key selected activities and benchmarks, and the current status of achievements with above-site investments to date.

Control Barrier or Systems Gap Identified	Key selected activities and benchmarks	Current status (value from investment to date)

Coordinated approach for CQI across PHIs in Tanzania linked to the National Star Rating System that meets needs of disease specific programs including HIV, TB and PMTCT	Improved Star Rating Tool – that incorporates disease specific programs' (NACP; NTLP; PMTCT; and National Health Laboratory) essential elements is in use. More than 90% of facilities are assessed using a revised Star Rating tool including HIV, TB and PMTCT elements and develop a QIP.	GOT has a draft of a revised tool including HIV, TB and PMTICT requirements for review by stakeholders. Close to 7000 facilities have initial Star Rating and QIP. Roll out of new tool scheduled for 2018
Service delivery data not used as proxy for quality of services.	CQI Dashboard linked with DHIS2 operationalized in >90% of high priority councils.	Dashboard has been developed for star rating and needs to be rolled out.

6.7.1. QA and QI Achievements to date

As described in the table, there are key achievements to report from above-site QA/QI investments to date. GOT has completed its first star rating assessment of close to 7000 health facilities. Star Rating assessments are resulting in Quality Improvement Plans (QIP) with the goal of ensuring that all facilities in Tanzania achieve a minimum rating of 3 stars.

A Functional National Technical Working Group on Quality Management that brings various stakeholders to discuss evolving needs on QA and QI has been revitalized to coordinate QI approaches. A needs assessment to institutionalize QA and QI in PHIs has been completed as an entry point to ensure PHIs are implementing programs and interventions effectively and with fidelity.

The Initial draft of a revised Star Rating tool that incorporates disease specific QA and QI essential elements has been developed. When this tool is completed and operationalized, it will provide a standardized way of assessing quality of care provided at the facility, and further guide facilities to improve in a step-wise manner that meets the needs of disease programs including HIV, TB and PMTCT. This national, MOHCDGEC led approach is vital to ensure GOT and ownership and commitment to monitoring interventions to sustain epidemic control.

6.7.2. Description of the QA & QI COP 2018 above Site Activities

As part of the QMEC plan, PEPFAR/T will work with GOT to strengthen governance in Quality Management at the national and subnational levels. QMEC program will build on lessons learned from SIMS implementation to ensure fidelity, scale and quality is upheld. The support provided by PEPFAR/T to GOT is geared towards coordinating CQI initiatives that have above site components to support site level performance improvement.

PEPFAR/T will work with GOT to coordinate efforts to take to scale the revised star rating system that incorporates HIV, TB and PMTCT requirements. By the end of FY 2018 15% of all facilities and 30% of all PEPFAR supported sites will have been assessed with revised tool. Target for 2020 is 50% of all sites and 80% of all PEPFAR supported sites.

PEPFAR/T will provide support to the GOT to develop systems that monitor implementation of Quality Improvement Plans (QIP) that are established through the Star Rating assessment process. The COP 2018 expected outcome is that within one year of assessment, 75% of assessed sites have completed implementation of their QIP. CQI dashboard will summarize star rating results and in COP 2018 PEPFAR/T will work with GOT to establish tools to triangulate star rating results with service delivery data.

Please see Appendix C for table 6.3.

6.8 Surveillance, Research, and Evaluation

In COP 2018, PEPFAR/T is proposing a total of 15 surveillance, research, and evaluation (SRE) activities. Of the 15, 11 are evaluations, two are research, and two are evaluations. The remainder of this section describes the SRE activities by agency.

The three DOD SREs approved for COP 2018 aligns with the key priorities outlined in the COP 2018 planning letter for PEPFAR/T. DOD will conduct one evaluation - *The African Cohort Evaluation Study (AFRICOS)* - which aims to longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV-1 infection and disease progression in an African context. DOD will conduct one research project on *Differentiated Care Models for Key Populations* which will focus on the goals of Differentiated Service Delivery (DSD) models to improve efficiency, deliver patient-centered care, and address bottlenecks in the health system for KPs in ART. The second DOD research project will focus on *Prevalence of, and factors associated with, virologic suppression and drug resistance in HIV-positive children and adolescents on antiretroviral therapy in Tanzania*. This study will determine the prevalence of viral load suppression and specifically examine factors associated with incomplete viral suppression through HIV drug-resistance testing. The data will provide important information for optimizing care models across different age groups to increase engagement in care, retention, adherence and viral load suppression which are key COP 2018 priorities.

CDC proposes three evaluation and two surveillance activities for COP 2018. The first evaluation is on *Self-testing for linkage to care* to explore best practices to increase linkage to care for people who test positive for HIV using self-testing. This activity relates to COP 2018 priorities focused on identification and linkage to care, as well as scale-up of self-testing. The second evaluation - *The DREAMS evaluation for AGYW ages 15-19 and 20-24* - is proposed to understand how the combination of DREAMS interventions measures the vulnerability of at risk AGYW. This activity relates to COP 2018 priorities for epidemic control and prevention among AGYW. The final evaluation - *The costs and cost-effectiveness of linkage and retention strategies in Tanzania* - is an evaluation designed to identify the cost for linkage case management and defaulter tracing activities for each standard of care strategy that is a part of linkage and retention programming. This activity relates to COP 2018 priorities because linkage and retention strategies that will be scaled need to be cost-effective and sustainable.

The two surveillance activities include key COP 2018 priorities related to integrating recency testing into routine program activities, and size estimates for key and vulnerable populations. *Establishing recent infection surveillance using point-of-care recency testing among persons newly diagnosed with HIV infection in Tanzania* is a surveillance activity designed to establish HIV recency surveillance using POC-RT as part of routine program activities. This activity is listed as

directive 9 under "policy directives and technical approaches" in the COP 2018 planning letter. HIV recency surveillance will start in quarter three of the current fiscal year among all the KP programs country-wide and among the general population in Dar es Salaam. In quarter four of the current fiscal year, it will be scaled-up into Mwanza, and will become part of routine HIV program activities country-wide in Cop 2018. Finally, *the key population size estimation, which includes extensive hotspots mapping and series of behavioral surveys among key populations in mainland Tanzania,* is a surveillance activity designed to determine size estimates, HIV burden, and identify behavioral risk factors that contribute to HIV infection among key and vulnerable populations. This is in alignment with COP 2018 priorities to focus on key populations, and will improve and update Tanzania's data on KP, which is outdated.

In addition, the Health Resources and Services Administration (HRSA) proposes one evaluation titled *Optimizing nurses task sharing strategies* for COP 2018. Nurse task sharing strategies are a priority given the COP 2018 emphasis on SDM scale-up, including multi-month scripting and identification interventions, which will require additional facility level human resources. Specific nurse task sharing strategies will be phased in and suggested as part of the standard of care based on the impact of the strategies on testing yields and linkage.

USAID/Tanzania will support six evaluations during the COP 2018 implementation period. Two of USAID's evaluations will explore the best approaches for preventing HIV among female sex workers, and for identifying, treating, and retaining female sex workers. The first will determine *Strategies to Optimize and Improve the Uptake of Biomedical, Behavioral, and Structural Program Interventions by FSW targeted by the Sauti Program*, and the be an *Assessment of a Community-based HIV Treatment Service Delivery Model on Linkages to Retention in HIV Care among FSWs in Tanzania*. Both of these studies are in line with COP 2018 guidance to improve programming with key populations. The third evaluation will focus on *Community ART Evaluation* to explore the effectiveness as well as linkage and retention rates among PLHIV seeking community-based ART services. This is an expansion of an existing project that is being prioritized for funding to help PEPFAR/T gather more evidence on community ART in the truest sense (including retention clubs) to aid advocacy efforts with GOT.

To assess the effectiveness of DREAMS interventions, USAID's fourth evaluation looks at *Cash Transfers for AGYW to reduce Sexual Risk Behavior.* USAID will conduct an in depth evaluation of the cash transfer component of the DREAMS approach to determine whether communities receiving unconditional cash transfers (UCT) have a lower incidence of HSV-2 compared to control communities not receiving cash transfers; whether communities receiving economic strengthening sessions in addition to conditional cash transfer (CCT) have a lower incidence of HSV-2 compared to control communities not receiving cash transfers, whether communities receiving economic strengthening sessions in additional to CCT have a lower HIV prevalence over time and at 18 months compared to control communities not receiving cash transfers, and how and whether unconditional and conditional cash transfers for adolescents and young women reduce sexual risk behavior.

USAID's fifth evaluation was conceptualized in response to the THIS results on the first 95. USAID proposes to conduct a *Cost Analysis for Monetary and non-Monetary Incentives for HIV testing* among populations that typically do not come forward on their own to get tested (e.g., adolescents, men). Specifically, the study will look at the effectiveness of both monetary and non-monetary incentives, such as increased access to other social service offerings. The costs for these

approaches are potentially minimal and incremental but may yield lard aggregate benefits. Finally, USAID's sixth evaluation will continue a study examining how effective an HIV screening tool is to identify HIV-positive children in the OVC program, and what the HIV prevalence is within this population. A better estimate of the HIV prevalence is important for determining whether Tanzania is effectively reaching all HIV-positive OVC and estimating how far away Tanzania is from reaching 95-95-95 targets within the lower age brackets.

7.0 Staffing Plan

PEPFAR/T used staffing tools and had extensive agency-level and interagency discussions to identify needs for new or repurposed staff across the interagency team. An interagency management team reviewed the tools and determined that no significant staffing shifts will be required for COP 2018. The team determined that the overall funding allocation by budget code and the budget code attribution by FTE are well-aligned.

There are currently 13 vacancies spread across the agencies. Most of these have gone through the recruitment process, and it's expected that offers of employment will be extended during the 2018 calendar year. These vacancies have been slow to fill due to the current USG hiring freeze. CDC has repurposed three positions: one contractor to U.S. direct hire, and two locally employed staff internally. These decisions will help ensure a more comprehensive skill set among staff based on staff turnover and programmatic needs. No other agency is repurposing positions. The PEPFAR Coordination Office will be adding one non-PEPFAR funded position approved through the Expanded Professional Associates Program to increase partnership between multilateral and bilateral development partners and the private sector. Peace Corps will be adding one new Medical Officer position. This reflects growth in volunteer numbers from approximately 200 to more than 250 over the period of FY 2015-FY 2017. All four of Peace Corps Tanzania's Medical Officers are locally employed staff on contract for one base year and four option years.

Each implementing agency in PEPFAR/T conducted an internal staffing review to ensure that staff time is aligned with core programmatic, population, and geographic priorities, as well as business process coverage. Agencies continuously assess the most important needs when vacancies occur and repurpose appropriately. USAID's cost of doing business (CODB) has decreased by 19% from the previous year. CDC's CODB has increased by about 10%, but its CODB as a percentage of agency budget is essentially unchanged. In COP 2018 it will be 9.8% of overall budget, slightly up from 9.5% of budget in COP 2017 and down from 10.2% in COP 2018. DOD anticipates its CODB to increase by about 12% due to the onboarding of the new Deputy Director as well as an anticipated move to larger office space, both of which will increase ICASS and other administration costs. Peace Corps' CODB will increase by 29% due to the addition of two medical officer positions.

With the above minor changes, staffing across PEPFAR/T is adequate to meet SIMS requirements, as well as addressing the large identified programmatic and data gaps.

In 2015, PEPFAR/T reviewed its interagency team structure and revised the approach to better correspond with the technical organization of activities within the cascade of services and support being provided. The streamlined structure reduced the number of technical working groups from 14 to seven, operating within three clusters: Cascade Cluster, Population Cluster, and Program Support Cluster. This structure is reviewed annually, and adjustments and additions are made as

needed. For example, in the current fiscal year, an interagency working group focused on PrEP and self-testing was formed to focus on these two important initiatives.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1

PSNU Prioritization (COP18)	# of PSNUs	COP	Results reported	both sexes		Males								Females								TOTAL
				<1	1-9	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	10-14	15-19	20-24	25-29	30-34	35-39	40-49	50+	
Attained	11	COP16	FY17	27%	63%	78%	61%	21%	44%	67%	74%	53%	109%	88%	53%	63%	112%	108%	87%	69%	107%	79%
		COP17	FY18	77%	89%	98%	95%	87%	89%	98%	102%	88%	134%	106%	97%	100%	137%	133%	108%	93%	127%	107%
		COP18	FY19	87%	94%	104%	101%	102%	104%	105%	107%	101%	118%	110%	104%	108%	134%	130%	106%	98%	104%	109%
ScaleUp Saturation	94	COP16	FY17	20%	40%	51%	35%	19%	36%	47%	50%	52%	73%	54%	46%	57%	95%	88%	75%	57%	71%	61%
		COP17	FY18	28%	51%	65%	47%	32%	48%	59%	62%	67%	84%	67%	57%	64%	106%	97%	83%	69%	81%	73%
		COP18	FY19	81%	87%	95%	74%	67%	73%	77%	79%	80%	88%	94%	79%	84%	114%	105%	93%	82%	84%	87%
Sustained	87	COP16	FY17	20%	39%	62%	36%	16%	23%	33%	39%	45%	71%	59%	48%	46%	85%	79%	66%	62%	85%	58%
		COP17	FY18	24%	47%	73%	47%	25%	33%	43%	50%	56%	84%	69%	60%	58%	100%	94%	79%	74%	99%	70%
		COP18	FY19	25%	49%	76%	58%	54%	52%	54%	56%	58%	76%	72%	63%	62%	89%	85%	71%	71%	88%	69%

Table A.2

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV (2019)**	**Expected current on ART (APR FY 2018)**	**Additional patients required for 90% ART coverage**	**Target current on ART (APR FY 2019) *TX_CURR***	**Newly initiated (APR FY 2019) *TX_NEW***	**ART Coverage (APR 2019)**
Attained (N = 11)	**164,540**	**173,125**	**0**	**180,459**	**20,800**	**109%**
Scale-Up Saturation (N = 94)	**1,055,647**	**768,580**	**34,134**	**915,948**	**226,551**	**87%**
Scale-Up Aggressive (N = 0)	n/a	n/a	n/a	n/a	n/a	n/a
Sustained (N = 87)	**276,350**	**183,771**	**56,287**	**192,428**	**30,550**	**70%**
Central Support	n/a	n/a	n/a	n/a	n/a	n/a
Commodities (if not included in previous categories)	n/a	n/a	n/a	n/a	n/a	n/a
Total (includes military)	**1,499,233**	**1,162,264**	**32,700**	**1,318,079**	**283,401**	**88%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP 2018 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

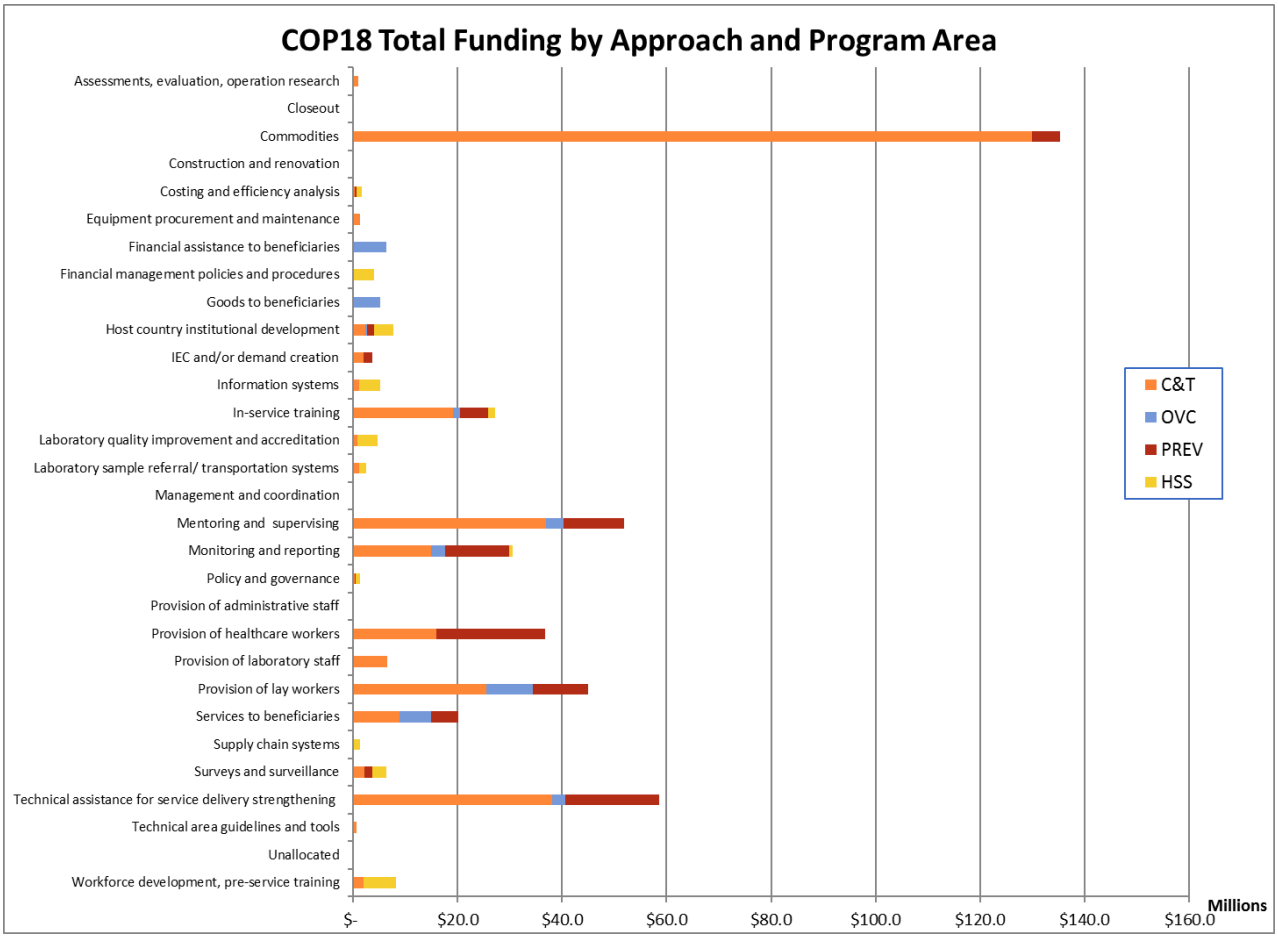


Table B.1.2 COP 2018 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$118,662,952	**$393,759,298**	**$512,422,250**

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$ 6,464,087
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$ 2,359,691
HVOP	Other Sexual Prevention	$ 11,290,796
IDUP	Injecting and Non-Injecting Drug Use	$ 269,128

HMBL	Blood Safety	$ 103,733
HMIN	Injection Safety	$ 34,432
CIRC	Male Circumcision	$ 33,842,022
HVCT	Counseling and Testing	$ 30,272,378
HBHC	Adult Care and Support	$ 10,953,945
PDCS	Pediatric Care and Support	$ 7,186,704
HKID	Orphans and Vulnerable Children	$ 35,427,626
HTXS	Adult Treatment	$ 88,334,827
HTXD	ARV Drugs	$ 94,980,937
PDTX	Pediatric Treatment	$ 11,491,584
HVTB	TB/HIV Care	$ 14,177,400
HLAB	Lab	$ 6,483,011
HVSI	Strategic Information	$ 4,971,231
OHSS	Health Systems Strengthening	$ 18,391,027
HVMS	Management and Operations	$ 16,724,739
TOTAL		$ 393,759,298

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

Primary input to budgeting process was recent PLHIV and coverage estimates from Tanzania PHIA (THIS) and updated projections from spectrum. Adjustments were made to existing agency and mechanism level allocations according to shifts in HIV treatment gap.

In addition, agencies and program officers consulted with expenditure analysis data, work plans, performance reports and S/APR data. Additional consideration was given to earmarks and expected cross-cutting attributions.

For above site investments, progress against expected milestones or outcomes was reviewed and budgets adjusted accordingly in relation to completed activities. New initiatives or system needs were reviewed in relation to gaps, barriers that directly impact capacity of program to achieve epidemic control or SID scores.

APPENDIX C – Tables and Systems Investments for Section 6.0

APPENDIX D – Expansion of Scope of Key Interventions

Percentage of facilities offering service indicated by quarter, FY 2018 (N=2817 Facilities)

	Q1	Q2	Q3	Q4
Extended Clinic Hours	18%	25%	30%	40%
Index testing	26%	40%	70%	100%
Self-testing*	0%	0%	0%	10%
Same Day ART Initiation	41%	60%	80%	100%

*Self-testing currently not allowed by law. Projections shown here assume change in law during April 2018, and test arrival in country in July 2018

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
1	USAID	Community Health and Social Systems Strengthening Program (CHSSP)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Workforce development, pre-service training	Increase coverage of new social welfare workforce at the community level (approximately 4,000 CCW) to support active referrals and linkages for retention and adherence among OVC, AGYW and PLHIV. This will include recruitment, training, and supervision/mentoring the new CCW)
2	USAID	Public Sector System Strengthening (PS3)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Prioritize allocation of GOT human resources based on service delivery needs, by combining POPSM's HR information system, recently extended to the facility level, with service delivery data
3	USAID	Public Sector System Strengthening (PS3)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Policy and governance	Develop and make functional formal channels for diverse civil society groups and the private sector to engage and provide feedback on the Government of Tanzania's HIV/AIDS policies, programs, and services
4	USAID	Public Sector System Strengthening (PS3)	HSS	Finance: Increased commitment, expenditure and efficient use of resources from government and private sector for the HIV/AIDS program in country.	Financial management policies and procedures	Improve efficiency in HIV spending by rolling out a national health insurance program that offers a comprehensive minimum benefit package that includes HIV/AIDS services, and shifting to output based payments to the facility level.
5	USAID	Public Sector System Strengthening (PS3)	HSS	Finance: Increased commitment, expenditure and efficient use of resources from government and private sector for the HIV/AIDS program in country.	Financial management policies and procedures	Ensure LGAs receive on time disbursements of allocated resources from Ministry of Finance to enable HIV service delivery
6	USAID	Public Sector System Strengthening (PS3)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	Assist LGAs to utilize multi-sectoral data from information systems relevant for making budget allocation decisions (ex -DHIS2, HCMIS, EpiCor, PlanRep). This includes making DHIS2, HCMIS, EpiCor, LGRCIS, and PlanRep systems interoperable. In addition, close feedback loop between scale-up LGAs and national level to improve utility of data
7	USAID	Public Sector System Strengthening (PS3)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Host country institutional development	Engage PORALG Health and Social Welfare Division to fullfill its designated role of rolling out and implementing key programmatic policies (for example: SDM, task-sharing, PreP). Also, facilitate collaboration between government and non-state actors (private sector and civil society organizations)
8	USAID	Public Sector System Strengthening (PS3)	OVC	OVC_SYSTEMS: Increase the coverage and performance of community case workers, systems and structures supporting OVC	Host country institutional development	Strengthen capacity of community development departments to lead lower local government planning processes, including incorporating plans into redesigned PlanRep implementation, and reporting back to lower local government structures and citizens on implementation status
9	USAID	Public Sector System Strengthening (PS3)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Strengthen performance management of health workforce to ensure workers are held accountable for following HIV/AIDS protocol and guidelines

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
1	Scale-Up Councils have a shortage of skilled social welfare service providers	6. Service Delivery	3.98	Improved referrals and linkages for retention and adherence among OVC, PLHIV and AGYW	1 year	Proportion of scale up LGAs that have health workers that support OVC activities	65%	100%
2	Scale up LGAs have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	7. Human Resources for Health	5.60	Available health workers are allocated to facilities of highest need based on evidence.	3 years	Percentage of targeted LGAs who have distributed or redistributed staff based on facility level HR and service delivery information	0%	30%
3	Tz Governance structures do not adequately support capacity to plan, implement, and monitor Test and Start.	3. Civil Society Engagement	3.83	LGAs have functional channels to receive and give feedback on planning and decision making to the community, private sector, and civil society organizations.	2 years	Percentage of targeted LGAs that incorporate feedback from citizens, private sector and civil society groups in planning and decision making	74%	81%
4	Inefficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	11. Domestic Resource Mobilization	3.21	Increased efficiency in use of existing funds, resulting in increased coverage.	3 years	Percentage of service providers paid through the use of new or improved output-based provider payment systems	0%	20%
5	Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	11. Domestic Resource Mobilization	3.21	LGAs receive on time payments from Ministry of Finance and Planning, which enables them to provide sufficient and high quality HIV/AIDS services.	2 years	Percentage of approved budget transferred from national level to LGA Level	75%	86%
6	Quality data and systems to inform decisions regarding new service delivery models	12. Technical and allocative effiencies	4.67	Budgets at national and LGA levels allocated according to financial and service delivery data.	2 years	Percentage of targeted LGAS with seven sets of national priority systems made interoperable and deployed to the LGA level systems	0%	50%
7	Tz Governance structures do not adequately support capacity to plan, implement, and monitor Test and Start.	2. Policies and Governance	6.96	Implementation of key policies relevant for HIV/AIDS service delivery at the regional, district, and service delivery level. Increased responsiveness of GOT to non-state actor input.	2 years	Number of key HIV policies(SDM, Task Sharing & PreP policies etc) where PO-RALG was actively engaged and contributed to the operational roll out	2	6
8	Tz Governance structures do not adequately support capacity to plan, implement, and monitor Test and Start.	3. Civil Society Engagement	3.83	Community Development Departments fullfill their roles of ensuring community and lower local government input is reflected in LGA plans and budgets and ensuring citizens and lower local governments receive feedback on implementation status.	2 years	Percentage of targeted LGAs (93) who submit LLG and O&OD template into PlanRep	0%	28%
9	Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	Service providers deliver services according to HIV/AIDS protocols and task sharing policy	3 years	Percentage of targeted LGAs (93) who submit performance data into the Human Capital Management Information System (HCMIS)	0%	20%

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
1					
2		50%		70	
3		90%			
4		90		100	
5		88			
6		90			
7		All new policies			
8		70			
9		40		70	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
10	USAID	Public Sector System Strengthening (PS3)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Develop customized retention packages in targeted LGAs, based on available local resources, to retain health workers key for prevention and treatment of HIV/AIDS and OIs
11	USAID	National Capacity Building	PREV	VMMC_Models: Design and test sustainability models for adult and infant program (VMMC & EIMC)	Policy and governance	Develop sustainability models that ensure improved linkages and retention for men in care.
12	USAID	National Capacity Building	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Host country institutional development	Support PORALG through LGAs to develop mechansims for advancing the AHS and AYAS at the local level.
13	USAID	MEASURE Associate Award	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Host country institutional development	Build capacity of CHMTs and RHMTs to monitor data collection, analysis and use at lower levels
14	USAID	MEASURE Associate Award	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Information systems	Support the Ministry of Health in both Mainland Tanzania and Zanzibar to develop an OVC/MVC database that's integrated to DHIS 2
15	HHS/CDC	HIS - UCC follow on - (GH001361)	C&T	SD Systems: Service delivery points utilize patient level electronic systems to improve testing, linkage, treatment, and retention services and support differentiated service delivery models.	Information systems	Support electronic system development , Continuous improvemet and evolution of CTC System Software according to emerging requirements. Support developmentand ongoing evolution and improvement of Integrated electronic Health Facility Management System (IeHFMS). Approach is to work with MOH on integrated health system that can meet wider health sector needs. HIV goal of this sytem is to expand electronic system support to additional service delivery points to capture HIV testing which will support improved quality of reporting of HIV testing, support monitoring of repeat testing and support integration with emerging client identification and client register work. Develop a client register that implements new GOT standards for client identification and supports linkages of client information across HIV services both within and across service delivery sites (use of biometric). Work with MOH and UDSM to support continuous improvement to MOH HMIS (DHIS2). This includes evolving system to support PEPFAR data requirements and gradually moving towards automated reporting from site, to CTC, to DHIS and then to DATIM.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
10	Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	Adeqaute numbers of health workers available to provide quality and high impact intreventions	2 years	Number of LGAs with retention packages	0%	26%
11	Decisions regarding new service delivery models are not informed by quality data from information systems	2. Policies and Governance	6.96	Static sites providing VMMC services continue after implementing partners transition on of these sites	1 year	Percent of static sites in scale up councils that continue to provide VMMC services without implementing partner support	0%	100%
12	Lack of coordination of adolescent health issues at the local level	1. Planning and Coordination	5.33	Strenthening data quality and further sustainability for adolescent health including HIV/FP integration	1 year	Percent of LGAs that track adolescent and young adult indicators as defined in the AYAS results framework	0%	100%
13	Efforts to use data within planning and resource allocation hindered by low quality data and evidence from evaluations and surveillance are not sufficiently identifying retention barriers	15. Performance Data	6.97	Scale up LGAs include results of HIV data triangulation within LGA level annual plans or health profiles by 2019.	1 year	Percent of scale-up LGAs that include results of HIV data triangulation in annual plans	30%	60%
14	Human Resources:Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	13. Epidemiological and Health Data	4.17	GOT has a community data reporting system for non-facility indicators by 2019 with 70% data completeness for home based care, OVC served and non-facility based HTC.	1 year	OVC/MVC database integrated to DHIS2	Database not operational	Existence of functional and operational OVC/MVC database
15	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	6. Service Delivery	3.98	Service statistics (DHIS), patient records, and logistics data (eLMIS) dashboard developed to facilitate stakeholder review across information systems by 2019.	3 years	% of HIV C&T clients within sites that are supported by electronic systems. C&T facilities with electronic system % of HIV C&T clients with data in national client level data repository (CTC3) % of HIV C&T clients linked to Client Register % of PEPFAR supported sites with automated reporting from CTC to DHIS % of newly identifed HIV positives within sites supported by electornic systems % of newly identifed HIV positives with data in natinal client level data repository % of newly identifed HIV positives clients linked to client register	75% of C&T client data in CTC3 thorugh automated process from CTC2,	85% of CTC client data in CTC3 through automated process from CTC2, Automated reporting from CTC3 to DHIS to support full range of age disaagregates and indicators. 25% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 20% of C&T clients records linked to National Client Regsiter

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10		93			
11					
12					
13					
14					
15		90% of CTC client data in CTC3 through automated process from CTC2, 45% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 50% of C&T clients records linked to National Client Regsiter		95% of CTC client data in CTC3 through automated process from CTC2, 60% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 75% of C&T clients records linked to National Client Regsiter	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
16	HHS/CDC	HIS - UCC follow on - (GH001361)	HSS	SD Systems: Service delivery points utilize patient level electronic systems to improve testing, linkage, treatment, and retention services and support differentiated service delivery models.	Information systems	New Initiative approved by interagency review to create new Shared Health Record. Support electronic system development to improve patient level data
17	HHS/CDC	MUHAS SPH Follow On - (GH001075)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Pre-service trianing on public health for Masters program through face to face classroom and distance learning sessions
18	HHS/CDC	MDH Kagera - (GH001179)	PREV	MTCT: Ensure comprehensive PMTCT services within RCH facilities to initiate ART for pregnant women and lactating mothers living with HIV.	Assessments, evaluation, operation research	Operational reseach to understand ARV resistance pattern among pregnat women AND use of unique identifiers to reduces double counting and lost to follow up at PMTCT sites
19	HHS/CDC	CDC PPP Management - (GH001531)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	IEC and/or demand creation	1.Expand mHealth PPP and support implementation and expansion of Fast Track ARV refills (FASTA) initiatives under NACP and MOH leadership on differentiated service delivery models remote patient check in and drug pickup, sms reminders, patient linkages and viral load results dissemination. 2.Continue to expand TB messaging reach and involve HIV/TB partners in enrolling patients for various services including TB awareness messaging, multi-drug resistance reporting and the pre-testing for TB. 3.Integrate m-health platform with other HIV national systems to enable exchange of data across systems for better health desion making
20	HHS/CDC	CDC PPP Management - (GH001531)	PREV	MTCT: Ensure comprehensive PMTCT services within RCH facilities to initiate ART for pregnant women and lactating mothers living with HIV.	IEC and/or demand creation	1.Deliver educational messaging to pregnant mothers, partners, information seekers and supporters through demand creation and close follow for PMTCT Services within ANC, L&D, PNC and early infant care. 2.Conduct semi-annual feedback sessions with clients and healthcare workers on the impact of messaging in relation to improving personal health of mothers, babies and HIV prevention 3.Training of HCW for demand creation and patients enrollment into PMTCT messaging service

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
						Milestone progress towards establishing health sector shared health record.	New Initiative	Software Development and testing process initiatied.
16	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	6. Service Delivery	3.98	Service statistics (DHIS), patient records, and logistics data (eLMIS) dashboard developed to facilitate stakeholder review across information systems by 2019.	3 years			
17	Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	Number of graduates: 111 individuals	1 year	HRH_PRE	86	111
18	PMTCT program is not adapting to emerging drug resistance patterns. Beneficiaries to PMTCT program are not uniquely tracked throughout the service cascade.	13. Epidemiological and Health Data	4.17	In country HIV drug resistance data available and unique identification system inplemented for PMTCT beneficieries	2 years	TX _PVLS, PMTCT ART,PMTCT_EID	ARV resistance pattern unknown and unique indentifier not in use	Data collection and analysis completed.
19	Current patient tracking systems do not have functionality to support differentiated service delivery models	6. Service Delivery	3.98	Increased number of clients receiving ART refills	2 years	% of CTC clients receiving ARV fast-track refill services % of CTC clients who attended CTC visits appointments for last year	N/A	80% 70%
20	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	6. Service Delivery	3.98	Increased number of Antenatal care visits and newly born being tested withn 12 month	2 years	% of women enrolled in PEDAIDS or WN that attended 4 antenatal care visits during pregnancy # of children exposed to HIV being tested within 12 months of birth	N/A	58% 464,100

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16		Software system developed and functional, data from CTC3 migrated to new platform, EMR and other facility systems previously submitting data to CTC3 now submitting data to new platform. New platform supports collection of client level HIV testing data, with de-duplication through linkages with Client register.		50% of newly identifed HIV positive clients data within national shared health record supporting de-duplication and linkage.	
17					
18		Data dissemination and application of the findings into PMTCT and ART programming			
19		85% 80%			
20		70% 564,000			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
21	HHS/CDC	NIMR Follow On - (GH001633)	HSS	Lab: Strengthen National Lab capacity including ability to administer and manage proficiency testing, coordinate lab training, accreditation and certification.	Laboratory quality improvement and accreditation	•Support maintenance of NIMR infrastructure and utilities for National HIV Reference Laboratory for effective, efficient, and safe operations for EQA, Viral Load, and EID to prevent service interruption.
22	HHS/CDC	NIMR Follow On - (GH001633)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	Provide technical support for GIS and spatial analysis for GoT and PRPFAR IPs.
23	HHS/CDC	NIMR Follow On - (GH001633)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Costing and efficiency analysis	Finalize data collection and analysis of the VL costing evaluation -SRE
24	HHS/CDC	University Partnership Field Epidemiology Expansion - (GH001304)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Host country institutional development	To provide TA to the Centre for Distance Education (CDE) under the ministry of health, to strengthen distance education /and e-learning platform by supporting the CDE to conduct ECHO (telehealth) sessions for health care workers delivering HIV care (including building competencies on SDM, test and start) in all regions. To provide TA to the MoHCDGEC in the implementation of task sharing through conducting of a task analysis of selectd cadres

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
21	Quality of HIV rapid testing according to WHO guidelines (new, repeat, retest and documented annual certification of testers/sites) Long turn-around-time for VL samples due to back log caused by equipment downtime, shortage of reagents, and unavailability of workforce in VL/EID testing labs	10. Laboratory	5.83	Laboratory management and accreditation system developed and deployed by 2019 HIV rapid test, Quality assurance systems deployed by 2019. At least 80% of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	3 years	Lab_PTCQI TX_PVLS	Continue to support maintenance of NIMR infrastructure and utilities for National HIV Reference Laboratory for effective, efficient, and safe operations for EQA, Viral Load, and EID to prevent service interruption. Currently 4,596 sites (87%) are participating in EQA/PT program, of those 2460 (54%) passed.	Laboratory management and accreditation system developed and deployed All facilities (5310 sites) participate in an 90% of participating sites pass PT/EQA.
22	Decisions regarding new service delivery models are not informed by quality data from information systems	13. Epidemiological and Health Data	4.17	GOT and PEPFAR HIV-related data sets synchronized	1 year	N/A	HFR available	GOT and PEPFAR HIV-related data sets synchronized
23	Efforts to use data within planning and resource allocation hindered by low quality VL data and evidence from evaluations are not designed to inform scale up decisions	10. Laboratory	5.83	Evaluation report on efficient and cost effective VL scale up strategies	1 year	N/A	Currently not started	Evaluation report on efficient and cost effective VL scale up strategies
24	Scale-Up Councils have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	7. Human Resources for Health	5.60	Nursing, Clinical Officers, pharmacy, and CHW cadres providing high quality services per task sharing policy in 100% of scale up districts, as well as improved quality of HIV care at participating HF	3 years	Number of ECHO session conducted Number of HCWs trained Task analysis report	Needs assessment of CDE completed and Multi-year strategic vision for the ongoing development of the CDE available (by the end of COP 17)	5 ECHO session conducted 20 Number of HCW/CHWs trained

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21		50% of PEPFAR-supported laboratories are accredited with competent staff		80% of PEPFAR-supported laboratories are accredited with competent staff	
22					
23					
24		7 ECHO session conducted 30 Number of HCW/CHWs trained		9 ECHO session conducted 40 Number of HCW/CHWs trained	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
25	HHS/CDC	University Partnership Field Epidemiology Expansion - (GH001304)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Train Intermediate FELTP Program residents to serve in Council Health Management Teams as evidence-based decision-makers to improve quality and coverage of surveillance, facility-based and community services, and capacity of CQI teams. They will conduct rapid operational research studies on challenges to PEPFAR implementation of Test and Treat and New Service Models.
26	HHS/HRSA	Twinning follow On (U7HA04128)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	1) Support Health Training Institutions and professional bodies (Tanzania Nursing Association) and regulatory body, to increase number of qualified nurses capable of initiating ART. Ensure implementation of the scheme of service for social welfare cadre to expand roles in HIV/AIDS as per national task sharing policy.
27	HHS/CDC	UNICEF Follow on - (GH001619)	PREV	MTCT: Ensure comprehensive PMTCT services within RCH facilities to initiate ART for pregnant women and lactating mothers living with HIV.	Host country institutional development	Dissemination of updated national HIV data collection tools in National and subnational(MINS) regions and districts • Provide technical assitance to MoHCDGEC on data quality, and accuracy; and identifying gaps and bariers from routine program data
28	HHS/CDC	UNICEF Follow on - (GH001619)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Information systems	• Support cohort analysis of the CTC data in MINS region to understand ART treatment and Treatment outcomes (ART initiation, loss to follow up, and viral load suppression, mortality , for PLHIV and ALHIV in MINS region. Support MOH through Registration Insolvency and Trusteeship Agency (RITA) to strengthen birth and death registration within the unique idetification efforts in health care services.
29	USAID	Maternal and Child Survival Program (MCSP)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	Customization of HIM to support data exchange from eLMIS, HFR, VIMS and HRHIS to DHIS2
30	USAID	Maternal and Child Survival Program (MCSP)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	In collaboration with the ICT unit, host the country's data locally in Tanzania

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							11 FELTP graduated (number of trainees may be increased to 15. It will cost $6,200 per trainee ($18,600) to increase the number of cohort 3 trainees from 12 to 15. Task sharing baseline indicators developed for tracking implementation process	12 Intermediate FELTP Program residents trained
25	Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	Graduates of the FELTP Intermediate course been deployed in their respective original councils to provide epidemiological and surveillance services to ensure epidemic control.	3 years	HRH_PRE		
				Improved access to HIV testing services, linkages to HIV care and treatment services, ART coverage, retention of PLHIV on ART and better targeted HIV testing services, offered at the facility level by nurses, social workers, frontline services providers practicing task sharing including NIMART.			The HRH_PRE APR FY17 4709 nurses supported in various pre-service modalities.	
26	Scale-Up Councils have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	7. Human Resources for Health	5.60		1 year	HRH_PRE		HRH_PRE: 5089 .
	Policy and programs not implementing new evidence-based strategies to achieve viral suppression among children, adolescents, and pregnant women. Data systems in PMTCT not effective leading to low self reported knowledge of HIV positive status among women of reproductive age.			Viral suppression 86% across all age and sex bands. Awareness of HIV status among women of reproductive age >=95%			FY17 APR, THIS 2017	50% high-volume facilities provide adolescent-friendly services MTCT rate <2%
27		6. Service Delivery	3.98		3 years	TX_NEW; TX_CURR,HVLS,PMTCT_EID,PMTCT_ART		
	HIC care & treatment database not linked to nationsl vital registration system leading to challenges in tracking and retaining individuals in services.			80% of PLHIV on treatment are captured in national vital registration system		Annual program report	No linkage of HIV care and treatment database with national vital registration system.	80% of PLHIV on treatment in one region are captured in national vital registration system
28		13. Epidemiological and Health Data	4.17		3 years			
	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.			Tracking and linkage across HIV Services supported via electronic systems for 60% of HIV positives identified and 90% of clients on treatment in scale up SNUs by 2019.		Number of information systems exchanging and sharing data through Health Information Mediator (e.g. eLMIS, HFR, VIMS, HRHIS)	2	4
29		15. Performance Data	6.97		1 year			
	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.			ICT infrustructure to facilitate data exchange and sharing is in place		HIM server installed and supporting data sharing between information systems	HIM server not fully operational	HIM server fully operational and supporting data sharing and exchange across systems
30		15. Performance Data	6.97		1 year			

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25		12 FELTP graduates 12 FELTP graduates		12 FELTP graduates 12 FELTP graduates	
26					
27		70% of high-volume facilities provide adolescent-friendly services MTCT rate <1%		100% of high-volume facilities provide adolescent-friendly services MTCT rate 0%	
28		80% of PLHIV on treatment in four regions are captured in national vital registration system		80% of PLHIV on treatment in ten regions are captured in national vital registration system	
29					
30					

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31	USAID	Maternal and Child Survival Program (MCSP)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	Build the capacity of the MOHCDEGC ICT team by secondment of technical advisors at the ICT unit for training and online sessions
32	USAID	Maternal and Child Survival Program (MCSP)	HSS	Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	Customization of HIM to support data exchange from eLMIS, HFR, VIMS and HRHIS to DHIS2, and **CTC** 3(Client registry)
33	USAID	USAID Social Enterprise Support Activity (USESA)	PREV	PP_KP: Implement comprehensive evidence-based community outreach programs tailored to priority populations and key populations.	Host country institutional development	Build the capcity of indigenous CSO to support HIV prevention through locally mobilised resources
34	USAID	Challenge TB	C&T	TB: Increase comprehensive TB-HIV services with focus on scaling up TB screening of HIV+ clients and provide IPT to TB exposed clients.	Laboratory sample referral/ transportation systems	Support revision of country TB sample collection and transportation protocol
35	USAID	Challenge TB	C&T	TB: Increase comprehensive TB-HIV services with focus on scaling up TB screening of HIV+ clients and provide IPT to TB exposed clients.	Laboratory sample referral/ transportation systems	Provide logistical support for collection and transportation of sputum sample for Gene Xpert testing
36	USAID	Challenge TB	C&T	TB: Increase comprehensive TB-HIV services with focus on scaling up TB screening of HIV+ clients and provide IPT to TB exposed clients.	Laboratory quality improvement and accreditation	Provide TA required for mentorship and assessment for accreditation for ISO certification for TB Reference lab.
37	USAID	Challenge TB	C&T	TB: Increase comprehensive TB-HIV services with focus on scaling up TB screening of HIV+ clients and provide IPT to TB exposed clients.	Laboratory quality improvement and accreditation	Support infrastructure improvement and biosafety maintenance for National TB Reference lab.
38	HHS/CDC	TBD Institutional Capacity Building TA - (GH001929)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Host country institutional development	To provide continued TA to the MoHCDGEC on the activities currently being implemented by PHII/HITRAC. • To support the MoHCDGEC in the implementation of the task sharing policy in PHIs, including TA in development of a retention plan to assit to reduce the vacancy rates To support the MoHCDGEC in increasing recruitment, retention and allocation of health and social welfare workers at all levels

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31	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	15. Performance Data	6.97	MOHCDGEC ICT unit technical capacity to manage HIM and futher system configuration is in place	1 year	Number of ICT officers trained in system administration and configuration	0	10
32	Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	15. Performance Data	6.97	Tracking and linkage across HIV Services supported via electronic systems for 60% of HIV positives identified and 90% of clients on treatment in scale up SNUs by 2019.	1 year	Number of information systems exchanging and sharing data through Health Information Mediator and linked to the CTC 3 (e.g. eLMIS, HFR, VIMS, HRHIS)	2	5
33	Low capacity in CSO delivering social marketing of health products	3. Civil Society Engagement	3.83	Increased engagement of the CSO in HIV prevention and control	1 year	CSO engaged in rollout of TMA for condom distribution	CSO do not use Total Marketing Approach to condom distribution	Targetted CSO use Total Marketing Approach to condom distribution
34	Outdated protocol for sample collection and referral	10. Laboratory	5.83	Revised protocol for TB sample transportation with adoption of current WHO recommendations	1 year	An updated sample transportation protocol according to WHO recommendation	Not operational	Operational
35	Lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB)	10. Laboratory	5.83	Timely and accurate laboratory results available for patients in 100% of scale-up LGAs	2 years	Number of samples transported using hub and spoke system	50%	60%
36	Inaequate resources to conduct Lab mentorship and assessment for accreditation	10. Laboratory	5.83	National Reference TB Lab ISO- certified	3 years	Central Tuberculosis Reference Laboratory acquires International Standard Organization(ISO) 15189 rating	No	No-Initial rating shows improvement
37	Inadequate support for biosafety requirement.	10. Laboratory	5.83	Improved capacities; equipment and biosafety maintaenance at National TB Reference lab	3 years	Central Tuberculosis Reference Laboratory acquires International Standard Organization(ISO) 15189 infrastructure	No	Yes
38	Scale-Up Councils have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	7. Human Resources for Health	5.6	Outcome of improving retention process per developed National recruitment plan for effective delivery of HIV/AIDS services. Improved management of Human Resources for Health to meet service delivery requirements	3 years	Vacancy rate/shortage gap	The vacancy rate is about 56%, where the aim is to gradually reduce the gap, by ensuring positions are filled and retention is enhanced (for HCWs to remain)/attrition rate is decreased	A reduction in vacancy rate to 50%

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31					
32					
33					
34					
35		80%			
36		Yes		Yes_CTRL becomes supra- national laboratory with increased capacity to prepare External Quality Assurance samples	
37		Yes		Yes-CTRL becomes supra- national laboratory with increased capacity to prepare External Quality Assurance samples	
38		A reduction in vacacy rate to 48%		A reduction in vacacy rate to 44%	

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39	HHS/CDC	TBD Institutional Capacity Building TA - (GH001929)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Host country institutional development	Provide technical support to the MOHCDGEC in managing and coordinating the roll out of EMR Integrate EMR use monitoring into DHIS 2
40	HHS/CDC	TBD Institutional Capacity Building TA - (GH001929)	HSS	QI: Strengthening QA and QI systems and approaches to ensure provision of high quality services for supporting efforts towards epidemic control	Host country institutional development	To support the MoH in institutionalizing QA and QI methodologies
41	HHS/CDC	TBD Institutional Capacity Building TA - (GH001929)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Information systems	MSH provides technical assitance to key Public Health Institutions (PHI) to strengthen specific and targeted health sector systems to address key gaps and barriers impeding HIV epidemic control. In COP 18 a new Initiative to is being added to support systems analysis, system selection and program management related to creation of new shared health record. Goal of Shared health record would be to continue to capture data within CTC3 but migrate to new technology and platform that can support wider health sector requirements. This is important for HIV so system can start to capture HIV testing information that requires integration with multiple service delivery points across the facility including inpatient, out patient, RCH, TB, etc. Systems analysis and technical support role of MSH is distinct and separate from software and system development role of HIS follow on implemented by MDH.
42	HHS/CDC	TBD Surveillance TA - (GH000977)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Surveys and surveillance	1. Implement IBBS in select scale up councils, by writing protocol, training data collectors, procuring reagents, sample collection logistics, data analysis and report writing. these include TISINI, BSS in fisherfolks, TA to mainland and Zanzibar on IBBS activities 2. In collaboration with GOT, continue training of a cadre of well-trained M&E professionals to full district and regional M&E positions in order to improve the culture of data use, strategic decision making, and data quality in Tanzania
43	HHS/CDC	TBD Surveillance TA - (GH000977)	HSS	SD Systems: Service delivery points utilize patient level electronic systems to improve testing, linkage, treatment, and retention services and support differentiated service delivery models.	Information systems	1. Following the DQA findings done in FY17, Support HIV specific DQA plans and toolS that are aligned with Health sector approach to data quality and ensure all regions, districts and implementing partners are oriented on DQA strategy, tools and minimum DQA requirements.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
39	Tracking clients HIV Testing Services (HTS) and Linkages to Treatment] 2. HIS: Current paper based systems do not adequately support linkages between HTS and treatment services.	15. Performance Data	6.97	Digitilized HIV client data in PEPFAR supported sites	3 years	% of HIV C&T clients within sites that are supported by electronic systems. C&T facilities with electronic system % of HIV C&T clients with data in national client level data repository (CTC3) % of HIV C&T clients linked to Client Register % of PEPFAR supported sites with automated reporting from CTC to DHIS % of newly identifed HIV positives within sites supported by electornic systems % of newly identifed HIV positives with data in natinal client level data repository % of newly identifed HIV positives clients linked to client register	75% of C&T client data in CTC3 thorugh automated process from CTC2,	85% of CTC client data in CTC3 through automated process from CTC2, Automated reporting from CTC3 to DHIS to support full range of age disaagregates and indicators. 25% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 20% of C&T clients records linked to National Client Regsiter
40	Capability of the MoH to coordinate CQI initiatives in PHIs and at the subnational level	9. Quality Management	5.62	Institutionalized quality management system	3 years	Improved star rating tool is in use Proportion of facilities scoring above 3 stars using a revised tool	None	A revised start rating tool in use 15% of facilities have been assessed by a revised tool
41	Tracking clients HIV Testing Services (HTS) and Linkages to Treatment] 2. HIS: Current paper based systems do not adequately support linkages between HTS and treatment services.	15. Performance Data	6.97	Digitilized HIV client data in PEPFAR supported sites	3 years	Milestone progress towards establishing health sector shared health record.	Demostration completed	National stakeholder and e-health governance approval of concept note for shared health record, initial requirements and technology selection.
42	Quality routine data and survey evidence which is not consistently used to inform efforts to improve program and making right and correct decision. Scale up LGAs have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	13. Epidemiological and Health Data	4.17	Improved culture of data use, strategic decision making, and data quality in Tanzania	3 years	Number of scale-up councils with IBBS reports	Protocol development	Protocol developed and ethics approval received
43	data quality is still a challenge for the program implementation	13. Epidemiological and Health Data	4.17	M&E paper tools and routine reporting updated to track initial, repeat and confirmatory tests and high quality data available for decision making 2. HIV specific DQA plan and tools, which are aligned with Health sector approach to data quality, are developed.	3 years	Revised M&E tools and DQA reports	updating M&E tools	revising M&E tools

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39		90% of CTC client data in CTC3 through automated process from CTC2, 45% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 50% of C&T clients records linked to National Client Regsiter		95% of CTC client data in CTC3 through automated process from CTC2, 60% of newly idenifed HIV positives data captured through electronic systems and submitted to national client level data system 75% of C&T clients records linked to National Client Regsiter	
40		More than 50% of facilities are assessed using a revised tool		All facilities are assessed using a revised tool	
41		Software system developed and functional, data from CTC3 migrated to new platform, EMR and other facility systems previously submitting data to CTC3 now submitting data to new platform. New platform supports collection of client level HIV testing data, with de-duplication through linkages with Client register.		50% of newly identifed HIV positive clients data within national shared health record supporting de-duplication and linkage.	
42		Implementation of protocol (50% of scale up councils with IBBS reports)		(90% of scale up councils with IBBS reports)	
43		prinitng and dissemination of M&E tools, conducting DQAs		Use of the findings from the DQAs to improve program implementation	

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44	HHS/CDC	TBD Surveillance TA - (GH000977)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Surveys and surveillance	implement HIV Drug resistance survey to determine the presence of VL suppression and HIV DR among adults and children
45	HHS/CDC	TBD Surveillance TA - (GH000977)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Surveys and surveillance	To support DREAMS M&E, eg on going support to DAMES and evaluation to answer some questions with regards to DREAMS, eg Are we successfully layering the interventions, are we implementing with quality, how can we improve the program
46	HHS/CDC	TBD Clinical TA (International) - (GH001950)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Information systems	Provide technical assistance to local indeginous partners and R/CHMTs on data verification, timely submission and routine data use at respective levels.
47	HHS/CDC	TBD Comprehensive High Impact HIV Prevention IP (Local) - (GH002018)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Surveys and surveillance	Collaborate with the Ministry to 1) develop a surveillance system for HIV self testing and PrEP building on the existing surveillance system; 2) Facilitate roll out of HIV self-test and PREP and scaling up of HIV self testing and PrEP approaches with specific emphasis on linkage to care and treatment; 3) implement outcome evaluation for the early phase of HIV self-testing and PrEP especially on successful linkage to care and treatment to inform and improve the quality of our programme.
48	HHS/CDC	TBD Multilateral AIDS Sector Follow On	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Information systems	• Create and maintain national and regional Spectrum files and train/capacitate RHMT to routinely update and use files for programming. • Develop City Fast Track plans in collaboration with RHMT/ CHMTS in priority cities of Dar es Salaam, Mwanza, Mbeya, and Arusha with focus on targeting Key population for testing and monitoring of prevention, linkages, and treatment strategies at community level.
49	USAID	Comprehensive Platform for Integrated Communication Interventions (CPICI)	PREV	HTS_Men: Focus on identify men living with HIV and link them to ART through integrated, innovative and evidence-based HIV testing approaches	Host country institutional development	Provide capacity building to NACP health promotion unit and Ministry of Health on appropraite communication approaches and methodologies for key and priority populations
50	USAID	Comprehensive Platform for Integrated Communication Interventions (CPICI)	C&T	HTS_Men: Focus on identify men living with HIV and link them to ART through integrated, innovative and evidence-based HIV testing approaches	IEC and/or demand creation	Provide targeted messages to men for the uptake of HIV services, specifically discussing the benefits of early detection, use of self-testing, and index testing, promoting community ART.
51	USAID	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+)	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	Refine and scale clinical practicum program at private medical training institutes, which includes HIV care and treatment clinical rotations at private health facilities.

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44	Limited data in the areas of ARV drug resistance	13. Epidemiological and Health Data	4.17	Data and evidence developed for decision making and program improvement	3 years	Availability of HIV drug surveillance data	Development of Protocol for ARV DR survey	Development of Protocol for ARV DR survey
45	AGYW is still one of the low covered population and its data and information are limited	13. Epidemiological and Health Data	4.17	data and evidence developed for decision making and program improvement	3 years	Availability of DREAMS evaluation reprot and data	Implementation of DREAMS evaluation	implementation of DREAMS evaluation
46	Limited capacity of council and regional management teams, and IPs to utilize quality management methodologies to improve HIV/ AIDS services	13. Epidemiological and Health Data	4.17	Service delivery interventions implemented by IPs are informed by quality monitoring findings in a real time	3 years	HTS_TST_POS, TX_NEW, TX_CURR, and TX_PVLS	~15% of the facilities are using weekly perfomance data to track progress	~30% of the facilities are using weekly perfomance data to track progress
47	HIV Identification of the KVP, men and their sub populations	6. Service Delivery	3.98	Integrated bio-behavioral survey in scale up councils completed, findings disseminated and used to improve HTS self testing and PrEP by 2020. Decrease rate of HIV incidence	2 years	HTS_TST_Self, PrEP_ NEW	Six month of Program Data on the use of PrEP	Increased HIV identification for KVP, men and their sub-populations by 25% through self testing Increase linkage and retention for PrEP by 40%
48	Efforts to use data within planning and resource allocation hindered by low quality data and evidence from evaluations and surveillance are not sufficiently identifying retention barriers	13. Epidemiological and Health Data	4.17	90% of scale up LGAs include results of HIV data triangulation within LGA level annual plans or health profiles by 2019.	3 years	Generation of national and regional HIV estimate and routine use of relevant HIV data	2018 HIV estimates developed	2018 HIV estimates developed and annual support for maintenance of regional spectrum files
49	Inadequare capaciity to delivery communication messages	1. Planning and Coordination	5.33	Adequate number of technical staff from the relevant health promotion unit at MoH competent and skilled to develop quality prevention services for priority populations	3 years	Proportion of key staff within the relevant units of MoH and NACP having received TA	0%	50%
50	Tanzania does not have a comprehensive policy or operational guidelines for Test and Start	5. Public Access to Information	6	4. Information, Education and Communication for awareness and understanding of test and start policy, benefits of early treatment and promote service uptake amongst KP, and PP.	3 years	Number of men under 35 reached with targeted messages	1,000	500,000
51	Scale-Up Councils have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines.	7. Human Resources for Health	5.60	Nursing, Clinical Officer, pharmacy, and CHW cadres providing high quality services per task sharing policy in 100% of scale up districts	3 years	-Number of HRH students matriculating from practicum program per year	-Number of nurses matriculating = 0	-Number of nurses matriculating=50

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44		implementation of the survey		Use of the findings from the survey to improve program implementation	
45		Use of the findings from theevaluation to improve program implementation		Use of the findings from the evaluation to improve program implementation	
46		~70% of the facilities are using weekly perfomance data to track progress		~100% of the facilities are using weekly perfomance data to track progress	
47		Increased HIV identification for KVP, men and their sub-populations by 50% through self testing Increase linkage and retention for PrEP by 80%			
48		2019 HIV estimates and annual support for maintenance of regional spectrum files		2020 HIV estimates and annual support for maintenance of regional spectrum files	
49		75%		100%	
50		1,000,000		1,500,000	
51		-Number of nurses matriculating (Round 2) = 50 -Number of CHWs matriculating = 30 -Number of Pharmacist Assistants matriculating = 50		-Number of nurses matriculating (Round 3) = 50 -Number of CHWs matriculating (Round 2) = 30 -Number of Pharmacist Assistants matriculating (Round 2) = 50	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
52	USAID	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Policy and governance	Advocate change in GOT policy re: assisted self-testing & multimonth ARV prescription dispensing at private Accredited Drug Dispensing Outles (ADDOs).
53	USAID	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+)	PREV	PP_Other: Implement comprehensive community outreach for other priority populations.	Costing and efficiency analysis	Promote scaling with fidelity a Total Market Approach (TMA) and Build capacity of T-MARC to increase its capacity to support integrated FP/HIV services for women and their partners.
54	USAID	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+)	PREV	PP_Other: Implement comprehensive community outreach for other priority populations.	Costing and efficiency analysis	Provide TA to health insurers (National Health Insurance Fund, Jubilee Insurance, AAR Insurance) to assess feasibility of an affordable HIV/AIDS care insurance packages for customers who are able to pay, based on commercial costs of HIV basic commodities and services.
55	USAID	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Host country institutional development	Revitalize employer/corporate engagement in HIV/AIDs and to develop innovative solutions in collaboration with PEPFAR-funded implementing partners in priority areas outside of Dar-es-Salaam in male dominated industries such as transportation, security, minerals and mining, cement manufacturing, and bottling.

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52	System for distribution of commodities under new service delivery platform	6. Service Delivery	3.98	Private Accredited Drug Dispensing Outlets (ADDOs) provide assisted self-testing and dispensing multimonth ARV prescriptions	3 years	-Number of new ADDOs providing assisted self-testing -Number of new ADDOs dispensing multimonth ARV prescriptions	-Number of new ADDOs providing assisted self-testing = 0 -Number of new ADDOs dispensing multimonth ARV prescriptions = 0	-Number of new ADDOs providing assisted self-testing = 100 -Number of new ADDOs dispensing multimonth ARV prescriptions = 100 (assuming suppportive policy in place)
53	Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	4. Private Sector Engagement	4.13	Free or subsidized provision of condoms as total market share decreases and total market share of commercially provided condoms increases.	3 years	-% of condoms in the market that are free -% of condoms in the market that are subsidized -% of condoms in the market that are purchased at commercial prices -Number of condom policy documents and programs with TMA principles incorporated	-% of condoms in the marketplace free = 21% -% of condoms in the marketplace subsidized = 76% -% of condoms in the marketplace purchased at commercial prices = 3% -Number of condom policy documents and programs with TMA principles incorporated = 0	-% of condoms in the marketplace free = 21% -% of condoms in the marketplace subsidized = 76% -% of condoms in the marketplace purchased at commercial prices = 3% -Number of condom policy documents and programs with TMA principles incorporated = 2
54	Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	4. Private Sector Engagement	4.13	NHIF and commercial insurers develop complementary health insurance packages for customers able and willing to pay HIV/AIDs services.	3 years	Number of private health facilities providing HIV services to HIV/AIDS care insurance holders	Number of private health facilities providing HIV services to HIV/AIDS care insurance holders = 0	Number of private health facilities providing HIV services to HIV/AIDS care insurance holders = 50
55	Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	4. Private Sector Engagement	4.13	Increased number of commercial firms collaborating with PEPFAR-funded IPs in testing and treatment programs.	3 years	-Number of new commercial firms collaborating with PEPFAR-funded IPs in testing and treatment programs (Patient level data to be collected by PEPFAR-funded IPs)	-Number of new commercial firms collaboring with PEPFAR-funded IPs in testing and treatment programs = 0 (Patient level data to be collected by PEPFAR-funded IPs)	-Number of new commercial firms collaboring with PEPFAR-funded IPs in testing and treatment programs = 2 (Patient level data to be collected by PEPFAR-funded IPs)

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52		-Number of new ADDOs providing assisted self-testing = 400 -Number of new ADDOs dispensing multimonth ARV prescriptions = 400 (assuming suppportive policy in place)		-Number of new ADDOs providing assisted self-testing = 800 -Number of new ADDOs dispensing multimonth ARV prescriptions = 800 (assuming suppportive policy in place)	
53		-% of condoms in the market that are free = 21% -% of condoms in the market that are subsidized = 73% -% of condoms in the market that are purchased at commercial prices = 6% -Number of condom policy documents and programs with TMA principles incorporated = 2		-% of condoms in the market that are free = 21% -% of condoms in the market that are subsidized = 64% -% of condoms in the market that are purchased at commercial prices = 15% -Number of condom policy documents and programs with TMA principles incorporated = 2	
54		'Number of private health facilities providing HIV services to HIV/AIDS care insurance holders = 100		'Number of private health facilities providing HIV services to HIV/AIDS care insurance holders = 150	
55		-Number of new commercial firms collaboring with PEPFAR-funded IPs in testing and treatment programs = 15 (Patient level data to be collected by PEPFAR-funded IPs)		-Number of new commercial firms collaboring with PEPFAR-funded IPs in testing and treatment programs = 30 (Patient level data to be collected by PEPFAR-funded IPs)	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
56	USAID	Health Policy Plus (HP+)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Costing and efficiency analysis	Conduct specific and targeted cost analysis that will assess the estimates on prospective cost and impact of introducing monetary and non-monetary incentives for HIV testing among specific population groups and regions in Tanzania and how to improve yield curves over time through changes in the mix of home-based, PICT, and targeted community testing drives.
57	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	HSS	Lab: Strengthen National Lab capacity including ability to administer and manage proficiency testing, coordinate lab training, accreditation and certification.	Laboratory quality improvement and accreditation	• Coordinate and oversee the enrollment of PT/EQA program to all HIV rapid testing sites • Implement the national mapping of both conventional and Point of Care (POC) instruments • Implementation of the National HIV rapid testers and testing sites Certification Program and laboratory quality management System (Accreditation/SLMTA) • Continue to implement the linkage of Viral Load / EID lab results from testing labs to Care and Treatment Clinic (CTC3/2) databases • Ensure at least 3 months of stock of lab reagents and commodities are available, timely servicing of laboratory equipment by vendors, and support availability of additional laboratory testing staff.
58	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	HSS	SD Systems: Service delivery points utilize patient level electronic systems to improve testing, linkage, treatment, and retention services and support differentiated service delivery models.	Information systems	Implement Data Use Strategy, Establish national systems and standard practice to improve dissemination products, feedback, district profiles to support use of data to inform HIV service planning. M&E and HMIS strengthening to improve data quality and MOHCDGEC leadership to incorporate new features to support integrated GOT and PEPFAR data systems.
59	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Surveys and surveillance	Creating an HIV specific DQA plan and tool that is aligned with Health sector approach to data quality and ensure all regions, districts and implementing partners are oriented on DQA strategy, tools and minimum DQA requirements. Develop training materials and conduct ToT for ANC surveillance based on PMTCT routine data with quality and monitoring framework to inform transition and produce estimates of district level prevalence

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56	Current HTS modalities not capturing all potential HIV positives.	6. Service Delivery	3.98	Targeted and improved HTS programming that motivates populations that don't typically come forward on their own to get tested (e.g., adolescents, men)	1 year	Cost effective approaches to incentivize HIV testing services identified	None exist	Available cost effective approaches that incentivize HTC
57	• Low participation in the national PT/EQA by HIV testing sites • Laboratory Testing Capacity of conventional and Point of Care Platforms not Optimized • Annual certification of HIV testers/sites not implement as per the WHO guidelines • Long lab results turn-around-time for VL/EID samples. •Frequent stock out of lab reagents, long equipment downtime, and inadequate staff in VL/EID testing labs	10. Laboratory	5.83	HIV rapid test, Quality assurance systems deployed At least 80% of PEPFAR-supported laboratories have competent and adequate staff to meet testing targets.	3 years	Lab_PTCQI TX_PVLS	• Currently there are 17 labs providing HRT/EID/VL/TB services (5 fully accredited, 12 labs are in the process towards accreditation). •About 693 rapid HIV testing points have been audited out of which 208 are implementing the Rapid Test Continuous Quality Improvement (RTCQI) •5310 (52%) HIV testing points are participating in the EQA/PT program nation wide • 13 out of 17 VL/EID testing laboratories are electronically	• 6 labs (out of 12 labs) mentored achieve at least 3 stars. • At least 50% of sites providing HRT services implement the RTCQI. • At least 80% of HIV testing points are participating and successfully passing the EQA/PT • All 17 VL/EID testing laboratories are electronically linked to Care and Treatment Clinic databases (CTC2) through the Central Laboratory Database
58	Current patient tracking systems do not have functionality to support differentiated service delivery models	13. Epidemiological and Health Data	4.17	Synchronization of PEPFAR and GoT information systems to improve data sharing and use for decision making. To improve data quality and MOHCDGEC leadership to incorporate new features to support integrated GOT and PEPFAR data systems.	3 years	Timely reporting by GoT facilities to PEPFAR system	None	70% of GoT facilities timely report to PEPFAR system
59	Decisions regarding new service delivery models are not informed by quality data from information systems	13. Epidemiological and Health Data	4.17	At 90% of facilities without data discrepancy for selected indicators	3 years	%. of the councils/districts report conducting DQA	None	70% of councils/districts report conducting DQA

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56					
57		•All 12 labs mentored achieve at least 3 stars . •At least 75% of sites providing HRT services implement the RTCQI •At least 90% of HIV testing points are participating and successfully passing the EQA/PT • All new and Point-of-Care Testing (POCT) VL/EID results are electronically linked to CTC2 databases		•All 12 labs are fully accredited and maintain accreditation status •At least 90% of sites providing HRT services implement the RTCQI •At least 95% of HIV testing points are participating and successfully passing the EQA/PT	
58		80% of GoT facilities timely report to PEPFAR system		> 90% of GoT facilities timely report to PEPFAR system	
59		80% of councils/districts report conducting DQA		> 90% of the councils/districts report conducting DQA	

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60	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Host country institutional development	Facilitate the collaboration and active engagement in all levels of government entities to plan, implement and evaluate Key and vulnerable Population size estimates development and results. Establish National KVP tracking system across cinical cascade as far as retention and viral supression.
61	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	PREV	PP_KP: Implement comprehensive evidence-based community outreach programs tailored to priority populations and key populations.	Surveys and surveillance	To conduct Key and Vulnerable Population (KVP) size estimate
62	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	HSS	QI: Strengthening QA and QI systems and approaches to ensure provision of high quality services for supporting efforts towards epidemic control	Host country institutional development	Creating a system that enables utilization of patient level data in a real time to inform policy recommendations and resource prioritization to MOHCDGEC leadership.
63	HHS/CDC	Consolidated MOH Coag - (GH17-1722)	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Technical area guidelines and tools	1). Adopt and disseminate evidence-based best practices for HIV care and treatment through national guidelines, SOP and other relevant tools. 2). Introducing retesting for verification policy and revision of reporting tools. Revise, print and disseminate SOPs, M& E tools and training packages for PrEP, self testing services for KVP. Coordinate and support HTC technical working quarterly meetings .
64	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Host country institutional development	Implement the new streamlined structure of LMU transitioning some responsibilities to CHMTs. Including work with PO RALG to adjust job descriptions to include supply chain responsibilities and the implementation of a standardized supportive supervision checklist and use eLMIS data through the establisment of IMPACT Teams
65	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Information systems	Support the integration of supply chain data into the larger Health Information Systems ecosystem, including the integration of the logistics data domain into the Health Information Mediator (HIM) Implement a standardized health commodity registry which would be GS1 standardized and sit in HIM
66	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Supply chain systems	Support NACP and MSD as they transition and scale up TLD regimen
67	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Host country institutional development	Strengthen quantification process increase forecast accuracy and ensure quantification adherence
68	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Information systems	Develop standardized protocol for DQAs of supply chain data in the eLMIS. Strengthen confidence in eLMIS data by triangulating with service statistics in the HMIS

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60	Current patient tracking systems do not have functionality to support differentiated service delivery models, especially for KVP	6. Service Delivery	3.98	90% of KVP indicators are reported as a result of a robust National KVP tracking monitoring & evaluation system	3 years	KP_HTS_ TST, KP_HTS, KP_TST_POS, KP_TX_NEW, KP_TX_RET, KP_TX_PVLS and KP National Size estimates	Draft National tracking tools	70% of KVP indicators are reported
61	Decisions regarding new service delivery models are not informed by quality data from information systems	6. Service Delivery	3.98	Data and evidence generated for scaling up of sustainable service delivery platforms for prevention and treatment of HIV/AIDS in scale-up LGAs	3 years	Availability of data (KP and AGYW)	None	Protocol development, Survey IRB approved Initial data collection started
62	Routine patient level data do not support service level decisions.	1. Planning and Coordination	5.33	Patient level data-driven analysis informs policy recommendations to MOHCDGEC leadership, including mobilization and prioritization of resources	3 years	CQI Dashboard/ DHIS2 QIP monitoring system	None	CQI Dashboard linked with DHIS2 rolled out
63	Limited data in the areas of ARV drug resistance	13. Epidemiological and Health Data	4.17	Data and evidence generated for program improvement (ART monitoring and adherence)	3 years	Availability of HIV drug surveillance data	None	Protocol for ARV DR survey developed
64	System for distribution of commodities under new service delivery platform	8. Commodity Security and Supply Chain	4.25	Proactive management of facility level supply chains done by RHMTs and CHMTs	2 years	Percent of LMU operational cost paid by GOT	0%	25%
65	Poor linkage between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of ARVs and commodities	8. Commodity Security and Supply Chain	4.25	Facility level health information systems have pharmacy management capabilities and data standards are in place to automate reporting and requisition of ARVs and HIV commodities for sites covering 70% of all current on treatment by 2019.	2 years	eLMIS integrated with DHIS2, MSD's ERP and other information systems	Minimal Integration with MSD's Epicor 9	eLMIS information loaded into the Health Information Mediator
66	Poor linkage between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of ARVs and commodities	8. Commodity Security and Supply Chain	4.25	All eligible patients on first line regimins transititioned to TLD	2 years	% of Patients on TLD	0%	50%
67	Financing gap between ARV and viral load needs and GOT/PEPFAR/GFATM allocation	8. Commodity Security and Supply Chain	4.25	Coordinated procurement plan for commodities developed and implemented on annual basis.	1 year	Forecast Accuracy	75%	80%
68	Poor linkage between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of ARVs and commodities	8. Commodity Security and Supply Chain	4.25	Service statistics (DHIS), patient records, and logistics data (eLMIS) dashboard developed to facilitate stakeholder review across information systems by 2019.	1 year	% of Report and Requisition forms passing their data quality check	48%	65%

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60		80% of KVP indicators are reported		> 90% of KVP indicators are reported	
61		Data collection and analysis is complete		Survey results inform program adjustment for performance improvement	
62		CQI Dashboard linked with DHIS2 operationalized in 50% of councils		CQI Dashboard linked with DHIS2 operationalized in >90% of councils	
63		Survey completed		Survey results inform program adjustment for performance improvement	
64					
65					
66		100%			
67					
68		80%			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
69	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Supply chain systems	Assist the Pharmaceutical Services Unit and MSD to redesign the supply chain system using the data now available through eLMIS and other information systems. Implement new design with change management benefitting all 6,000 health facilities.
70	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Information systems	The eLMIS Open Source system upgraded to the latest version which includes a new functionality for facility level data entry and be modified to the Tanzanian context including the relevant linkages to the Health Information Mediator and Facility level electronic registries.
71	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Supply chain systems	Lab Optimization with LabEquip software to assist with equipment placement decisions and think through sample transportaton options.
72	USAID	Global Health Supply Chain- Technical Assistance (GHSC-TA)	HSS	Supply Chain: Improved security, reliability and distribution of key products for the prevention, diagnosis and treatment of HIV/AIDS	Supply chain systems	Update supply chain dashboards reflecting increased data visibility due to the change to monthly reporting in the supply chain re-design
73	USAID	Boresha Afya Southern Zone	C&T	VL_TEST: Rapid scale-up of VL testing	Laboratory sample referral/ transportation systems	mplement hub and spoke sample transport system in all CTC facilities.
74	USAID	Boresha Afya Southern Zone	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Laboratory quality improvement and accreditation	Accreditation of 4 Laboratory sites in the Southern Highlands zone to improve Quality of laboratory

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
69	System for distribution of commodities under new service delivery platform	8. Commodity Security and Supply Chain	4.25	Average in-country distribution costs for health commodities reduced from 20% to 15% by 2019.	2 years	Activities carried out in accordance with CIP from holistic supply chain review	20%	50%
70	Poor linkage between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of ARVs and commodities	8. Commodity Security and Supply Chain	4.25	Facility level health information systems have pharmacy management capabilities and data standards are in place to automate reporting and requisition of ARVs and HIV commodities for sites covering 70% of all current on treatment by 2019.	2 years	% facilities entering data directly into eLMIS system	25%	40%
71	3. Lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB)	10. Laboratory	5.83	Timely and accurate laboratory results available for patients in 100% of scale-up LGAs	2 years	Optimization exercise recommendations implemented	Lab system not informed by optimization software	Optimization software exercise completed and 25% of recommendations implemented
72	Poor linkage between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of ARVs and commodities	8. Commodity Security and Supply Chain	4.25	Service statistics (DHIS), patient records, and logistics data (eLMIS) dashboard developed to facilitate stakeholder review across information systems by 2019.	2 years	% of Report and Requisition forms passing their data quality check	48%	65%
73	Timely and accurate laboratory results available for patients in 100% of scale-up LGAs Improved patient management at all facility levels	10. Laboratory	5.83	Functional hub and spoke system that allow HVL and DBS sample transportation in 5 regions of support	1 year	Percent of CTC facilities supported by functional hub and spoke system	50%	100%
74	At least 4 of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	10. Laboratory	5.83	4 regional labs in Southern regions receive accreditation	2 years	Number of laboratories fully accredited	0	2

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69		80%			
70		60%			
71		100% of recommendations implemented			
72		80%			
73					
74		4			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
75	HHS/CDC	AFENET Follow-On	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Workforce development, pre-service training	To train Advance FELTP Program residents (two year Master program) to conduct rapid operational research studies on challenges to PEPFAR implementation of HIV&AIDS, including Test & Start plus SDMs.
76	HHS/CDC	Laboratory	HSS	Lab: Strengthen National Lab capacity including ability to administer and manage proficiency testing, coordinate lab training, accreditation and certification.	Laboratory quality improvement and accreditation	•Provide Technical Assistance (TA) on scale up of Rapid Test Continuous Quality Improvement (RTCQI) • Provide TA on how conduct competency assessment to non-laboratory Rapid HIV testers and certification. • Provide TA on roll out of PT/EQA program to all HIV rapid testing sites. •Provide TA to central TB reference lab (CTRL) for Gene Xpert machines for TB and EID testing in priority councils not covered by KNCV. • Provide TA on forecasting and quantification of laboratory HIV reagents and commodities. • Provide TA on rollout / implimentation of new technologies including POC testing for TB, VL/EID • Provide TA on QI/QA activities for Blood Safety and Blood information system and Accreditation

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75	Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	The graduates and trainees of FELTP advanced course are expected to provide public health service (epidemiological and surveillance) at the national, regional and district levels and create a culture of critical thinking to ensure epidemic control. They will also contribute to improve quality and coverage of surveillance, facility-based and community services, and capacity of CQI team	3 years	HRH_PRE	Twelve out of 14 Cohort VII residents enrolled in 2014 (eight field epidemiologists and four public health laboratorians) graduated in December 2016, with 15 of the Cohort VIII residents graduating on December 2017. Cohort IX (15 residents) are attending various modules, while cohort X are attending module 1 of the course. COP targets are set to a maximize number of residents who complete the course within two years of enrollment.	14 (with the possibility of increasing the number)
76	• Limited knowledge and skills on implemetation of: - RTCQI, - Competency assessment of HIV rapid testers and testing sites, - roll out of PT/EQA programs, - use of GeneXpert for EID and TB testing, - Forecasting and Quantification of lab reagents, and - Blood safety.	10. Laboratory	5.83	Improved CQI in HIV RT and Increased access to quality HIV RT/VL/EID/TB at all levels of health system Improved patient management at all facility levels	3 years	Lab_PTCQI	•Currently there are 17 labs providing EID/VL services. 5 are fully accredited.12 labs are in the process towards accreditation. •About 693 rapid HIV testing points have been audited of which 208 are implementing the RTCQI •5310 (52%) HIV testing points are participating in the EQA/PT program nation wide	•6 labs will be mentored to achieve at least 3 stars . •At least 50% of sites providing HRT services implement the RTCQI Atleast 90% of HIV testing points are participating and successfully passing the EQA/PT R51:AA51R51:X51

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75		15 (with the possibility of increasing the number)		15 (with the possibility of increasing the number)	
76		At least 6 labs will be mentored to achieve full accreditation. At least 75% of sites providing HRT services implement the RTCQI All HIV testing points are participating and successfully passing the EQA/PT		At least all 12 labs will have five stars in preparation for full accreditation All sites providing HRT services implement the RTCQI Maintain and sustain all HIV testing points participating and successfully passing the EQA/PT	

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77	HHS/CDC	Laboratory	HSS	Lab: Strengthen National Lab capacity including ability to administer and manage proficiency testing, coordinate lab training, accreditation and certification.	Laboratory sample referral/ transportation systems	•Create open source tool that can act as a data repository for information relevant to laboratory network performance and Link relevant data and provide uses with the ability to visualize the system (map, charts, etc), •Implement the national mapping of both conventional and Point of care (POC) instruments procured by different stakeholders in the country. •Support laboratory instrument calibration center and Biosafety cabinet (BSC) repair training program at MUHAS
78	HHS/CDC	Laboratory	HSS	Lab: Strengthen National Lab capacity including ability to administer and manage proficiency testing, coordinate lab training, accreditation and certification.	Workforce development, pre-service training	• Provide TA on implementation of the viral load and EID scorecard tool to identify gaps and monitor improvements in viral load and IVT testing over time. •Provide TA on scale up of the sample referral system and Strengthening of Hub and spoke for VL/EID samples • Provide TA on intensification of VL mentorship to all facilities: ensure 100% coverage per guidelines (deploy mentors) • Provide TA on implementation of Nurse-Laboratory Quality Improvement Initiative on VL results return to patients level • Provide TA on development and review of VL inservice training materials for Laboratorians, Counselors and Clinicians. • Provide TA on on linking Viral Load / EID results from testing labs to Central Lab Database and to CTC3/2 databases.
79	USAID	Human Rights Support Mechanism (HRSM)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Host country institutional development	Strengthen and support CSO coalitions to advocate and engage on women's health and rights (for example, gender-based violence campaigns) that emphasise the nexus of SGBV and HIV /Health
80	USAID	Human Rights Support Mechanism (HRSM)	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Host country institutional development	Issue sub-grants to CSOs to implement advocacy strategies that promote changes in policy and practice against sexual and gender based violence to impact HIV prevention and control

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
77	• Lack of laboratory network performance visualization tool to help in monitoring its efficiency. • Lack of optimization of conventional and Point of care (POC) instruments lead to suboptimal use of testing capacity. • Lack of in-country capacity to perform calibration of lab equipment hinders our effort to timely certify Biosafety Cabinets.	10. Laboratory	5.83	• Real time monitoring of performance of laboratory networks available. • Laboratory capacity for both conventional and Point of care (POC) platforms function in complementary way increasing its efficiency. • Local capacity to certify laboratory instruments deployed and all Biosafety cabinets in PEPFAR-supported laboratories are certified at least once annually.	3 years	Lab_PTCQI TX_PVLS	• MOH received training on LabEquip Mapping tool. • List and location of both conventional and POCTs available.	• Mapping of all conventional and Point of care (POC) instruments procured by different stakeholders in the country completed. • Lab Equipment Calibration Center established and 10 Biosafety Cabinet repair technicians trained.
78	• Limited knowledge on identification of gaps and development of improvement action plans. • Only 50.8% (157/309) hubs are functional. • Low VL coverage (35%) amongst patients on ART. • Low utilization of VL/EID laboratory results for management of patients. • VL training materials outdated. • limited knowledge and skills on database management and programming.	10. Laboratory	5.83	Timely and accurate laboratory results available for patients in 100% of scale-up LGAs Improved patient management at all facility levels	3 years	TX_PVLS	• All facilities mapped to 309 hubs. • Central Laboratory Database collecting data from all VL/EID testing laboratories. • Current VL training materials available.	• 64% increase in functional Sample Collection and Referral Hubs (157 to 257 hubs). • All VL lab results are electronically entered into CTC2 database on real time.
79	CSOs lack a unified voice and common platforms to address women's human rights violation and their impact on health	3. Civil Society Engagement	3.83	Effective CSO coalitions and advocacy campaigns that support activities and messages focused on the nexus of GBV,HIV and health	2 years	Number of targeted CSO coalitions supported to advocate and influence women's health and rights for HIV prevention and control	0	2
80	CSOs have limited access to financial resouces and technical capacityto implement advocacy interventions against SGBV	3. Civil Society Engagement	3.83	Effective advocacy interventions linked to policy reforms against sexual and gender based violence implemented	3 years	Number of civil society organizations (CSOs) receiving USG assistance engaged in advocacy interventions	0	6

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77		• Data (maps, charts) on the efficiency laboratory networks available. • All Biosafety Cabinets certifying instructments are calibrated in-country, saving time and money for not shipping to United States.		• Data (maps, charts) on the efficiency laboratory networks available. • All Biosafety Cabinets certifying instructments are calibrated in-country, saving time and money for not shipping to United States.	
78		• 100% Sample Collection and Referral hubs are functional.		Maintain and sustain the sample referral and result feedbak system for VL/EID/TB	
79					
80		12			

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
81	DOD	TBD HJFMRI Follow on	C&T	VL_TEST: Rapid scale-up of VL testing	Laboratory quality improvement and accreditation	Accreditation of 8 Laboratory sites in the Southern Highlands Regions to improve Quaility
82	DOD	TBD HJFMRI Follow on	C&T	VL_TEST: Rapid scale-up of VL testing	Laboratory sample referral/ transportation systems	80% of the laboratories operationalize the hub and spoke sample referral/ transportation systems
83	DOD	TBD HJFMRI Follow on	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Assessments, evaluation, operation research	Cross-sectional study to identify factors associated with virologic outcome and HIV drug resistance patterns extended to children & adolescents aged 1-19 years
84	DOD	TBD HJFMRI Follow on	C&T	PEDS: Scale up coverage of ART among pediatric and adolescent PLHIV to improve viral suppression.	Assessments, evaluation, operation research	Longitudinal cohort study to assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.
85	DOD	TBD HJFMRI Follow on	C&T	RET: Maintain retention rate of 90% for PLHIV initiated within the past year and 95% for all other PLHIV currently on treatment with a specific focus on retaining men.	Assessments, evaluation, operation research	Cluster-randomized controlled trial to improve retention and viral load suppression among key populations via differentiated care models at the facility and community levels

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
81	Quality of HIV rapid testing according to WHO guidelines (new, repeat, retest and documented annual certification of testers/sites) Long turn-around-time for VL samples due to back log caused by equipment downtime, shortage of reagents, and unavailability of workforce in VL/EID testing labs	10. Laboratory	5.83	8 of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	3 years	Number of laboratories s accredited to quality standardsa for the effective, efficient, and safe operations for EQA, Viral Load, and EID without service interruptions.	Current labs in Mbeya Ruvuma and Sumbawanga Regional Hospitals are not accredited to quality standards	**3** Laboratory sites accredited for the effective, efficient, and safe operations for EQA, Viral Load, and EID without service interruptions- in the Southern Highlands Regions to improve Quaility
82	Lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB)	10. Laboratory	5.83	Timely and accurate laboratory results available for patients in 100% of scale-up LGAs	2 years	Number of labs that operationalise the hub and spoke referral systems	Mapping of both conventional and POCs is on going.	50% of the laboratories operationalize the hub and spoke sample referral/ transportation systems
83	Poor adherence and retention in HIV exposed infants	13. Epidemiological and Health Data	4.17	Evidence of prevalence of and factors associated with virologic failure in children and adolescents 1-19 years and HIV drug resistance patterns, disaggregated by age group and gender, used to optimize differentiated care models for increasing engagement in care, retention, adherence and viral load suppression.	2 years	No of studies conducted to describe the virologic outcomes and HIV resistance patterns among children and adolescents aged 1-19 yrs	**Study Progress:** Initial mapping conducted to inform the study	**Study progress** • 80% of target numbers (n=1000) enrolled; • viral failure prevalence estimated based on completed enrollment in those on first and second line treatment • prevalence/patterns of HIV drug resistance
84	Gaps in evidence on clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression	13. Epidemiological and Health Data	4.17	Long-term cohort results of key outcomes in the areas of: • Demographic, social factors • HIV Outcomes • Non-HIV Health Outcomes • Health and Risk Behaviors • Mental Health and Cognition Additional detail available in quarterly HOP reports.	2 year	Study conducted to assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in a multi-country African context.	**Study progress**: Mapping of both conventional and POCs to inform the study	**Study progress**: 50 % of target enrolled;
85	Challenges in reaching key populations using facility-based service delivery and keeping them on treatment	6. Service Delivery	3.98	Evidence of effect of differentiated service delivery model on retention, viral load and CD4 count in key populations	3 years	Lab_PTCQI TX_PVLS	**Study progress**: Mapping of both conventional and POCs to inform the study	**Study Progress**: Protocol developed and ethics approval received

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81		**6** Laboratory sites accreditedfor the effective, efficient, and safe operations for EQA, Viral Load, and EID without service interruptions- in the Southern Highlands Regions to improve Quaility		**8** Laboratory sites accredited for the effective, efficient, and safe operations for EQA, Viral Load, and EID without service interruptions. in the Southern Highlands Regions to improve Quaility	
82		80% of the laboratories operationalize the hub and spoke sample referral/ transportation systems			
83		**Study progress** 100% of target numbers enrolled; • viral failure prevalence estimated based on completed enrollment in those on first and second line treatment for all enrolees • prevalence/patterns of HIV drug resistance described for all study enrolees			
84		Study progress: 100 % of target enrolled; Study Completed			
85		**Study Progress:** 100% of target numbers enrolled; report of findings on factors supporting and impeding retention among the targeted KP groups in the local context; report on acceptability of care components and planned DSDM adjustments		**Study Progress:** Report on preliminary findings of RCT of the effect of DSDM on retention, viral load and CD4 count	

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86	DOD	TBD PAI-DOD Follow on	C&T	VL_TEST: Rapid scale-up of VL testing	Laboratory quality improvement and accreditation	Accreditation of 4 Laboratories in military sites in the Southern Highlands Regions to improve Quaility
87	DOD	TBD PAI-DOD Follow on	C&T	VL_TEST: Rapid scale-up of VL testing	Laboratory sample referral/ transportation systems	Support laboratories to operationalize the hub and spoke sample referral/ transportation systems(military sites)
88	DOD	TBD PAI-DOD Follow on	HSS	Governance: Strengthening governance including key policies, guidelines and standard operating procedures that improve the coverage of high impact HIV interventions across scale up councils and reaching key populations	Host country institutional development	Improve Capacity of the Tanzania Military (TPDF) in Data Management, Implementation of new policies (SDM, Self Testing, PrEP, Men) and Surveilance including Seroprevalence and Behavioral Epidemiology Risk Surveys (SABERS)
89	HHS/CDC	WHO Follow ON COP18	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Technical area guidelines and tools	1.Support the monitoring of HIVDR early warning indicators (EWI) including pharmacovigilance. 2.Finalization HIVDR strategic plan which started in 2014
90	USAID	Boresha Afya Northern Zone	C&T	ART: Scale-up comprehensive facility and community care and treatment services to increase coverage of ART and treatment literacy amongst PLHIV and improve overall quality of services to achieve viral suppression.	Laboratory quality improvement and accreditation	Accreditation of 4 Laboratories in the nothern and central zones to improve Quality of laboratory tests
91	HHS/CDC	TBD Comprehensive High Impact HIV Prevention IP (Local) - (GH002018)	PREV	PP_KP: Implement comprehensive evidence-based community outreach programs tailored to priority populations and key populations.	Surveys and surveillance	1. Size estimation for Tanzania Mainland 2. Implement IBBS in select scale up councils, by writing protocol, training data collectors, procuring reagents, sample collection logistics, data analysis and report writing. These include TISINI, BSS in fisherfolks, TA to mainland and Zanzibar on IBBS activities
92	HHS/CDC	TBD Comprehensive High Impact HIV Prevention IP (Local) - (GH002018)	C&T	HTS: Identify PLHIV through high quality and targeted HTS including index testing, EID, and HIV self-testing in facility and community settings, improve awareness of HIV, and link PLHIV to treatment	Surveys and surveillance	1. Size estimation for Tanzania Zanzibar 2. Implement IBBS in select scale up councils, by writing protocol, training data collectors, procuring reagents, sample collection logistics, data analysis and report writing.

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
86	Quality of HIV rapid testing according to WHO guidelines (new, repeat, retest and documented annual certification of testers/sites) Long turn-around-time for VL samples due to back log caused by equipment downtime, shortage of reagents, and unavailability of workforce in VL/EID testing labs	10. Laboratory	5.83	At least 4 of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	2 years	Number of labs accredited in military sites	Mapping of both conventional and POCs is on going.	2 new Laboratory sites accredited in the military sites to improve Quaility
87	Lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB)	10. Laboratory	5.83	Timely and accurate laboratory results available for patients in 100% of the military sites	2 years	Number of labs that operationalise the hub and spoke referral systems	20% the supported laboratories operationalize the hub and spoke sample referral/ transportation systems	50 % of the laboratories operationalize the hub and spoke sample referral/ transportation systems(military sites)
88	Decisions regarding new service delivery models are not informed by quality data from information systems	6. Service Delivery	3.98	Data used by PEPFAR and GOT Military to evaluate and scale up sustainable service delivery platforms for prevention and treatment of HIV/AIDS in scale-up at Military sites	2 years	New policies (SDM, Self Testing, PrEP, Men) and Surveilance including Seroprevalence and Behavioral Epidemiology Risk Surveys (SABERS) implemented in the Military, S/APR program data	None	50% of the new policies (SDM, Self Testing, PrEP, Men) and Surveilance including Seroprevalence and Behavioral Epidemiology Risk Surveys (SABERS) implemented in the Military, S/APR program data
89	Inadequate drug resistance monitoring system in Tanzania	8. Commodity Security and Supply Chain	4.25	TLD rolled out as first line ART combination. Pharmacovigilance monitoring systems established. HIV drug resistance strategic plan in place.	3 years	TX_PVLS	Transtioning of TLE to TLD	50% TX_CURR on TLD
90	At least 4 of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	10. Laboratory	5.83	4 regional labs in Nothern and Central regions receive accreditations	2 years	Number of laboratories fully accredited	0	2
91	Quality routine data and survey evidence which is not consistently used to inform efforts to improve program and making right and correct decision.	13. Epidemiological and Health Data	4.17	Data and evidence developed for decision making and program improvement	3 years	Number of scale-up councils with IBBS reports	Protocol development in process	Protocol development
92	Quality routine data and survey evidence which is not consistently used to inform efforts to improve program and making right and correct decision.	13. Epidemiological and Health Data	4.17	Data and evidence developed for decision making and program improvement	3 years	Number of scale-up councils with IBBS reports	Protocol development in process	Protocol development

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86		2 new Laboratory sites accredited in the military sites to improve Quaility			
87		100% of laboratories operationalize the hub and spoke sample referral/ transportation systems(military sites)			
88		50% of the new policies (SDM, Self Testing, PrEP, Men) and Surveilance including Seroprevalence and Behavioral Epidemiology Risk Surveys (SABERS) implemented in the Military, S/APR program data			
89		Full transition to TLD completed		86% viral suppression among TX_CURR across all age and sex bands.	
90		4			
91		Implementation and data use according to the number of scale up councils with IBBS reports ((50% of scale up councils with IBBS reports)		(90% of scale up councils with IBBS reports)	
92		Implementation and data use according to the number of scale up councils with IBBS reports (50% of scale up councils with IBBS reports)		(90% of scale up councils with IBBS reports)	

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)
93	USAID	Touch Foundation- PPP Follow-on	HSS	HRH: Service Delivery Points in priority scale up councils have sufficient and competent (skilled, qualified) health care workers to deliver quality HIV prevention, care and treatment services.	Costing and efficiency analysis	Support POPSM to connect and access to three systems to improve HRH allocation and deployment (Workload Indicators and Staff Needs, which determines HRH need at the facility and LGA level, Prioritization and Optimization Analysis (POA), which provides analysis of HRH need and HRH supply in relationship to budget, and Workforce Optimization Allocation (WOA), which allocates new HRH to permitsSupport)
94	USAID	GHSC-RTK	HSS	Data: Increased capacity for host and local systems to collect, analyze and use timely data to inform HIV program decisions and policy actions	Surveys and surveillance	Commodities for recency assay testing of new infections

Row	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)
93	Human Resources:Scale up LGAs have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up.	7. Human Resources for Health	5.60	POPSM will access and use detailed information about the HRH needs in each council to more accurately determine allocation of permits.	2 years	POPSM has access to WISN-POA-WAO tools and uses them in the efficient allocation of Human Reource permits	POPSM - at the national level- currently not using efficient HRH allocation tools in permit allocation	POPSM supported, trainined and accessing the WISN-POA tools
94	Quality routine data and survey evidence which is not consistently used to inform efforts to target HTS, increase yield and identify barriers and facilitators.	13. Epidemiological and Health Data	4.17	90 percent of newly identified HIV clients tested for HIV recent infection.	2 years	Percent of newly identified HIV clients tested for HIV recent infection	0%	50%

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark	Note: FY21 Q2 and Q4 results will be recorded here for monitoring.
93		POPSM supported, trainined and accessing the combined WISN-POA- and WOA tools			
94		90% of newly identified HIV clients tested for recent infection			