

Tanzania

Country Operational Plan

COP 2019

Strategic Direction Summary

May 10, 2019



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1.0 Goal Statement

The Tanzania HIV/AIDS Impact Survey 2016-2017 (THIS) transformed our understanding of the HIV epidemic in Tanzania. Prior to the survey, United States Government (USG) investments were focused on improving linkage and retention, which was thought to be the primary programmatic gap in Tanzania, and on saturating Dar es Salaam, which was thought to have low antiretroviral therapy (ART) coverage. Instead, the survey found that only 61% of Tanzanians who are HIV-positive know their status. Of those who knew their status, 94% were receiving ART. The survey estimated that Dar es Salaam had far fewer people living with HIV (PLHIV) than originally thought, whereas some other regions had unexpectedly large gaps in coverage. This transformation in our understanding of the epidemiology transformed our programmatic approach. The change included scaling up targeted testing strategies, such as index testing, improving linkage case management, and adjusting the geographic focus of programmatic activities in line with THIS estimates of HIV burden. While data show improvements in each of these areas in the 2-3 quarters of implementation following the 2018 PEPFAR/T planning meetings, substantial acceleration is needed to achieve 95/95/95 targets before 2020.

The abundance of available data clearly identifies **what** needs to be done. Indeed, Country Operational Plan (COP) 2018 implementation and COP 2019 require focus on rapidly accelerating implementation to achieve important epidemic control goals. While Tanzania has added 145,000 PLHIV to ART treatment each year for 3 consecutive years, our aim is to increase this to 245,000. Our primary strategies to accomplish this are to continue our rapid scale-up of index testing, and to decrease net loss (inclusive of death) from current (approximately 7%) to approximately 3%. These two actions on their own would lead to an additional growth in people on ART of 100,000 per year above prior levels, allowing us to reach targets. We will continue community activities for index testing and key and vulnerable populations, and strategies with demonstrated and increasing success in finding men, who are the majority of individuals not yet on ART. At the same time, we have optimized facility-based testing strategies to avoid over-testing while ensuring that testing services reach those who need it. Recency testing will be built into our routine case-finding strategies, and in-depth sexual network tracing will be conducted for all cases of recent infection.

Strategies alone, even the right ones, are not sufficient for success. Those strategies must be built on a solid foundation of political will and an enabling policy environment. Same-day ART initiation has been scaled-up, with over 90% of people starting ART in <7 days. On the other hand, multi-month scripting scale-up was only recently initiated, with just over 30% of PLHIV receiving scripts of at least 3 months as of December 2018. Self-testing is not permissible under Tanzania's current HIV law, and the amendment of the law has been delayed. Finally, there has been systematic resistance to optimizing pediatric HIV regimens, which would improve viral suppression among children and adolescents. At the Regional Planning Meeting in Johannesburg in 2019, the Government of Tanzania (GOT) proposed key policy shifts that will greatly strengthen the foundation of the HIV program. These included scale-up of 6 month dispensing nation-wide for clients having successfully completed two-rounds of three-month scripting, and scale-up of self-testing nation-wide upon passage of the HIV law revision, which is anticipated by July 2019. The GOT will also allow lower level cadres to conduct HIV testing, rapid roll out of the Tenofovir, Lamivudine, Dolutegravir (TLD) transition (already in progress), community-based ART initiation with one-month refills, and other key approaches that will be described later in more detail. As an initial step to follow-through on these commitments, in early May 2019, the

GOT released a circular to authorize health facilities to transition to six-month dispensing, support community ART and refills, and to adjust current guidelines to ensure clients testing HIV positive are initiated on treatment within seven instead of 14 days.

Even strategies built on a strong policy foundation are not enough for rapid progress. Wise use of data, with analysis down to the site-level, is needed to rapidly accelerate progress. At the Regional Planning Meeting, the GOT, along with USG, fully committed to working closely together to review site-level data and to use those data for rapid action. Since the meeting, the GOT offered to activate the Emergency Operations Center (EOC) to rapidly scale-up implementation of key policies at the 241 largest facilities in Tanzania. The EOC, which was initially developed with USG support for Global Health Security needs, will collect data from the 241 sites, coordinate, and communicate progress to regions and districts. GOT and USG will work side-by-side throughout this process to ensure that proposed policy changes quickly roll-out at facility and patient levels.

Patient-level data are now available for >90% of people covered by PEPFAR/T, due to prior PEPFAR/T investments in systems strengthening. These data have been used to accelerate implementation of index testing, same-day initiation, isoniazid preventive therapy (IPT), and other key priorities. The USG will invest in GOT staff capacity to ensure that they are able to use these data with a high degree of effectiveness. The GOT and USG will also build on existing strategies for optimizing partner performance including placing lower performing partners on performance improvement plans (PIPs), transitioning most program activities in Ruvuma and Tabora towards partners with historical success, and streamlining community and facility activities to the same partner in 11 regions. In addition, USG staff have been divided into regional teams, and GOT staff have been assigned to work with these teams. This strategy will be expanded, such that each region is covered, and so that GOT and USG work side-by-side to understand and enhance partner performance.

Ensuring that the strategies used continue to evolve to meet the changing needs of the epidemic, and that they are implemented well and in a person-centered manner requires broad engagement with a wide range of stakeholders. Civil society organizations (CSOs) have had an expanding role in Tanzania, and their contributions have substantially aided progress, including reach to key populations. PEPFAR/T will continue this engagement with the aim of expanding their role in Tanzania. Close collaboration with United Nations Joint Program on HIV/AIDS (UNAIDS), World Health Organization (WHO), The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), and other key stakeholders is also key to success. PEPFAR/T will build upon our successful high-level meetings between the Embassy Executive Office and the Deputy Minister of Health. The U.S. President's Emergency Plan for AIDS Relief in Tanzania (PEPFAR/T) will participate in monthly meetings with GOT technical staff to review monthly site-level data, identify shortcomings in policy roll out, and develop strategies to scale-up successes. The high-level political / diplomatic / strategic meetings will continue quarterly. Quarterly meetings among the development partners will continue to ensure a unified approach towards achieving epidemic control.

As a step towards immediate progress, PEPFAR/T has already initiated a focus on 241 facilities that account for 50% of clients currently on treatment. These sites will be a focus of rapid scale-up of the Bukoba Combination Prevention (BCPE) model for optimized provider-initiated testing and counseling (PITC) and linkage case management, which is now in place at all sites. PEPFAR/T is using a composite indicator to measure performance of each of these facilities in detail, and

aims to rapidly accelerate multi-month scripting, same-day initiation, and IPT uptake at these sites. Optimized PITC will also be scaled to an additional 765 facilities with a high number of HIV-positive clients that have also shown to have high-yield testing results. Approximately 1/3 of these have already been reached. As a step towards sustainability, and in an effort to focus PEPFAR testing resources, testing at the remaining 2332 sites will transition to the GOT, as will all testing for voluntary medical male circumcision (VMMC).

Finally, above-site investments focus on supporting all of these priorities through human resources for health (HRH) to facilitate implementation; systems for rapid access to and use of high quality data that will facilitate immediate use of data for improvement, and foster the principle of having one unified data system for Tanzania; laboratory investments to ensure high quality testing and viral load monitoring; and institutional strengthening that will continue steps towards sustainability.

Success in achieving rapid epidemic control in Tanzania is not impeded by a lack of knowledge of the epidemic, nor by any other insurmountable barrier. Rather, our success is ensured by a proactive choice to succeed, and by careful, collaborative, evidence-based management to ensure that those choices translate into exceptional implementation. That choice has been made, the strategies are in place, and we intend to deliver.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

According to THIS 2016-2017¹, the prevalence of HIV among adults aged 15- 64 years in Tanzania is 5% (7% among females and 4% among males). UNAIDS Spectrum 2019 estimates approximately 1.59 million² PLHIV in Tanzania out of a total population of 55,890,747,³ with regional variations from 12,000 (Zanzibar) to 219,000 (Dar es Salaam).⁴ The prevalence of viral load suppression (VLS) among HIV-positive adults aged 15-64 years in Tanzania who self-report current use of ART is 87% (89% among females and 83% among males)⁵. The prevalence of HIV among children aged 0-14 years is less than 1% (0.3%) yet the proportion of children with HIV who are virally suppressed is low at 18%. The annual incidence of HIV among adults ages 15 to 64 years in Tanzania is 0.3% (0.4% among females and 0.12% among males).

While the major programmatic and system gaps are considerable, data show some areas of important progress. The Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) from 2011/2012 showed that HIV prevalence among adults aged 15-49 years was 5% [CI: 4.6-5.6] while the THIS showed an HIV prevalence of 4.7% [CI: 4.3-5.0]. Projections from the UNAIDS Spectrum 2019 model show that, the number of new HIV infections have been declining steadily over the years, from 85,006 to 83,166 between 2015 and 2016; and in 2017, it was estimated to be 78,481 while in 2018 was 74,243.

¹ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

² 2019 Spectrum estimates, 2018 point estimate

³ National Bureau of Statistics (NBS) Population Projection, February 2018

⁴ 2019 Spectrum estimates

⁵ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

THIS 2016-17 showed that only 52% of people with HIV in Tanzania self-reported knowledge of HIV status, although this increased to 61% after analysis of the antiretroviral drugs (ARV)-metabolite data. Of those who self-reported knowing their HIV status, 94% self-reported current use of ART and 87% of those on ART are virally suppressed.

Key populations (KPs) play a critical role in HIV transmission dynamics. 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).⁶ Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. 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 in Tanzania has risen from a national overall average of 72% (THMIS 2012) to 80% in males aged 15-29yrs (THIS, 2016-2017). In addition, COP 2019 coverage for key and vulnerable populations (KVP) include expanding geographic and hotspot coverage of adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and PWID to 30%; 95%; 80%; and 75% respectively.

THIS 2016-2017 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 8.4 % among males aged 40 to 44 years. Prevalence among adults aged 15 to 24 years is 1% (2% among females and 0.6% among males), while prevalence among children aged 0-14 years is 0.3%. 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% in Njombe to less than one percent (<1%) in Zanzibar. HIV prevalence also varies between urban (6%) and rural (4%) areas. Spectrum 2019 modelling estimates used THIS 2016-2017 and past survey data, sentinel surveillance data, as well as routine program data to estimate the number of PLHIV in the country. Spectrum 2018 showed a significant shift of HIV burden among regions compared to previous Spectrum files due to inclusion of newly available THIS survey data, with Mwanza, Tanga, Kagera, Dodoma and Iringa showing the highest increment of estimated number of PLHIV. Dar es Salaam, Arusha, Mtwara and Njombe showing highest decrease of the estimated number of PLHIV. In COP 2018, PEPFAR/T adjusted HIV programming basing on this shift of HIV burden to better align resources with the latest epidemiologic information.

For COP 2019, the Spectrum 2019 draft national file was used to determine regional PLHIV estimates, to which the UNAIDS Spectrum 2019 District Estimates Tool was applied to distribute regional estimates down to the council level, the subnational unit level required for PEPFAR planning in Tanzania. Small Area Estimation (SAE) prevalence for 15-49 years conducted during COP18 as well as granular program data were included in the Spectrum District Estimate Tools to produce council level age disaggregated estimates for the number of PLHIV. Due to the inclusion of routine program data into the Spectrum 2019 model methodology, denominators between COP18 and COP19 were largely effected, particularly for regions outside of the top 10 highest burden for which THIS was powered.

⁶ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

As such, in COP 2019, PEPFAR/T has used the Spectrum 2019 estimates in the COP 2019 Data Pack, but adjusted TX_CURR targets by region accordingly to align with triangulated THIS survey data and programmatic knowledge. This approach guides the geographic breadth and scope of activities to sustain the gains of COP 2018.

In terms of implementation of key policies, GOT has initiated policy revisions to move Tanzania closer to epidemic control. Following 2018 shifts to scale-up pre-exposure prophylaxis (PrEP) for key populations and discordant couples as well as initial roll out of self-testing, in preparation for COP 2019, the GOT has proposed to immediately scale-up PrEP nationwide, including expanding eligibility criteria to include adolescent girls and young women. The GOT has also proposed to fully scale-up self-testing after approval of the revised HIV/AIDS law, which is anticipated by July 2019. Rollout will include a focus on models and populations where self-testing can have an impact (including uptake and linkage) in the short-term (e.g. male partners of women in antenatal settings) with structured programming to learn how best to use kits amongst other groups including partners of sex workers and key and vulnerable populations. For the differentiated service delivery models (DSM) and Revised Treatment Guidelines, scale-up of same-day ART initiation has seen substantial progress in scope, scale, and fidelity in COP 2018 and will continue in COP 2019. The GOT also released a circular in May 2019 to amend guidelines so that the definition of “same-day” ART initiation aligns with the WHO recommendation of seven days, rather than the current definition of 14-days. This circular also authorizes health facilities to support community ART initiation and refills for up to one month and to dispense a 6-month supply of ARVs to clients who have completed two rounds of three-month dispensing. The GOT has also agreed to move forward with the capacitation of lay cadres to deliver HIV education and testing. Finally, the GOT is supportive of ongoing efforts to scale-up TB preventive treatment (TPT) to more than 75 % of eligible clients on IPT.

To address gaps in HRH, PEPFAR/T shall continue to support the implementation of the task sharing policy, in conjunction with the HIV DSM roll out. In COP 2019, PEPFAR/T will focus on the continued implementation of the task sharing policy including in-service training through distance and blended learning approaches. PEPFAR/T will work with the GOT to ensure the integration of developed tools into the existing national Human Resource Information Systems (HRHIS) towards strengthening of workforce capacity, needed to reach HIV epidemic control. PEPFAR/T will also focus on designing a customized HRH cascade to guide decision making during allocation of HRH, recruitment, and retention, to complement the existing Health Systems Strengthening/HRH Monitoring, Evaluation, and Reporting (MER) indicators. This will also include a deeper analysis using the PEPFAR/T Health Worker Inventory of 2018 and other data sources to triangulate information to effectively guide HRH investment based on needs.

The major programmatic and system gaps and barriers to achieve epidemic control were assessed in 2017 using the Sustainability Index Dashboard (SID), which is discussed in more detail in section 2.3. The findings from the 2017 SID showed 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 2017 was \$936⁷, which indicates limited income to accommodate health expenditures. Tanzania’s total health expenditure (THE) was

⁷ World Bank national accounts data, 2017

6.1% of gross domestic product (GDP) in 2015 and 11% of government spending in 2015⁸, 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.⁹

⁸ Health Policy Project, Health financing profile Tanzania, 2016

⁹ World Bank development indicator

Standard Table 2.1.1

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	55,890,747	100	12,104,023	22	12,250,461	22	5,475,698	10	5,406,712	10	10,954,837	20	9,699,016	17	National Population Projections, Feb 2018
HIV Prevalence (%)		4.9		0.5		0.3		2.1		0.6		Not available		Not available	THIS 2016-2017
AIDS Deaths (per year)	26,105		3,289		3,454		1270		1064		6,506		10,521		SPECTRUM (2019)
# PLHIV	1,590,497		52,618		54,005		120,993		65,004		772,813		525,064		SPECTRUM (2019)
Incidence Rate (Yr)		0.21		Not available		Not available		Not available		Not available		Not available		Not available	SPECTRUM (2019)
New Infections (Yr)	74,243														SPECTRUM (2019)
Annual births	2,101,519	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	84,588	Not available													SPECTRUM (2019)
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	Males 15-29yrs	80%			Not available	Not available			Not available	Not available			Not available	Not available	(THIS, 2017)
Estimated Population Size of MSM*	49,700	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence	25%	Not available													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014

Standard Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#) ¹⁰	HIV Prevalence (%)	Estimated Total PLHIV (#) ¹¹	PLHIV diagnosed (#) ¹²	On ART (#) ¹³	ART Coverage (%) ¹⁴	Viral Suppression (%)	Tested for HIV (#) ¹⁵	Diagnosed HIV Positive (#) ¹⁶	Initiated on ART (#) ¹⁷
Total population	55,890,747	4.9 ¹⁸	1,590,499	1,103,016	1,103,016	69%	87% ¹⁹	13,304,587	334,453	245,847
Population <15 years	24,354,484	0.4	106,625	59,059	18,131	55%	29% ²⁰	1,757,910	15,985	13,263
Men 15-24 years	5,406,712	1.24 ²¹	65,004	18,131	304,790	28%	66% ²²	1,434,574	10,985	5,986
Men 25+ years	9,699,016	Not available	525,064	304,790	59,324	58%	87%	2,706,816	99,599	75,291
Women 15-24 years	5,475,698	2.28 ²³	120,993	59,324	634,016	49%	81%	2,360,776	40,959	29,489
Women 25+ years	10,954,837	Not available	772,813	634,016	18,131	82%	90%	3,763,969	149,079	116,274
MSM	49,700 ²⁴	25 ²⁵	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
FSW	155,450	26	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
PWID	30,000	36	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Priority Pop (Adolescent Girls and Young Women)	6,211,713	11.4	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Priority Pop Estimated Size of Priority Populations Prevalence (Military Community)	61,632	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available

¹⁰ National Population Projection, Feb 2018

¹¹ SPECTRUM Estimates 2018

¹² NACP & PEPFAR Program Data FY18

¹³ NACP & PEPFAR Program Data FY18

¹⁴ NACP & PEPFAR Program Data FY18

¹⁵ NACP & PEPFAR Program Data FY18

¹⁶ NACP & PEPFAR Program Data FY18

¹⁷ NACP & PEPFAR Program Data FY18

¹⁸ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017 (15+yrs)

¹⁹ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

²⁰ Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017

²¹ SPECTRUM estimates 2018

²² PEPFAR Program Data FY18

²³ SPECTRUM estimates 2018

²⁴ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

²⁵ Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

Figure 2.1.3 National and PEPFAR/T Trend for Individuals currently on Treatment

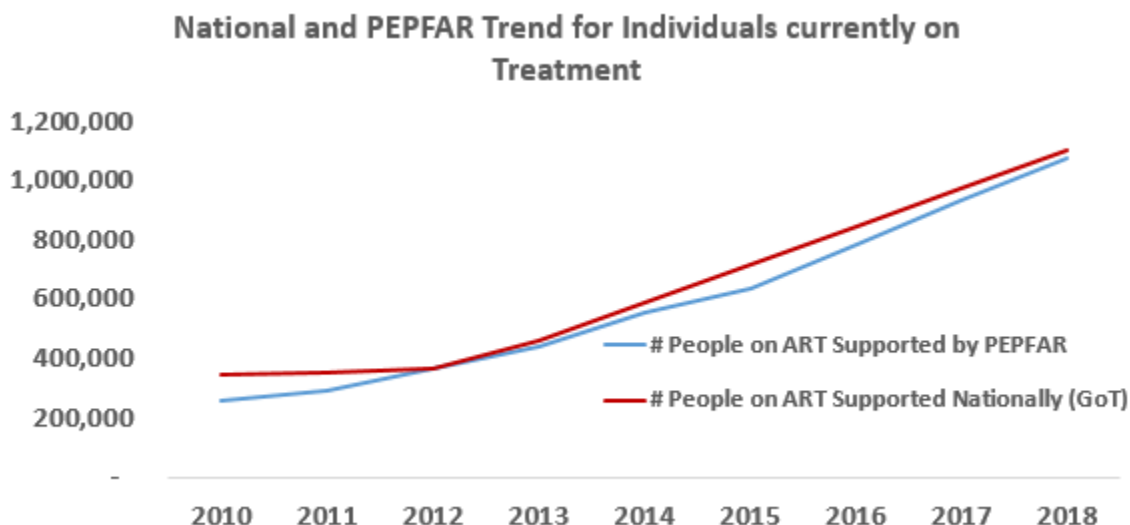
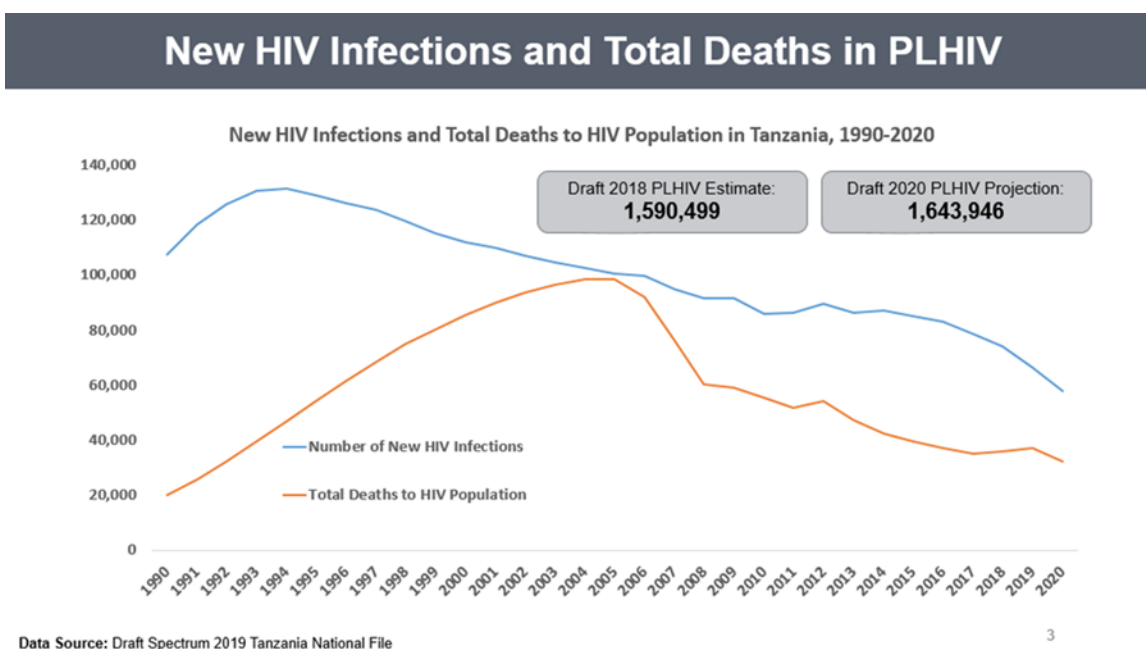


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



2.2 Investment Profile

The Tanzania HIV and AIDS response is almost entirely donor funded. The major donors include the U.S. Government, United Nations Development Programme, Canada, Japan, and GFATM, which together contribute 93% of the overall funding available for HIV programming in Tanzania according to the HIV and AIDS 2017-2018 Public Expenditure Review (2018). PEPFAR/T funds 58% of the total budget for the HIV response and remains the largest single donor excluding

human resources and infrastructure.²⁶ GFATM is projected to cover 31% of Tanzania's HIV response in FY2020.²⁷ These calculations exclude the GOT expenditures on health worker wages and health facilities. GOT co-financing that includes expenditures on HRH and health facilities is projected to be 22% of the total HIV and AIDS program funding, this proportion has increased by 1% each year since 2016.²⁸

In FY2017/2018, the total expenditure for HIV and AIDS-dedicated programs, including the Tanzania Commission for AIDS (TACAIDS) constituted 1% of the GOT's total spending,²⁹ and expenditures on HIV prevention programs constituted 26% of total development expenditures of Tanzania's Ministry of Health, Community Development, Gender, Elderly and Children (MoHCDGEC). This was an increase from two percent for the preceding year. The Government of Tanzania's commitment to respond to and mitigate the effects of HIV/AIDS is challenged by the limited domestic financing allocated for HIV and AIDS interventions.

Tanzania's budget for the health sector remains low at seven percent of its total annual budget. Despite the inclusion of a budget line item for purchase of antiretroviral drugs in FY2017/2018, no recorded disbursement for the purchase of medication has been made. Tanzania is further constrained by the low budget execution rates at TACAIDS, the main body responsible for strategic planning of HIV and AIDS, and the MoHCDGEC. Budget performance in FY2016/2017 was 66%.³⁰ The key challenges were identified as lack of predictable revenue collection and unrealistic budget. Despite some expected improvements in HIV policy, low funding, low budget execution levels for service delivery, and human resources for health (HRH) may negatively affect the country's ability to achieve and sustain epidemic control.

PEPFAR/T's investments in short term solutions, such as strengthening HRH remuneration, as well as longer term solutions, such as increased financial management capacity and strengthening HRH allocation and deployment systems, as outlined in Table 6, will support Tanzania to overcome these challenges to advance progress toward sustained epidemic control. Additionally, The United Nations (UN) and World Bank provide a small proportion of additional funding. There are currently no other bilateral donors anticipated in FY2020.

Tanzania's budget per each person living with HIV is lower than in its peer countries. For example, 20% of the HIV and AIDS budget in Kenya is funded from domestic resources.³¹ However, the largest share of Government finance for HIV and AIDS interventions comes through the provision of health facilities and human resources for health. Unfortunately, the most recent National Health Accounts spending assessment on HIV found that the GOT's spending on HRH and infrastructure could not be disaggregated for HIV program spending.³² Improving reporting and accounting of Tanzania's contribution to HIV programs, including an estimate of

²⁶ HIV and AIDS Public Expenditure Review 2017/18

²⁷ Global Fund Program Coordination presentation - PEPFAR Stakeholder Meeting, 2019

²⁸ Tanzania Global Fund Funding Request (2018-2020)_Narrative

²⁹ UNICEF, Tanzania HIV and AIDS budget brief 2018. Extracted from Public Expenditure Report, 2015

³⁰ UNICEF, Tanzania HIV and AIDS budget brief 2018. Extracted from Integrated Financial Management Information System (IFMIS), Ministry of Finance and Planning, 2018

³¹ UNICEF, Tanzania HIV and AIDS budget brief 2018

³² UNICEF, Tanzania HIV and AIDS budget brief 2018

infrastructure and human resources, will provide a more comprehensive data and a basis to attribute Tanzania's investments in HIV programs.

In FY2020 PEPFAR/T will finance 64% of clinical care, treatment and support, 100% of Voluntary Medical Male Circumcision (VMMC), orphans and vulnerable children (OVC) and laboratory activities, 92% of prevention of mother to child transmission of HIV (PMTCT) and over 70% of each for priority population prevention, health systems strengthening, and surveillance. GFATM will dedicate about 84% of its \$128 million grant budget in FY2020 to commodities. About 13% of the GFATM grant will fund prevention interventions and an additional 4% will support the MoHCDGEC through the Resilient and Sustainable Systems for Health (RSSH) grant to cover procurement and supply chain management systems, health management information systems and community responses.

Tanzania's national strategic plans and funding proposal for HIV and AIDS prioritizes specific activities, populations, and geographies for maximum impact. The National Multi-Sectoral Framework (NMSF III) prioritizes investments by intervention category. The GFATM that prioritizes prevention activities for general population and key and priority populations in the top ten high-prevalence regions. These funding priorities are coordinated with PEPFAR/T; which prioritizes support to 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 considerably to reach sustained epidemic control.

In addition, during the past year PEPFAR/T has engaged intensively with the Christian Social Service Commission (CSSC) on issues pertaining to the financial sustainability of the hospitals owned by the Christian Council of Tanzania and Tanzania Episcopal Conference. CSSC hospitals comprise 43% of all hospitals in the country and nearly all of them are participating in the national HIV/AIDS program. PEPFAR/T is planning to support human resources to faith-based hospitals in COP 2019, while the GOT is withdrawing financial and human resources support to these institutions.

Standard Table 2.2.1 Annual Investment Profile by Program Area for COP 2019 (new funds only)

Table 2.2.1 Annual Investment Profile by Program Area				
Program Area	Total Expenditure	% PEPFAR 1 Oct 2019-30 Sept 2020	% GF 1 Jan-31 Dec 2020	% Host Country 1 July 2019-30 June 2020
Clinical care, treatment and support	\$263,939,706	64%	36%	0%
PMTCT	\$16,730,465	92%	8%	0%
HTS	\$28,033,229	73%	27%	0%
VMMC	\$23,004,814	100%	0%	0%
Priority population prevention	\$12,825,896	71%	29%	0%
AGYW Prevention	\$5,120,000			0%
*Key population prevention	\$5,387,882	38%	62%	0%
OVC	\$14,106,046	100%	0%	0%
Laboratory	\$3,229,416	100%	0%	0%
SI, Surveys and Surveillance	\$10,689,871	76%	24%	0%
HSS	\$12,872,983	77%	23%	0%
Other 52121	\$23,188,903	60%	40%	0%
Total	\$291,001,211	69%	31%	0%

**PEPFAR funds only includes injecting and non-injecting drug use*

Standard Table 2.2.2 Annual Procurement Profile for Key Commodities

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	\$150,434,347	43%	57%	0%	0%
Rapid test kits	\$13,013,277	0%	34.8%	0%	65.2%
Other drugs	\$1,129,530	100%	0%	0%	0%
Lab reagents	\$15,727,708	21.7%	78.3%	0%	0%
Condoms	\$5,000,000	0	95%	5%	0%
Viral Load commodities	\$33,727,186	66.7%	6.0%	0%	27.3%
VMMC kits	\$5,163,866	100%	0%	0%	0%
Total	\$190,468,728	45%	54.5%	0.5%	

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
USAID MCH	\$9,922,584	\$16,110,887	9	\$19,496,374	These activities are Boresha Afya – Deloitte, GHSC – PWC, PS3- Abt, Tulonge Afya – FHI360, TBD- HRH Allocation and Retention, TBD – Systems Strengthening
USAID TB	\$2,852,435	\$10,819,479	10	\$25,914,646	These activities are Tulonge Afya – FHI360, Boresha Afya – EGPAF, Boresha Afya-Deloitte, Challenge TB-KNCV, GHSC-PWC, MCSP – JHPIEGO, CIRCLE-Social Solutions, TBD-Baylor, TBD – Police & Prisons and TBD – Systems Strengthening
USAID Malaria	\$38,680,400	\$12,773,887	9	\$20,358,874	These activities are Boresha Afya –Deloitte, GHSC TA- PWC, Measure-UNC, Shops plus – Abt, Tulonge Afya – FHI360, Circle-Social Solutions and TBD Systems Strengthening
Family Planning	\$16,878,063	\$20,320,887	12	\$50,888,827	These activities are Boresha Afya – EGPAF, Boresha Afya – Deloitte, GHSC TA- PWC, PS3- Abt, Sauti – JHPIEGO, Shops plus – Abt, Tulonge Afya – FHI360, Circle-Social Solutions, TBD CCC-KVP and TBD Systems Strengthening
CDC (Global Health Security)	\$2,000,000	\$585,000	2	\$150,000	Co-funding is for FELTP
USAID (Global Health Security)	\$4,000,000	0	0	0	No co-funding
Peace Corps	2,728,400*	0	0	0	*Appropriated funds - \$ 2,528,400 SPA funds - \$ 200,000
Total	\$66,065,479	\$57,607,668	12	\$121,463,767	

Standard Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, 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						

2.3 National Sustainability Profile Update

2.3.1 Tanzania's Sustainability Index Dashboard 3.0

PEPFAR/T completed the HIV/AIDS Sustainability Index and Dashboard (SID) in 2017. The next SID will be completed in 2019. The aim of SID is to sharpen country-level understanding of the sustainability landscape in order to guide HIV/AIDS investment decisions. The SID 3.0 remains the guiding analytical document for assessing above-site level budgeting priorities in COP 2019 and provides a basis to track progress and identify gaps in Tanzania's ability to maintain a sustained response.

The Sustainability Index Tool employs a scoring system that generates responses to 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 color red signifying 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 - thus requiring limited investment. Tanzania has not been able to score within the green color range (7-10 points) across any of the four critical domains. There are several yellow scores representing areas of emerging sustainability and key vulnerabilities.

Figure 2.3.1: Changes in sustainability from SID 2.0 and SID 3.0

		2015 (SID 2.0)	2017 (SID 3.0)
Governance, Leadership, and Accountability			
SUSTAINABILITY DOMAINS and ELEMENTS	1. Planning and Coordination	4.43	5.33
	2. Policies and Governance	3.85	6.96
	3. Civil Society Engagement	4.17	3.83
	4. Private Sector Engagement	4.86	4.13
	5. Public Access to Information	5.00	6.00
National Health System and Service Delivery			
6. Service Delivery	3.38	3.98	
7. Human Resources for Health	5.00	5.60	
8. Commodity Security and Supply Chain	4.94	4.25	
9. Quality Management	5.19	5.62	
10. Laboratory	3.33	5.83	
Strategic Investments, Efficiency, and Sustainable Financing			
11. Domestic Resource Mobilization	1.94	3.21	
12. Technical and Allocative Efficiencies	3.17	4.67	
Strategic Information			
13. Epidemiological and Health Data	4.70	4.17	
14. Financial/Expenditure Data	4.58	5.00	
15. Performance Data	5.99	6.97	

2.3.2 Sustainability, Strengths, and Vulnerabilities

Tanzania demonstrated progress in *Governance, Leadership and Accountability; National Health System and Service Delivery; and Strategic Information* during the periods of assessments between SID 2.0 and SID 3.0. In COP19, these areas are directly reflected in PEPFAR/T investments in the above-site activities outlined in Table 6.

The greatest domain of improvement was in *Governance, Leadership and Accountability* due to the adoption of key policies and guidelines. These included the National Guidelines for the Management of HIV and AIDS (2017); the National Guidelines for a Comprehensive Package for HIV Interventions for Key and Vulnerable Populations (2017); National Policies on Test and Start (2016) that streamlined same-day ART initiation with guidelines updated in 2017; the task sharing policy (2016); and the incorporation of the guidelines on the provision of TB Preventive Treatment into the National HIV guidelines (2017). Despite progress made in governance through adoption of these key policies, PEPFAR/T faces daunting challenges to scale-up evidence-based solutions with fidelity due to slow community-level adoption of policies for successful case identification and retention. Such policies include but are not limited to passing legislature for self-testing, extending multi-month scripting and dispensing to six months capacitating lay cadres of health workers to conduct appropriate education and testing and the removal of PrEP from protocol to nationwide implementation. As part of COP 2019 planning, the GOT has demonstrated political will to swiftly move forward all three of these program areas.

On the HRH issue, the GOT has agreed to capacitate lay cadres, including community health workers (CHWs), community development workers (CDWs), community development officers (CDOs), social welfare officers (SWOs), health assistants (HAs), village health workers (VHW), HIV home based care providers and members of the health facility governing committee. Capacitating these health workers, who can perform HIV tests, creates an important opportunity to allocate HRH more effectively. By the end of Q1 of COP 2019, PEPFAR/T will work with government, stakeholders and other partners to review, revise and implement SOPs for community-, facility- and index- testing to maximize this opportunity, by identifying opportunities for shifting testing to previously unutilized or under-utilized lay cadres. Quarterly PEPFAR Oversight and Accountability Review (POART) will include analysis of testing, linkage (to PrEP and ART) and contact sharing in the context of index testing indicators and an analysis by site or partner use of lay cadres to provide evidence of impact and information on best practices will be tracked to monitor these shifts.

Beginning in COP 2018 and extending into COP 2019, PEPFAR/T will support the GOT to effectively scale-up these evidence-based high-impact interventions with particular emphasis on high volume, scale-up sites. Adoption and implementation of these key policies will strengthen Tanzania's ability to sustainably control its HIV epidemic.

Under the *Strategic Information* domain, *Performance Data* and *Financial/Expenditure Data* elements demonstrated improvements between SID 2.0 and 3.0. This result correlates with increased GOT and PEPFAR/T efforts to strengthen financial systems and increase data use for decision making on budgeting and planning processes. To sustain this momentum, PEPFAR/T supported the enhancement and deployment of a national planning database that improves transparency in budget planning processes and visibility on execution levels. PEPFAR/T also supported the expansion of direct facility financing that will strengthen public financial

management at health clinics and dispensaries. In COP 2019, PEPFAR/T will build on these achievements to enhance public engagement in the budget planning process to ensure it reflects priority health needs. Specifically, PEPFAR/T will support the GOT to establish risk-pooling insurance schemes and the inclusion of HIV services into scheme essential benefits package to improve equitable provision of HIV services for poor and vulnerable populations and sustainable financing for HIV services.

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. To address this gap, PEPFAR/T supported the implementation of the care and treatment center (CTC)₃ database that assisted in deduplication. As a result, data availability within CTC₃ has increased dramatically as it now captures data from over 2200 sites, covering approximately 90% of the treatment clients as of December 2018, up from 75% in December 2017. In COP 2019, PEPFAR/T will implement a strategic vision for data alignment between PEPFAR and national data to eliminate parallel reporting and reduce discrepancy between reporting mechanisms. PEPFAR/T will also support the GOT to implement a Unique Identification Strategy (UIS) to strengthen availability of client level data for effective, national case base management. To enhance Tanzania's ability to sustainably maintain the UIS, the strategy allows for multiple forms of identification, such as phone number, voter identification, birth registration identification, national insurance identification and biometrics. The biometric system will be used for HTS and will be scaled up to CTCs with the utilization target of 80% of patients on treatment by September 2019. Since the meeting, the GOT offered to activate the EOC to rapidly scale-up implementation of key policies at the 241 largest facilities in Tanzania. The EOC, which was initially developed with USG support for Global Health Security needs, will collect data from the 241 sites, coordinate, and communicate progress to regions and districts. GOT and USG will work side-by-side throughout this process to ensure that proposed policy changes quickly roll-out at facility and patient levels. Alignment of PEPFAR/T's data collection systems with national information management systems and establishment of a UIS is expected to boost Tanzania's sustainability index in epidemiological, health and performance data. GOT and all stakeholders will continue to ensure that data protections are in place and systems and protections are well understood by clients in the context of biometric systems. Unique identification is important for ensuring that people continue to receive appropriate care no matter where they are in Tanzania, and also to monitor retention well. PEPFAR will work with the GOT and implementing partners to review data collection tools and processes to ensure that these goals are achieved, while also ensuring that data protection policies, guidance, and SOPs are in place to protect confidentiality and to minimize risks of loss of privacy. Appropriate communication strategies will continue to be developed to ensure that patients are well informed about all aspects of these services.

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 because there incentives for the private sector to be engaged are insufficient. As a response in COP 2019 PEPFAR/T will expand direct engagement with small private pharmacies (Accredited Drug Dispensing Outlets). These pharmacies are highly accessible for rural and underserved populations to support multi-month dispensing of ARVs and can provide assisted self-testing due to 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 development of a National HIV Supply Plan, and the transition of the Logistics Management Unit within the MOHCDGEC has yielded positive results. Nevertheless, the review highlights the unsustainable dependence on the USG and GFATM for supply chain and commodities financing. In COP 2019 PEPFAR/T will focus on increasing efficiency of the national supply chain system. It will continue to provide technical assistance to strengthen supply chain performance management at site-level facilities and strengthen the quantification capacities of national level institutions. PEPFAR/T will extend its use of performance metrics to hold Medical Stores Department (MSD) and facilities accountable to a minimum standard of service. PEPFAR/T will continue to ensure complete transition of TLD by COP 2019 by supporting the MOHCDGEC Logistics Management Unit human resources and operations center.

The *Civil Society Engagement* element under the *Governance, Leadership, and Accountability* domain also experienced a marked decrease from SID 2.0 to 3.0. Civil society engagement has been limited, especially in relation to CSO roles in bridging the gap between the community and service providers; which 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 GOT and community structures. In COP 2019 PEPFAR/T will strengthen the capacity of local CSOs, especially those managed by PLHIVs, to reinforce their role as agents for change in planning, budgeting, service delivery provision, advocacy, and as key stakeholders to advise on improving case identification and index testing. With GOT support, this will include the establishment of an Advisory Committee of key populations. PEPFAR/T will work with GOT to establish this Committee which will meet regularly to help guide and inform policies and program implementation, especially with regard to new intervention areas including treatment literacy for the TLD transition, the unique identification system, index testing, and PrEP and self-testing roll out. Consisting of KPs and KP organizations, this committee will help ensure that the needs of KPs are well addressed in the HIV response and that GOT non-discrimination principles are promoted and supported. Further increase civil society sustainability in COP 2019 PEPFAR/T will take to scale engagement with Faith Based Organizations in order to reduce stigma and discrimination, accelerate index testing, support expansion and tracking of DREAMS and post-gender-based violence (GBV) care interventions for AGYW.

Although it's SID 3.0 score improved, HRH remains a vulnerability. 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. In COP19 PEPFAR/T will strengthen retention mechanisms to ensure HCWs are motivated to decrease the attrition rate among HCWs. PEPFAR/T will continue to support the implementation of the task sharing policy, in conjunction with the HIV DSM and full roll out of Nurse Initiated Management of Antiretroviral Therapy (NIMART). PEPFAR/T will deepen the PEPFAR/T Health Worker Inventory of 2018 analysis and other data sources to triangulate information to effectively guide HRH investments based on needs, and will improve HCWs allocation and retention through expanded use of Workload Indicators for Staffing Needs, Prioritization & Optimization Analysis (POA), and Workforce Allocation Optimization tools. PEPFAR/T will work with the GOT to ensure the integration of developed tools into the existing national Human Resource Information Systems (HRHIS) towards strengthening the capacity of the workforce needed to reach sustained HIV epidemic control. PEPFAR/T anticipates the health workforce vacancy levels will decrease as the GOT continues to increase absorption and availability of skilled of health

professionals; this will facilitate implementation of commitments from the Joint Annual Health Sector Review Policy meetings held in November 2018. In COP 2019, PEPFAR/T will also support capacitation and roll out of programs to ensure that lay cadres can provide HIV testing services to reduce the burden on nurses.

In COP 2019, the focus for the quality management element under the *National Health System and Services* domain is to establish data visualization dashboards in District Health Information System (DHIS)² that will help triangulate star rating scores and performance data. This will support utilization of service-level data in real-time to inform policy recommendations and resource prioritization at national and sub-national levels for quality and performance improvement. Efforts will build on key milestones from COP18 where the review of key strategic documents enabled the operationalization of harmonized quality assurance tools. Additionally, in COP 2019, PEPFAR/T will support a scale-up of a nationally coordinated peer-learning platform (ECHO platform) that will provide opportunities for sites to gain insights from other sites and interventions.

2.3.3 Funding for HIV epidemic

PEPFAR/T received a 23% funding reduction in COP 2019. The funding for the GFATM is projected to remain relatively the same in FY2020 with a modest 1.5% increase. Unfortunately, domestic funding from the GOT remains recurrently low. While marginal improvements were 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 HIV response needs in Tanzania remains a continual challenge. Data on government resources allocated to highest burden geographic areas is unavailable, and the latest HIV/AIDS Public Expenditures Review (PER, 2013-14) has not been finalized. The ARV benchmark pricing is not applied by the government because of Tanzania's aggregate dependence on USG and GFATM for ARV procurement.

The fiscal environment, together with the elements of *Domestic Resource Mobilization and Technical and Allocative Efficiencies*, is also currently unsustainable, meaning that Tanzania does not adequately generate the necessary financial resources for HIV to ensure sufficient resource commitments, and use data to strategically allocate funding and maximize investments. In COP 2019 PEPFAR/T will focus on increasing the transparency and accountability of investments made, and to advocate with the GOT for increased data sharing on performance, including financial information for effective decision making.

2.3.4 Transition to indigenous partners

PEPFAR/T is committed to continuing and protecting the progress that has been made over the past 15 years in Tanzania. In COP 2019, USG agencies are committed to promoting local capacity, development, and to responsibly transition to ingenious organizations that will effectively fulfill PEPFAR’s mandate. To avoid sudden and dramatic shifts that will put our overall impact and results at risk, PEPFAR/T is strategically positioning to contribute to the global goal of having 40% of funds transitioned to local partners in COP 2019. PEPFAR/T will expand its work with local actors by reengaging local private sector entities to improve and effectively integrate service delivery and system strengthening approaches. PEPFAR/T will expand broad based community service interventions and human resources provision through local partners. The commitment is that by the end of COP 2020, PEPFAR/T will be contributing appropriately to ensure the global goal for 70% of PEPFAR funds to go to indigenous organizations. In this transition, PEPFAR/T plans to focus on partner management and engagement to ensure expected program targets are met and the implementing local partners have adequate capacity to maintain the quality of results, manage increased financial resources, and diversify their revenue streams for their stronger sustenance.

2.4 Alignment of PEPFAR investments geographically to disease burden

In order to determine if budgets appropriately aligned with HIV disease burden in Tanzania, COP 2019 planned spending was mapped alongside the most recent Spectrum 2019 estimates of PLHIV. As displayed in Map 1, a large number of PLHIV reside in the Lake Zone, Southern Highlands and Dar es Salaam. Therefore, a proportionate amount of the COP 2019 budget will be invested in those same geographic areas.

Map 1: Number of PLHIV by Council as compared to COP 2019 Planned Budget by Council

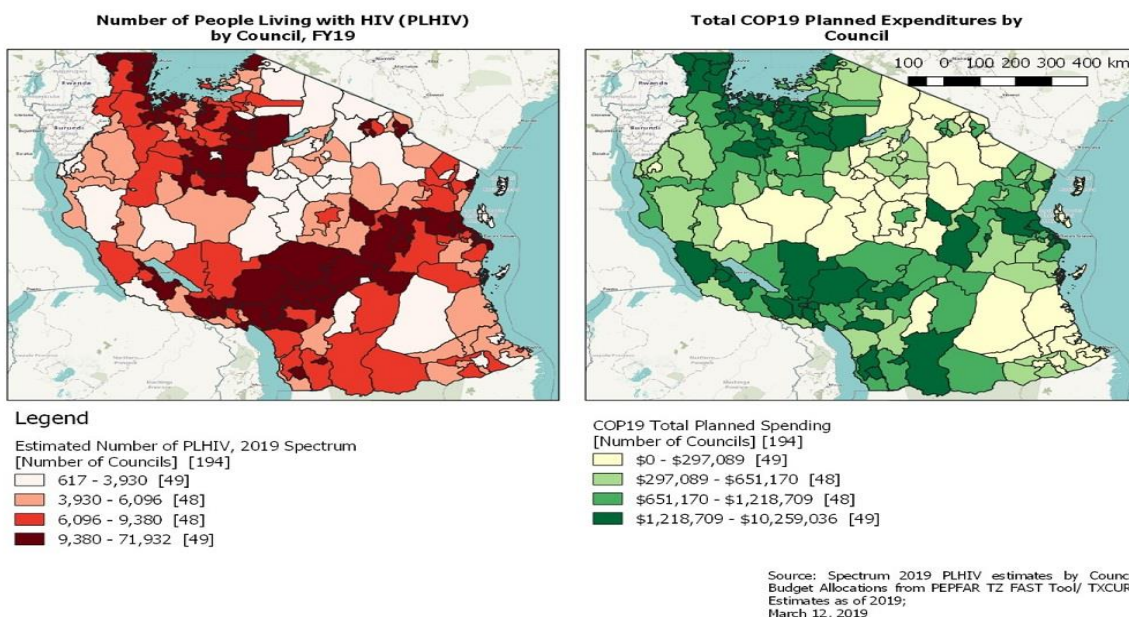
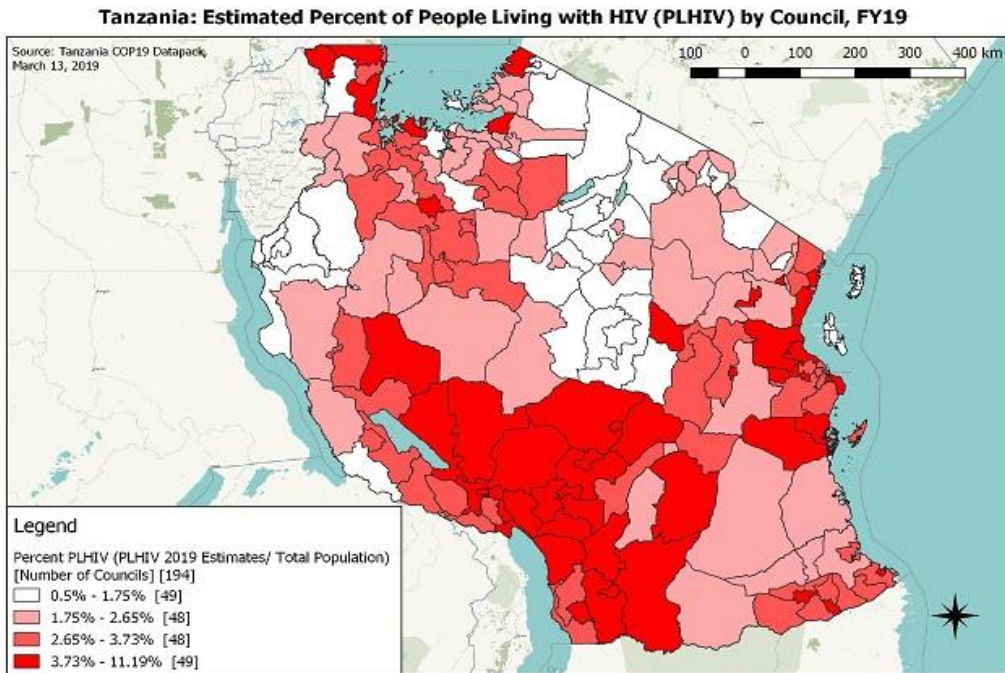


Figure 2.4.1 displays the percentage of PLHIV, estimated number of PLHIV, ART treatment coverage, and most recent viral load monitoring coverage for Tanzania. Councils with high HIV

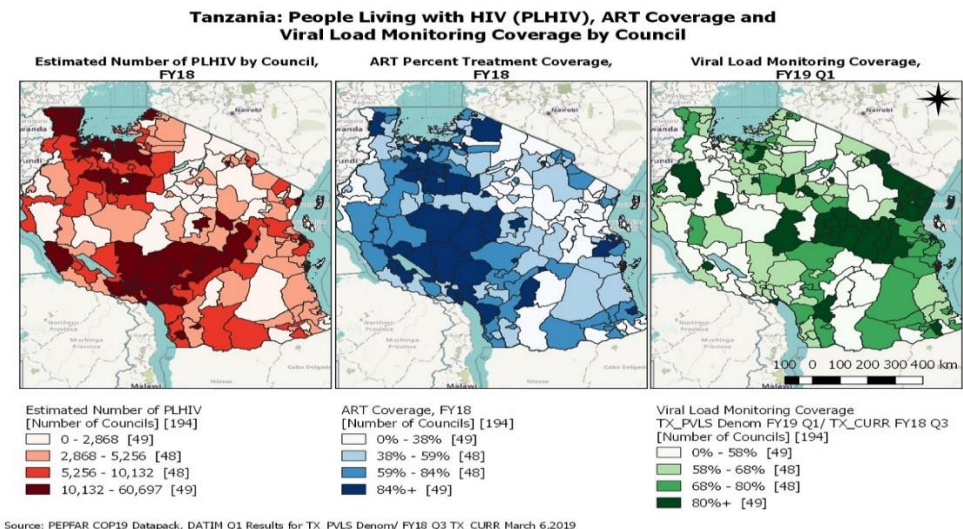
burden (within the highest quartile of PLHIV burden) also have the highest ART coverage, as seen in the Lake Zone and Southern Highlands.

Figure 2.4.1: Percentage of PLHIV, estimated number of PLHIV by Council



Map 2 shows that the scale-up of viral load capacity in the past year has resulted in clear improvements; with newly established viral load labs providing further coverage across the country.

Map 2: PLHIV, ART Coverage and Viral Load Coverage by Council



2.5 Stakeholder Engagement

Stakeholder Engagement in development of COP 2019 started in December 2018 when the COP 2019 draft guidelines were shared with GOT representatives, CSO representatives, development partners, UN agencies, and implementing partners. These stakeholders were encouraged to provide feedback to the Office of the U.S. Global AIDS Coordinator (OGAC) through the designated channels.

In mid-January PEPFAR/T leadership met with GOT (TACAIDS, Presidents Office Regional Authority and Local Government (PO-RALG), and MOHCDGEC) to share the final COP 2019 Guidelines and the Planning Level Letter, and to agree on national priorities in the context of the COP 2019 Minimum Requirements. During the same period, the PEPFAR/T Coordination Office attended a CSO COP 2019 preparation meeting and presented COP 2019 priorities as outlined in the COP Planning Letter.

PEPFAR/T held a COP 2019 Strategic Planning Workshop from January 23 to 25 during which the COP priorities were shared and various COP inputs and tools were discussed. More than 40 representatives from the GOT attended the meeting, as well as bilateral and multilateral development partners, including GFATM, implementing partners, and civil society worked with the PEPFAR/T headquarter and Tanzania-based technical teams throughout this process. Attention was paid to building consensus around key programmatic strategies, sensitizing participants on the COP tools, such as the funding allocation to strategy tool (FAST), and developing the assumptions for the data pack. The HIV commodities allocation was also discussed and agreed in consensus with the GFATM to ensure complete funding of the national supply plan.

Subsequent to the partner meeting, Tanzania CSOs met twice to finalize CSO priorities COP 2019. Through a democratic process they elected two representatives to attend the COP 2019 in-person meeting in Johannesburg. The two CSO representatives used the priorities developed in-country to inform their feedback, presentations, and engagement throughout the Johannesburg meeting.

Representing for-profit private health facilities, the Association of Private Health Facilities of Tanzania were also fully engaged in the COP 2019 Strategic Planning Workshop. Extra effort was put forth to engage faith based organization (FBO) community leaders and organizations in COP 2019 planning. For example, the Christian Social Services Commission, representing the majority of FBO health facilities in Tanzania, the Tanzania Interfaith Partnership, and more than 10 local and international FBOs were present and involved in the Strategic Planning Workshop. PEPFAR/T has continually engaged these entities in the development of the FBO strategy to support new activities for communities in raising awareness, HIV case-finding/linkage/retention, and prevention of sexual violence and HIV risk among ages 9-14 years.

Ultimately, the GOT selected a delegation of four to attend the Johannesburg meeting, including a representative from TACAIDS, National AIDS Control Program (NACP), the PO-RALG, as well as the Honorable Deputy Minister of Health himself. Several pre-meetings were held with the Government to discuss policy and program issues that were categorized as minimum requirements for COP 2019. The meeting in Johannesburg was also attended by the GFATM Country Team, UNAIDS, and WHO HQ and country office representatives.

One of the outcomes of the Johannesburg meeting was a CSO request to form a KP advisory committee to help guide the roll out of key, strategic interventions. In response, the GOT has agreed to the formation of such a committee, which would be separate and distinguishable from

the already existing Key Populations Working Group (KEPOWG). PEPFAR/T will work with the CSO community to establish the Advisory Committee, ensuring that the design is CSO-led.

PEPFAR/Tanzania participated in an additional in-person meeting in Washington, D.C. in April 2019 to further assess COP 2018 progress and finalize areas for strategic focus for COP 2019. Stakeholder participation in this meeting included two GOT representatives, and two (one Tanzanian and one international) CSO representatives. The team collectively reviewed FY19 Q2 data and site-level performance and ultimately accepted geographic and partner shifts determined by OGAC with the goal of improved performance. These changes included shifting partners in Ruvuma and Tabora districts, transitioning all OVC targets to the current OVC implementing partner, putting several partners on PIPs, and streamlining community and facility partners in 11 regions.

After the COP is finalized, PEPFAR/T will continue to engage CSOs, GOT, UN Agencies, and other stakeholders in quarterly meetings to examine progress on policy implementation and program activities. The purpose of these meetings is to review data and ensure that the country move from the reboot category and achieve HIV epidemic control. A monthly meeting between the U.S. Embassy Executive Office and the MOHCDGEC technical staff has been planned to share and review monthly PEPFAR/T data, review policy adoption and implementation, and review program implementation. In addition, quarterly meetings with Deputy Minister are planned to provide a platform to discuss and address serious bottlenecks that hinder program implementation, especially policy implementation of accepted best practices. PEPFAR/T will continue regular engagements with GFTAM to coordinate commodity procurement and supply chain as well as to ensure that program activities are complementary. Continued PEPFAR/T engagement with the private sector in COP2019 will take place through partner meetings and through the Public Private Health Forum Executive Board. This committee is comprised of eight representatives from ministries and twelve representatives of health providers, medical professional associations, medical manufacturers, and commercial sector associations. The U.S. Government and two other bilateral donors are observing members.

3.0 Geographic and Population Prioritization

The THIS 2016-17 demonstrated that large case-finding gaps existed across all age and sex bands, and that gaps also had a wide geographic distribution. However, some geographic areas, especially those around Lake Victoria, were found to have a higher than expected gap in ART coverage. Likewise, some populations, especially men, had larger than average gaps in ART coverage. Based on THIS 2016-2017 findings, Tanzania revised council classification from seven councils achieving attained status to 11 for COP 2018, and these will be maintained for COP 2019. This represents 10% of the national HIV burden, up from 3% in 2017. There has also been an increase in the number of scale-up councils from 81 in 2017 to 97 representing 68% of national HIV burden. There are now 87 Sustained Councils representing 22% of the national HIV burden.

PEPFAR/T is currently operational in 195 councils in the country, with a passive enrollment approach in 87 Sustained Councils. In COP 2018 PEPFAR/T realigned investments to better correspond with the epidemiology and THIS data, and prioritized investments to increase identification, yield, ART coverage, and ART adherence and retention. This included increased focus and investments in the Lake Victoria region, with its larger than expected gaps in ART coverage. It also includes a focus on seven metropolitan areas with the largest burden of HIV, in recognition that transmission in densely populated urban areas can be especially rapid. This geographic realignment will continue into COP 2019 to fill the large case-finding and ART gaps across all age and sex groups, and throughout all regions of the country. 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 considered the location of key and priority populations and hot spots. The package of interventions for continued scale-up will be described in detail in the next section.

The THIS also found important population gaps that require specific focus. In COP 2019, PEPFAR/T will continue prioritizing men for case finding, adolescent girls and young women for prevention, and pediatric and adolescent PLHIV for improved viral load suppression. 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 has prioritized same day ART initiation for all male and female clients found to be HIV-positive across all populations and age groups, and including pregnant women and infants identified through early infant diagnosis (EID). COP 2019 builds on the programmatic shifts operationalized in COP 2018 and continues to rely on the THIS results to focus efforts on the councils with the highest HIV burden to ensure maximum impact per dollar.

In COP 2019, PEPFAR/T will continue to prioritize VMMC in councils with low male circumcision coverage and high HIV prevalence, including the DREAMS districts. The COP 2019 strategy will 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. In COP 2019, PEPFAR/T will continue to address the programmatic gap of VMMC coverage in 25-29-year-old men by implementing focused demand creation strategies that addresses structural and accessibility challenges for this age group. The specific plans are described in detail later in the document. In addition, PEPFAR/T will provide TA to scale-up early infant male circumcision (EIMC) at key sites in all priority councils for program sustainability. Specifically, in collaboration with UNICEF, PEPFAR/T is implementing sustainability models for both adult and early infant VMMC programs in order to provide a long-term approach to service provision.

Prioritization Area	Total PLHIV/% of all PLHIV for COP 2019	# Current on ART COP 2018 (FY 2019)	# of SNU COP 2018 (FY 2019)	# of SNU COP 2019 (FY 2020)
Attained	160,975 (10%)	139,501	11	11
Scale-up Saturation	1,087,196 (68%)	731,716	94	97
Scale-up Aggressive	-	-	-	-
Sustained	341,406 (22%)	186,086	87	87
Central Support	-	-	-	-
N/A		28,460	1 (Military)	1 (Military)

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

4.1 – 4.3 COP19 Programmatic Priorities for Epidemic Control

The THIS data demonstrate that gaps in case finding are large across all age and sex sub-groups and all geographic areas. With a first 90 of 61%, the lowest among all countries with substantial PEPFAR funding, identification of people with HIV is Tanzania's single largest gap in achieving epidemic control. During 2016-2018, Tanzania added a net of approximately 145,000 people to ART treatment each year (this includes those newly started on ART, minus all persons lost from ART coverage for any reason). To reach Tanzania's goals of achieving 90/90/90 targets by 2020 (and to be on track for 95/95/95 goals) requires increasing this by another 100,000 per year. This is achievable through a combination of increased identification (of which the bulk of the increase will come from index testing), as well as reducing Tanzania's net loss (inclusive of death) of around 7% to about 3%. 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 low. Finally, all of this must be done while constraining the number of HIV tests conducted, in line with S/GAC guidance. 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 ensuring viral suppression

The recent data from the 2016/17 THIS suggest a decrease in national prevalence (4.7% overall; 6.2% for women and 3.1% for men), compared to THMIS 2011/12 (5.1 overall; 6.2% for women and 3.8% for men). Unfortunately, only 60.9% of PLHIV were aware of their status, presenting a key challenge to achieving the UNAIDS 95-95-95 goals. Following these findings, PEPFAR/T is using a focused approach to align targeted and effective case finding strategies to improve identification. In FY20, PEPFAR/T aims to increase the quality and focus of the HIV testing, care and treatment services to identify 308,176 new patients, enroll 246,210 on treatment and increase to 1,556,815 the number of patients on ART. To reach 95% treatment coverage in priority regions, PEPFAR/T employed a cascade approach to setting HIV testing targets and considered several critical program streams and testing modalities to most efficiently identify HIV-positive individuals and effectively link them to care and treatment. For COP 2019, PEPFAR/T will address the broad gaps in coverage across age and sex bands through enhanced, evidence-based implementation of three key aspects of HIV case finding: index testing, optimized PITC, and targeted community-based testing for key and priority populations. In COP 2019, PEPFAR/T has stopped support for low yield testing points in facility-based settings (i.e., VMMC, STI, IPD, and VCT). In addition, approximately 1006 high-priority, high volume and high yield facilities were identified for scale-up of optimized PITC, while transitioning testing services at the remaining over 2,000 PEPFAR/T-supported facilities to the Government of Tanzania. PEPFAR/T will continue to support all services for people diagnosed with HIV at those facilities. This approach focuses PEPFAR/T testing investments where the potential gains are greatest, and where the level of complexity (because of facility size and screening needed) is highest. This will reduce testing to approximately 3.7 million tests.

PEPFAR/T will continue to increase coverage and fidelity of index testing. The goal is to increase the number of index positives by almost 60,000 compared to COP 2017 results to achieve at least 41% of all HIV-positive people being identified through index testing modalities in FY2020. This increase will close 60% of the gap between the TX_NET_NEW observed in COP 2017 versus the net new needed to achieve goals. Data from the second-half of FY 18, which was the period reflecting post-THIS 2016-2017 implementation plans, show improvements in both the number of index positives identified and testing yield. The number of index positives rose from 19,018 in quarters 1 and 2 respectively to 23,604 in Q3 and Q4. The percentage of all positives coming from index rose from 12% in Q1 and 2 to 13% in Q3 and 15% in Q4. Testing yield rose from just over 5% in quarters 1 and 2 to around 9% in Q3 and 12% in Q4. When index testing is implemented with fidelity, index testing yield is > 20% among sexual contacts. In Q1 of FY2019, the yield of index testing in adults overall reached 18%, reflecting continued, substantial improvements in fidelity of implementation. This high-priority, high-yield strategy will include newly diagnosed people with HIV as well as existing clients with high viral load. All PEPFAR/T supported facilities will implement index testing, specifically, focusing on the scale-up of assisted partner notification to support index client elicitation, mapping of contacts for index testing, and active tracking of contacts for testing and linkage to treatment. At all of the large facilities, data on the number of sexual contacts identified per case, the proportion tested, and the yield are tracked to identify the facilities in which the greatest improvement is needed, and also to identify the specific gaps requiring improvement. This approach has demonstrated success in improving results. The post-contact tracing adverse event screen for index clients will include physical and non-physical violence, undesired disclosure of status, identity, and will be developed with input from civil society. Results of adverse event tracking will be monitored regularly along with performance against other indicators, triggering immediate action and reported in POART reviews as part of index testing progress assessment. A national training curricula and monitoring and evaluation (M&E) materials for index testing (HTS registers including elicitation forms) have been developed and rolled out and include HIV self-testing and linkages to treatment.

COP 2019 Identification Strategies for Screening Better and Testing Smarter

- Index testing (facility and facility-based community/outreach) to achieve substantial scale-up in COP 2018 and 2019
- Optimized PITC for increased yields, with focus in high-volume, high-yield facilities (Implementation of national screening tool)
- Targeted facility-led community testing used selectively and tailored to needs of men and KVP, PP and DREAMS
- HIV self-testing

For optimized PITC, PEPFAR/T will continue to scale up approaches for optimization of 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. The result of this effort will be to optimize yield for PITC in facilities where PEPFAR/T support for testing continues.

Furthermore, PEPFAR/T will intensify targeted facility-led community case finding strategies with high yield focusing on KVP and priority populations (PPs) in community settings. This will be a key area for the KP Advisory Committee involvement. The program will no longer support non-KVP, non-index community, non-targeted campaigns and general population testing approaches.

Facility-led community-based testing will focus on high-risk areas informed by mapping of KVP hotspots and concentrations of PLHIV. PEPFAR/T will also use the risk and symptom-based screening approach to focus testing on high-risk persons. These interventions will increase yield and will decrease testing in low burden areas. Data from PEPFAR/T community activities in COP 2018 demonstrate quarter-on-quarter improvements in finding men with HIV, whereas facility efforts have had less success in increasing case-finding in men. 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 facility-led community-based HTS activities, PEPFAR/T will continue to integrate night time and moonlight testing activities to better reach key and priority populations and communities surrounding KP hot spots. These activities have been critical to Tanzania's success in meeting KP targets, even in the challenging overall context that exists for KPs in Tanzania. Implementing partners (IPs) will focus on venue-based testing, social network testing, and mobile clinic trucks providing comprehensive HIV services (including clinical and lab services) that will help ensure services can be accessed in hard-to-reach communities. Finally, HTS providers will be trained on the new revised HTS M&E tools and index testing training package including competency assessments of non-laboratory HIV rapid testers in community settings as part of the national certification program to ensure the quality of testing. In order to achieve these changes in approach the IPs will increase the numbers of KVP and PLHIV peer volunteers to cover all districts and fast track HTS at all levels.

PEPFAR/T in collaboration with GOT will support community ART initiation and refills for KVP (30 day prescriptions), in line with the new MOHCDGEC guidelines. This is already being implemented in some regions, but will be implemented nationally starting immediately. 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.

PEPFAR/T implements activities to ensure strong partnership between community and facility IPs in regions where partner streamlining has not yet been initiated, along with regional and district health teams at the local government authority (LGA) level. Within the regions, IPs meet regularly together and with LGA staff to ensure proper coordination. At the national level, partner management meetings include the facility and community partners together to ensure proper coordination.

PEPFAR/T will implement the evidence-based linkage case management (LCM) model, assigning all newly initiated PLHIV to an expert client for the first 60 days, to support adherence to ART and promote early retention. LCM is prioritized in high-volume facilities, hosting approximately 80% of PLHIV on treatment.

4.1.1 Adult men

Based on program and THIS 2016-17 data, PEPFAR/T continues to struggle with identification of HIV-positive men and initiating these men on treatment. Currently 33% of PLHIV in Tanzania are men aged under 50 years but ART coverage has remained very low.

Age	FY 18 ART Coverage	
	Men	Women
	%ART Coverage	% ART Coverage
50+	93%	94%
40-49	69%	88%
35-39	52%	82%
30-34	45%	84%
25-29	36%	81%
20-24	24%	69%
15-19	45%	58%
10-14	63%	67%
1-9	47%	47%
<1	11%	11%

Data from the second-half of FY2018, which was the period of time reflecting implementation of post-THIS strategies, show quarter-on-quarter increases in identification of men in index and community modalities, but not in facility modalities. PEPFAR/T will build on these index and community successes, rapidly improving index testing as an approach to increase identification of males. The community successes came from KVP activities that were enhanced in the second half of FY2018, incorporating post-THIS planning. These activities included outreach to miners, fisher-folk, clients of sex workers, and others. These activities will continue as part of our community outreach KVP activities. Data from facility-based testing, including after-hours clinics, did not show success in increasing the number of men with HIV identified. Early in 2019, we benefited from technical assistance from Lesotho, sending staff from Tanzania there to understand their successful models. Current facility-based models in Tanzania will be modified based on that experience and data tracked to determine if this produces success. 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 by distribution of HIV self-testing (HIVST) in male dominated workplaces, both public and private. PEPFAR/T will also accelerate case finding in the military setting through the U.S. Department of Defense (DOD) funded programs.

PEPFAR/T’s FY2018 annual report showed that viral suppression is consistently lower among males than females across the age groups. To improve treatment outcomes among males, PEPFAR/T will build on COP 2017 efforts to make clinics more “male-friendly” through extended operating hours, enhanced 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 DSM models that includes multi-month prescriptions – including the new MOHCDGEC approach to providing six-month dispensing - and ART outreach services that reach men will continue and should help to improve retention by decreasing the need for monthly facility visits.

4.1.1 Adult women

ART coverage among women living with HIV who are age 25 years or older is over 81%. PEPFAR/T plans to continue to close remaining gaps in ART coverage in women through support for index testing by promoting more complete enumeration of sexual partners, including through engagement of expert clients (ECs) in index contact elicitation and notification. ANC coverage

based on recent data is very high, with 99% of people visiting ANC for the first-time receiving HIV testing. The program will introduce HIVST for high-risk females in facility and community-based settings. As a mature and successful PMTCT testing program supported by PEPFAR/T, we will begin transitioning PMTCT testing services to the GOT. Phase 1 will transition PMTCT testing services in approximately 1,000 sites to GOT support. In COP 2019 PEPFAR/T will support testing in the remaining regions and facilities. PEPFAR/T will continue to improve counseling to promote retention in PMTCT through same day and weekly tracking of clients including regular updates of national tools, as well as, monthly data driven M&E patient follow-up status to achieve viral load suppression among beneficiaries of PMTCT. Furthermore, PEPFAR/T will strengthen and integrate viraemic clinics in facilities with high volume clients to increase retention into care as well as adherence to treatment. Lastly, PEPFAR/T will continue to support family-centered approaches and GBV services as part of these testing activities.

4.1.2 AGYW/KP

Please see section 4.2.4.

4.1.3 Pediatrics

Program data show major gaps in reaching pediatric populations and low yield of HIV testing and viral suppression. The overall strategy for addressing the gap in ART coverage in pediatric populations has 4 elements: 1) Improving EID coverage; 2) Index testing for biological children of mothers with HIV; 3) OVC activities; and 4) Focused PITC.

PEPFAR/T achieved only 64.2% of EID at 2 months, with only 79.9% of HIV-exposed infants being tested for HIV at the age of 12 months. Based on FY19 Q1 results, 15,518 pregnant women tested positive for HIV and 12,932 HIV-exposed infants (83% of eligible infants) had dried blood spot (DBS) collected. Of the 12,932 HIV-exposed infants (HEI), 289 tested HIV-positive, and 328 (114%) were initiated on ART. The figure below shows the complete PMTCT and EID cascade.

Challenges contributing to this gap include missed opportunities to utilize immunization platforms to identify HEI due to shortages in human resources, sub optimal use of lay workers including peer mothers to identify and follow-up mother-baby pairs. Long turn-around times for DBS results also contribute to low EID coverage.

PEPFAR/T is working to ensure a systematic approach is used to identify all HEI through screening their immunization cards and have an EID sample collected at the first immunization visit. PEPFAR/T will continue to support LGAs and IPs to ensure that all PMTCT sites are equipped to provide EID services and utilize peer mothers to screen immunization cards to identify those eligible for testing and follow up mother-baby pairs. Furthermore, PEPFAR/T will scale-up the use of Gene-Xpert - near point of care (POC) - for EID testing to address challenges related to the long turn-around time and low coverage. IPs will continue to support mentorship and supervision on the use of the mother cohort register to improve EID data quality. In addition, PEPFAR/T will leverage the OVC platform to increase HEI referrals for EID.

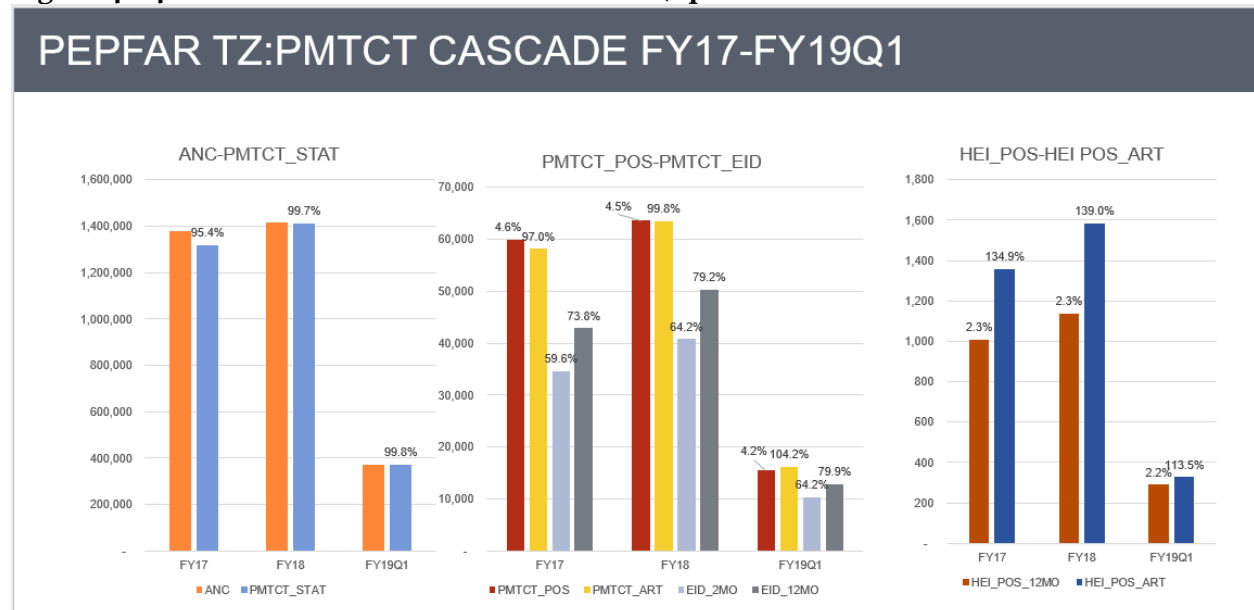
PEPFAR/T has scaled-up index testing and continues to strengthen index testing with fidelity. PEPFAR/T continues to strengthen testing of biological children of HIV positive clients through index testing as a core intervention. PEPFAR/T will also scale-up testing children of HIV-positive

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 after being screened for eligibility. OVC community case managers will support linkages from the community to the facility through escort referrals and track clients that are lost to follow up.

PEPFAR/T will enhance optimized PITC at inpatient, TB and malnutrition wards and increase the use of screening tools in outpatient and high-volume facilities. PEPFAR/T will strengthen pediatric and adolescent friendly services to improve retention and viral suppression. In addition, viremia clinics will be conducted to address challenges regarding unsuppressed children.

Viral suppression is another key area of focus for children and adolescents in light of the FY18 program data that shows only 66% viral suppression among children aged 0-14 years. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T expanded the use of age/weight appropriate dosing charts including providing advocacy and roll out support to the GOT during the TLD transition for children weighing >30kg. PEPFAR/T has also worked with GOT on a plan to phase out Nevirapine and efavirenz-based regimens. The GOT has agreed to introduce Lopinavir granules based on a quantification that will be completed by May 2019, with estimated first date of patient enrollment of September 2019. As of now, PEPFAR/T and GOT are supporting HWCs use of available dolutegravir (DTG) and Lopinavir syrup and tablets for children able to swallow while awaiting the introduction of the granules, which is expected prior to the beginning of FY2020. Site mentorship will be included to ensure HCWs understand and are competent in ART dose adjustment and transitioning to optimal regimens. To improve viral suppression, PEPFAR/T will also conduct site-level analyses to assess adolescents and children for timely identification of non-suppressed individuals and ultimately fast track enhanced adherence counseling and regimen changes to pediatric and adolescent clients.

Figure 4.1.4: PMTCT and EID Cascade from FY18, quarter one



4.1.4 Focusing on cities with high burden

PEPFAR/T will increase the quality and coverage of HIV testing, care and treatment services in high burden cities as essential activities to reach epidemic control. Based on THIS 2016-2017 and other key variables available from COP 2019 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 additionally receive focus during FY 2019. In these cities, PEPFAR/T will scale-up the package of identification activities described earlier. Targeted community testing approaches will be implemented in all seven of these cities, where testing after screening will be implemented to reach KVPs including: fisher-folk, truck drivers, miners, sex workers and their clients, ‘Bodaboda’ drivers and other mobile populations that play an important role in HIV transmission within cities. Sexual network tracing will be used to enhance standard index testing in these cities. PEPFAR/T will improve linkages to ART and retention by strengthening linkage and case management (LCM), as is being done throughout the country.

4.1.5 Linkage and Retention

Tanzania had the third best second-90 THIS result of all countries implementing a THIS, with 94% of people with known HIV status on ART. Program data show that the 1 – net loss /TX_CURR is 90.4%. This is up slightly from FY17’s result of 89.5%, and is similar to Uganda and Kenya, which were 90.6% and 90.8%. The 9.6% found be “lost” by this analysis include true loss, death, duplicated TX_NEW (from people registering as new more than once), and transfers in or out of PEPFAR. In Tanzania, we estimate death to be 1-2% of TX_CURR, duplicated TX_NEW to be around 2% of TX_CURR, and transfers in and out of PEPFAR to be negligible. This leaves a true loss other than death of 5.6-6.6%. We aim to reduce this by 4%, which would increase TX_NEW new by approximately 40,000. When combined with proposed gains in index testing, this would result in achieving TX_NET_NEW goals.

PEPFAR/T Retention Response

All sites:

- Appointment reminders prior to expected visit date
- Multi-month prescription for stable clients
- Tracking by facility team up to day 14
- Enhanced community tracking up to day 28 through facility-community collaboration
- Tracking outcome in database within 30 days

Priority sites:

- 60-day linkage case management for new clients

To improve retention, PEPFAR/T will implement the BCPE linkage case management model in high-volume facilities whereby new clients are assigned to peer supporter for service navigation and follow-up for the first 60 days since enrollment. PEPFAR/T will also support scale-up of the use of text (SMS) reminder messages to reinforce appointment attendance. Furthermore, PEPFAR/T supported sites will initiate contact to clients who miss their appointments on the same day and initiate community tracking within three to seven days. Facility initiatives of tracking will be augmented by engaging community IP if clients is not reached within 14 days for final outcome within a total of 4 weeks. These efforts will be used not only to improve retention, but to gather accurate information about patients who do leave a given clinic, as this information will be essential for making the TX ML indicator accurate.

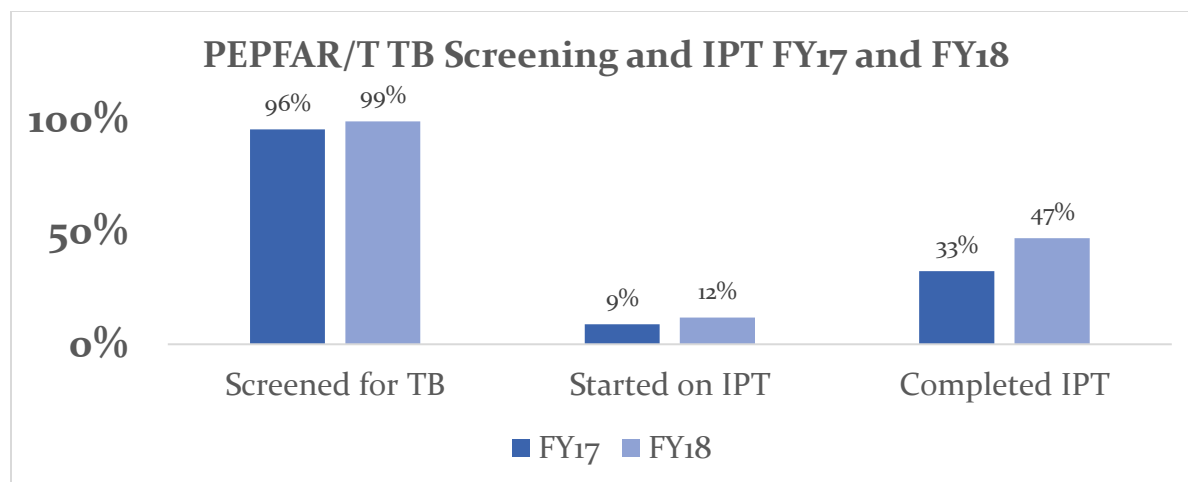
PEPFAR/T and GOT currently support and are scaling up six-month scripting with three-month dispensing and block appointments to reduce costs and service waiting times and to clients. In line with the May 2019 MOH circular, six-month dispensing will be implemented nationwide with an initial focus on clients who have successfully completed two-rounds of three-month dispensing.

For adolescents and children, PEPFAR/T plans to strengthen pediatric and adolescent friendly health services (AFHS) to address adolescents' needs and to promote retention. AFHS, including adolescent/teen clubs and peer treatment support groups, will be strengthened to reach more adolescents for HIV prevention and risk reduction and will include components addressing poor viral suppression through advance adherence counselling and ARV transitioning and switching to superior regimen according to ART guidelines.

PEPFAR/T investments in information systems in prior years has recently facilitated 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 expand a unique identification system for PLHIV to enable tracking clients in ART services. Based on GOT request, PEPFAR/T will look for a way to integrate registration for the national ID card into this process, and this is another opportunity for engagement with the KP Advisory Committee, as well as with CSOs more broadly. Biometric identification has already been implemented in three facilities in Zanzibar during early 2018, and in Kigamboni district council. It will be rolled out country wide to 750 facilities by September 2019 for people on ART. This will allow for more accurate measurement of retention, including knowing when duplicate TX_NEW occurs, and better measuring silent transfers.

4.1.6 TB Screening with Fidelity and Isoniazid preventive therapy Coverage

Despite high reported coverage of TB screening (99%) among PLHIV, program data shows low numbers of people with HIV who screen positive (39,444), and low numbers of people diagnosed with TB (13,601). To address this, PEPFAR/T will strengthen TB screening with fidelity for case detection by focusing on screening QI measures. Additionally, the screening that is used prior to HIV testing includes screening for TB symptoms. This allows for an integrated approach to HIV and TB screening. Whenever a person is identified with TB symptoms, that person will receive both HIV testing and TB testing (using the Xpert MTB/Rif Assay). PEPFAR/T will also optimize the use of Gene-Xpert 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. IPT coverage only increased from 9% (FY2017) to 12% (FY2018) and IPT completion increased from 33% (FY2017) to 47% (FY2018). Coverage and completion rates were low due to inadequate supply of isoniazid-rifampin (3HP) at the site level. However, that issue was resolved, and substantial increases in INH initiations occurred in Q4 FY 2018 and Q1 FY2019.

Isoniazid-rifampin (3HP) is currently not a registered treatment option in Tanzania. Discussions are underway to explore including 3HP as a treatment option provided technical and financial priorities align and based on outcomes of a planned pilot in the coming year. In the interim, PEPFAR/T aims to achieve 100% IPT coverage of all eligible clients during COP 2019. To achieve this PEPFAR/T is working in close collaboration with the government (NACP, NTLN and PO-RALG) to ensure a reliable supply of Isoniazid to increase the number of clients enrolled in and completing IPT. PEPFAR/T implementing partners will follow up on IPT implementation through regular supervision, on-job training and mentorship to health care providers. 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

4.2.1 HIV prevention for AGYW and children

In Tanzania, there are 6.2 million AGYW age 15-24 and, according to the THIS, this population is at considerable risk for contracting HIV. A variety of factors – including harmful social and gender norms, lack of education, and GBV – mean that adolescent girls are more than twice as likely as their male counterparts to become infected.

For COP 2019, PEPFAR/T has identified vulnerable AGYW (vAGYW) age 15-24 as a priority population, with a target of 418,059 for PP_PREV in scale-up districts. This intervention includes delivery of the evidence-based *Stepping Stones* curriculum and targeted demand creation activities. For COP 2019, the OVC program will incorporate new modules on sexual violence and prevention for 9-14-year-old girls and boys into the *Huru* curriculum which focuses on menstrual hygiene management, reproductive health (RH), risk avoidance, and GBV prevention. To complement interventions for OVC, the *Furaha* curriculum (an adaptation of South Africa's *Sinovuyo* curriculum for parents) will also be implemented for caregivers of adolescents. The

above interventions will also include strong engagement of faith and community leaders to ensure their critical support for AGYW and OVC programming. Other prevention strategies include community-based GBV screening in safe spaces, escorted referrals for family planning (FP) services, post-violence care services, PrEP for those at high risk of HIV acquisition and scaled-up AFHS.

Since 2015, PEPFAR/T has intensified efforts to avert new infections among AGYW and OVC 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 age-appropriate biomedical, behavioral, and structural interventions that have been proven to reduce the risk of HIV in AGYW. These efforts include expanding and deepening coverage within the existing priority councils by saturating priority geographic areas and population groups with combination prevention interventions, ensuring targeted testing and improved testing yields for AGYW. By the end of FY 2019, it is expected that 56,233 new AGYW (age 10-24) will be reached with DREAMS primary interventions. Approximately 70% of the total AGYW reached will also receive appropriate secondary interventions. The table below summarizes the DREAMS primary and secondary interventions:

Age Disaggregates	9-14	15-19	20-24
Population Description	OVC in- and out-of-school (priority for girls actively enrolled in school)	Sexually active, condom-less sex out-of-school (uncompleted secondary)	Sexually active, condom-less sex (priority for young mothers, girls engaged in transactional sex)
Proportion of the Vulnerable Population*	70%	60-100%	60-100%
Primary Individual Interventions	<ul style="list-style-type: none"> • Education subsidies • Parenting and care giver programming (Furaha) • Huru kits and curriculum (+ new modules on sexual violence prevention for 9-14 year olds) 	<ul style="list-style-type: none"> • HTS • Condom provision • Community-based HIV and GBV prevention (Stepping Stones) • Combination socio-economic approaches (Worth+) 	<ul style="list-style-type: none"> • HTS • Condom provision • Community-based HIV and GBV prevention (Stepping Stones) • Combination socio-economic approaches (Worth+)
Secondary Individual Interventions	<ul style="list-style-type: none"> • Referrals to, or if clinical partner, provision of post-violence care 	<ul style="list-style-type: none"> • Contraceptive method mix • Parenting and care giver programming (Sinovuyo) • Referrals for biomedical services • PrEP • Referrals to, or if clinical partner, provision of post-violence care 	<ul style="list-style-type: none"> • Contraceptive method mix • Parenting and care giver programming (Sinovuyo) • Referrals for biomedical services • PrEP • Referrals to, or if clinical partner, provision of post-violence care

Contextual Interventions	Influential men and women (all ages)	
	<ul style="list-style-type: none"> Community mobilization and norms change using SASA! package 	<ul style="list-style-type: none"> SASA! package does not target AGYW directly but rather general and adult influencers at the interpersonal and community levels Index testing will be offered for male sexual partners of AGYW who test positive

To ensure young women are identified and offered a core package of services at the community and facility levels, the Tanzania DREAMS program leverages the capacity of key partners for OVC, community prevention, and facility-based interventions. Primary beneficiaries are targeted through OVC programming (age 9-14) and intensive peer and community-based outreach (age 15-24). Once identified, a vulnerability assessment (i.e., 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 olds OVC in-/out-of-school; 15-19 year olds out-of-school and sexually active; and 20-24 year olds dropped out of school and engage in high risk sexual activity. Girls are maintained in the program until they meet the established program completion criteria which typically takes about 18 months.

Up to FY2019, DREAMS was implemented in eight sub-national units (SNUs) (Kahama TC, Shinyanga MC, Shinyanga DC, Ushetu, Msalala, Muleba, Kyela, and Mbeya CC). According to the 2016-17 THIS, the estimate of the burden of HIV was substantially lower in Temeke than had previously been projected; hence, the council was dropped and replaced with two other identified councils (i.e., Shinyanga MC and Muleba). Further, based on prevalence and proximity to current DREAMS councils, the GOT prioritized the Lake Zone with the aim of optimizing existing investments and program efforts. The table below highlights COP 2019 targets for the eight remaining councils:

Original DREAMS Councils	Target Type	Targets (9-24 Combined)
Shinyanga MC	Maintenance* + New**	15,590
Ushetu DC	Maintenance + New	21,556
Msalala DC	Maintenance + New	19,996
Kahama TC	Maintenance + New	18,729
Mbeya CC	Maintenance + New	30,872
Kyela DC	Maintenance + New	13,954
Muleba DC	Maintenance* + New**	32,371
Shinyanga DC	Maintenance + New	31,236

* Maintenance: Beneficiaries enrolled in the program in FY 2019 and completing in FY 2020

** New: Newly enrolled beneficiaries for FY 2020, expected to complete in FY 2021

For an SNU to be classified as saturated it must reach at least 90% of vulnerable population in each of the three age categories targeted in DREAMS (10-14, 15-19 and 20-14). While girls aged 10-

14 are mostly unreached in all DREAMS' SNUs due to limited resources required to deliver intensive Furaha Curriculum (primary service intervention), high achievement is reported for 20-24 age band across all DREAMS' SNUs. This achievement is attributed to methodological use of various estimated approaches. In COP 2019 PEPFAR/T will support partners to undertake enumeration using girls' roster to establish and document close by estimates of vulnerable population. Below is a table highlighting status of councils (by age band) implementing DREAMS, towards reaching saturation.

DREAMS SNUs	Age	Estimated Female Popn (2018)	Vulnerable Population (Est.)	*FY20 New Targets	**Saturation Status (COP19)	Saturation status in COP19
Kahama TC***	10-14	19,535	6,634	4,768	72%	In-Progress
Kahama TC	15-19	14,271	7,670	8,124	106%	
Kahama TC	20-24	12,264	6,505	5,837	90%	
Kyela DC	10-14	15,835	15,529	3,540	23%	No
Kyela DC	15-19	14,286	3,880	8,511	219%	
Kyela DC	20-24	11,410	2,795	1,903	68%	
Mbeya CC	10-14	22,807	36,182	6,452	18%	No
Mbeya CC	15-19	30,601	8,311	17,323	208%	
Mbeya CC	20-24	28,807	7,056	7,097	101%	
Msalala DC***	10-14	21,480	6,634	7,280	110%	In-Progress
Msalala DC	15-19	14,704	7,917	6,820	86%	
Msalala DC	20-24	12,636	6,702	5,896	88%	
Shinyanga MC****	10-14	13,008	13,485	3,592	27%	No
Shinyanga MC	15-19	10,524	5,667	6,614	117%	
Shinyanga MC	20-24	10,018	5,314	5,384	101%	
Ushetu DC***	10-14	23,760	6,634	7,680	116%	In-Progress
Ushetu DC	15-19	15,888	8,555	7,828	92%	
Ushetu DC	20-24	13,653	7,242	6,048	84%	
Muleba****	10-14	44,737	29,833	0	0%	No
Muleba	15-19	30,632	15,990	22,670	142%	
Muleba	20-24	23,837	12,676	9,701	77%	
Shinyanga DC	10-14	28,514	27,269	11,468	42%	No
Shinyanga DC	15-19	18,660	10,029	12,591	126%	
Shinyanga DC	20-24	16,133	8,557	7,177	84%	

*FY20 Maintenance Targets Inclusive

**Assumption Saturation => 90%+

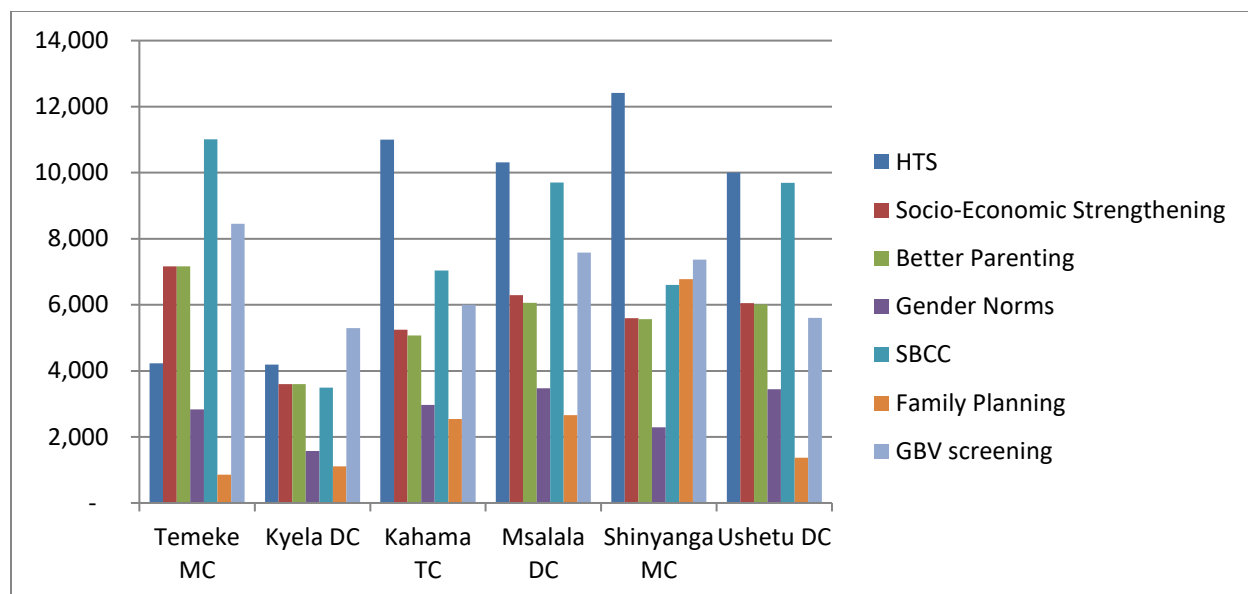
***Vulnerable Population Estimates in Ushetu, Msalala and Kahama TC are split equally; these three councils were formerly under one SNU (Kahama)

****Muleba and Shinyanga MC = New DREAMS Councils

In COP 2019, DREAMS will increase coverage in the same SNU by targeting 236,875 (64,500 maintenance) vAGYW and their sexual partners, and all non-military OVC targets will be streamlined to the primary OVC partner. All DREAMS girls will access HIV testing as part of a core package of services to increase knowledge of their serostatus. HIV testing will promote prevention and facilitate earlier linkage of HIV-positive girls to care, ART, and index testing for sexual partners. Starting in COP 2018 PEPFAR/T DREAMS Implementing Partners will ensure health providers are trained on SOPs, job aides, elicitation and screening tools to ensure index testing is implemented with appropriate quality and fidelity; possible violence is minimized; and different approaches are used to notify partners who pose a risk for intimate partner's violence. To strengthen linkages among AGYW, PEPFAR/T will ensure those who are HIV-positive are attached to expert patients and community-based service providers for escorting to facilities of their choice and tracing (in case of unsuccessful linkage at first encounter). Linkages will be tracked on a weekly basis at facilities so as to determine immediate intervention needs. PEPFAR/T will scale-up PrEP among vAGYW to determine whether or not it helps them to take control of their sexual health and reduce their HIV risk and that of their sexual partners who may also be at risk of infection. There will also be an enhanced focus on reaching and improving access to services for both men and women under 30 with 236,875 men and community members being reached through evidence-based gender norms interventions, including SASA!.

On average, AGYW age 15-19 and 20-24 receive at least five services, including: HTS, social and behavior change (SBC) interventions, GBV screening, socio-economic strengthening, and better parenting interventions. Community-based mobile health units provide a one-stop suite of services including HIV testing, FP, screening for GBV, TB, and substance/alcohol use, and escorted GBV referrals. Layering data reveal a need to improve FP commodity availability to ensure AGYW have consistent access to contraceptive the methods in a timely manner.

In COP 2019, PEPFAR/T will assist the GOT to adopt a total market approach for condoms by directly supporting the social marketing sector, which complements GFATM support for male and female condoms distributed within the public sector. Support for condom programming will remain national in scope, with condom promotion activities limited to scale-up councils where targets are set for comprehensive prevention interventions. PEPFAR/T will work with a local social marketing organization to gradually transition its socially marketed branded condoms to become self-sustaining by leveraging their program income.



Source: FY 2018, Q4 DREAMS partners reports

DREAMS provides PEPFAR/T with a platform to enable GOT structures to better coordinate adolescent health activities at the council level across key sectors (health, education, livelihoods, etc.) for improved service uptake and health outcomes. In the eight councils with new DREAMS targets, PEPFAR/T will work with the TACAIDS to ensure effective coordination of AGYW activities at national and sub-national levels and smooth implementation of DREAMS interventions. The PO-RALG will specifically generate and utilize improved age- and sex-disaggregated data, including for HIV and health, to inform budget development and decision making related to AGYW interventions at the sub-national level. This includes strengthening adolescent participation in local governance and sensitization of communities on priorities of adolescents and young people.

According to the 2016-17 Tanzania DHS (TDHS), 27% of girls age 15-19 have begun child bearing. These statistics are even higher in some regions where DREAMS is being implemented such as Shinyanga (34%) and Mbeya (33%). Harmful social and gender norms and lack of RH knowledge are just two of many factors that contribute to such high rates of pregnancy among young girls. Tanzania's DHS further indicates that knowledge of FP is inadequate, with 43% of young women age 15-24 unaware of any modern contraceptive method. For those who have not completed primary school, knowledge and use are even more limited, with only 9% uptake of modern FP in this group. Tanzania also has one of the highest child marriage 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 age 15.

DREAMS addresses some of the key drivers of teen pregnancy and early marriage through behavioral and structural interventions including: support for continued education; puberty and body awareness education; FP and RH education and services; sexual violence prevention; and parent and community sensitization on the effects of harmful social and gender norms.

While the 2015-16 TDHS 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, many regions and districts have put in place mandatory pregnancy testing that includes physical examination of AGYW and/or urine pregnancy tests. If a female is found to be pregnant, she is immediately dismissed from school and not allowed to return. In COP 2019, PEPFAR/T will continue to work with the MOHCDGEC and PO-RALG to identify more 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 teenage pregnancy and early marriage. It is important to note, however, that the current political environment penalizes AGYW who become pregnant by systematically blocking them from accessing opportunities to pursue formal studies, thus limiting PEPFAR/T's impact.

Tanzania has 2.3 million OVC affected by HIV (MEASURE Evaluation, 2018). The recent violence against children (VAC) study conducted in Tanzania showed that more than one-third (33%) of girls experience sexual violence. The goal of the OVC program is to prevent new HIV infection among at-risk OVC and improve OVC and family wellbeing through improved access and utilization of HIV and other health services. The program contributes to HIV epidemic control goal by ensuring that all OVC know their HIV status and that those who are HIV-positive are immediately linked to treatment. In COP18, greater collaboration between the OVC implementing partner and partners working in the community and facility have further enhanced opportunities to for the OVC program to improve HIV identification, linkages, retention and viral load suppression. The program also works to reduce HIV risk and to prevent new HIV infections and GBV and VAC for OVC age 9-14 in higher HIV impact councils. 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 programming in Tanzania.

PEPFAR/T will serve 614,434 OVC under age 18 in priority councils. DREAMS implementers will contribute 14% (90,481) of <18 OVC targets. OVC age 10-14 form 38% (232,079) of <18 targets and, for this age-band, females account for 67% (139,463). PEPFAR/T will also reach 254,855 OVC caregivers. In FY 2019, about 10% of OVC (61,784) are expected to graduate, resulting in 552,650 active OVC in the program. As OVC exit due to graduation, the program will focus on enrolling new OVC age 10-14 so as to reach more boys and girls with sexual violence and HIV prevention interventions. OVC enrollment will prioritize HEI, children living with HIV (CLHIV), adolescents living with HIV (ALHIV), children of people living with HIV, children of female sex workers (FSW) and women who inject drugs, children and young women age 10-17 years living or working in the streets, and children from mining communities. OVC identification and enrollment at health facilities will occur through PMTCT (including mother-baby pair follow-up). The first postnatal visit will identify HIV-exposed and HIV-positive OVC missed at facilities. Community-based case identification will prioritize OVC and adolescents who are highly vulnerable to HIV infection, particularly adolescent girls.

In FY 2018, about 74.6% of OVC reported their HIV status. In COP 2019, PEPFAR/T will ensure 100% of OVC active in the program have knowledge of their HIV status and have their HIV status documented on file. The use of the OVC HIV risk assessment tool has proven to be effective in targeting children at risk of HIV. Four questions in the risk assessment tool, in particular, have shown potential to identify more HIV-positive children. These questions include asking whether: there is one or more household PLHIV (24% of these children are HIV-positive); one or both biological parents of the child are deceased (12%); a child is living with a chronically ill caregiver

(7%); and the child has ever been admitted to the hospital (6%). Further refining these questions to make the HIV screening tool more HIV-sensitive is ongoing. PEPFAR/T will continue to 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). PEPFAR/T will also continue to strengthen testing of biological children of HIV-positive clients through index testing as a core intervention. PEPFAR/T will also scale-up testing children of HIV-positive FSW and women who inject drugs.

DREAMS interventions are integrated within the OVC program and implemented as part of the OVC package in DREAMS' SNUs. Early sexual debut is associated with exposure to violence, and childhood sexual violence is associated with increases in young adults' sexual risk behaviors. Therefore, the program will implement activities related to primary prevention of sexual violence and HIV. Specific activities will include risk avoidance interventions, e.g., prevention of forced, coerced, or non-consensual sex, and risk avoidance/reduction interventions for adolescents age 15-17, e.g., linkage to PrEP, condom use, reduction of number of sexual partners, and linkage to post-GBV care. Specific interventions will reduce early sexual debut and sexual violence prevention with a focus on boys and girls age 9-14. The program will ensure that victims of sexual violence are linked to post-GBV care at facilities and, in collaboration with local authorities, ensure they are linked to justice services. Other interventions layered with DREAMS include community mobilization and norms transformation and implementation of the *Furaha* curriculum which aims to foster open communication on HIV and sexuality issues between adolescents age 15-17 and their caregivers. The program will provide *Huru* kits for menstrual hygiene management, violence risk screening, educational support, household economic strengthening, and community prevention and response.

To improve sexual prevention programming, PEPFAR-recommended evidence-based sexual violence and HIV prevention modules will be incorporated into existing curricula and materials. These will focus on healthy and unhealthy relationships and prevention of non-consensual sex. The program will also use evidence-based programs such as *Coaching Boys to Men* and incorporate related messages into interventions for parents and caregivers. Emphasis will be given to ensuring that all programs dealing with children implement child safeguard policies and procedures to prevent GBV and child abuse.

Faith-based organizations will be key partners in addressing GBV/VAC and the stigma that often prevents children and adolescents from accessing HIV services. PEPFAR/T will continue partnering with the Christian Social Services Commission (CSSC) which manages an extensive network of health, education, and social structures. Assistance will be provided to CSSC to develop and disseminate messages on the prevention of GBV/VAC and HIV among children throughout their network. Additionally, PEPFAR/T and CSSC are jointly mapping their member religious institutions and HIV services within targeted regions to identify further entry points to address sexual violence and HIV prevention among children.

To sustain the OVC response, community ownership will play a critical role; therefore, caregiver strengthening will continue to be an 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 LGAs, and community child protection committees. Continuous robust partner management, program monitoring, quality

improvement, and learning, adaptation, and operational research will all be employed to advance the evidence base on HIV risk and reduction among underserved OVC sub-populations.

In FY 2018, 112,121 OVC had unknown HIV status of which 38,889 (35%) were assessed to be at risk of HIV and referred for HTS. Of these, 10,886 were confirmed as HIV-positive, of which 10,518 (97%) are on ART. To improve the pediatric continuum of care and prevention of new infections among children, the program will continue to scale-up, learn from, and adapt best practices that strengthen linkages across HIV services. Effective interventions to improve linkages among OVC and adolescents will include flexible clinical hours, peer support and adherence clubs, adherence monitoring, and family disclosure support. Memoranda of understandings (MOUs) between PEPFAR/T care and PEPFAR/T treatment partners and the PO-RALG will continue to be used to designate the roles of facility healthcare workers and community case workers, as these have demonstrated effectiveness in tracking HIV-exposed and HIV-positive children who are lost or missed at facilities and linking them back to care and treatment. Moreover, 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 SNU by 92%. The OVC partners will also collaborate with demand creation programs to generate demand and uptake of HIV services among ALHIV.

Within the clinical setting, program data show major gaps in reaching pediatric populations and low yield of HIV testing and viral suppression. PEPFAR/T achieved only 89% of the annual target for EID, with only 79% of HEI being tested for HIV at the age of 12 months. Based on FY 2019 Q1 results, 15,518 pregnant women tested positive for HIV, and 12,932 HEI (83% of eligible infants) had a DBS sample collected. Of the 12,932 HEI, 289 (2.2%) tested HIV-positive, and 328 (114%) were initiated on ART. Challenges contributing to this gap include reporting issues, shortages in skilled human resources, missed opportunities to utilize immunization platforms to identify HEI who require EID services, and sub-optimal use of peer mothers to track clients lost to follow-up.

PEPFAR/T is working to ensure that all HEI have an EID sample collected at the first immunization visit. PEPFAR/T will continue to support LGAs and partners to ensure that all PMTCT sites are equipped to provide EID services and utilize peer mothers to track clients lost to follow-up. Within faith-based health facilities managed by the CSSC, PEPFAR/T will introduce the mentor mother model, which is a family-centered approach to follow-up pediatric patients and improve adherence. Furthermore, PEPFAR/T will scale-up the use of Gene-Xpert – near point-of-care (POC) – for EID testing to address challenges related to the long turnaround time and low coverage. Partners will continue to support mentorship and supervision on the use of the mother cohort register to improve EID data quality. In addition, PEPFAR/T will leverage the OVC platform to increase HEI referrals for EID.

PEPFAR/T has scaled-up index testing and continues to strengthen index testing with fidelity. It will enhance PITC at inpatient, outpatient, and TB wards and increase the use of screening tools in some outpatient wards and high-volume facilities. PEPFAR/T will strengthen pediatric and AFHS to improve retention and viral suppression. Viremia clinics will also be conducted to address challenges regarding unsuppressed children.

Viral suppression is another key area of focus for children and adolescents in light of the COP 2018 program data that show only 18% viral suppression among children age 0-14. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T expanded the

use of age-/weight-appropriate dosing charts including providing advocacy and rollout support to the GOT during the TLD transition for children weighing >30kg. In COP 2018 PEPFAR/T is also working with the GOT to phase out the Nevirapine regimen by supporting healthcare workers use of available DTG and Lopinavir tablets for children able to swallow while awaiting the introduction of Lopinavir/Ritonavir granules. Site mentorship will be included to ensure service providers understand and are competent in ART dose adjustment and transitioning. To improve viral suppression, PEPFAR/T will also conduct site-level cascade analyses to assess adolescents and children for timely identification of non-suppressed individuals and ultimately fast-track enhanced adherence counseling to pediatrics and adolescents.

4.2.2 Key Populations

PEPFAR/T provides targeted interventions for key and priority populations (KP/PP), including FSW, MSM, transgender people, people who inject drugs (PWID), and at-risk individuals within these sexual networks. Activities reaching KP are implemented in all scale-up councils, 11 attained councils, and 11 selected sustained councils with known hotspots. In COP 2019, these councils account for 84%, 12%, and, 4% of KP_PREV targets, respectively.

Cumulatively for FY 2018, implementing partners reached 141,293 KP which are 110% of the annual target. For Tanzania, KPs who were “reached” also received appropriate services. FY 2018 Q4 (June-September 2018), data indicate that PEPFAR/T reached 69,234 KP with core intervention packages. Of those KP reached, 68,786 (99%) were tested for HIV during the implementation period, 5,345 (8%) were identified positive, and 3,732 (70%) were documented as linked to ART. While some of these “unlinked” persons may be people who came for testing a second or third time without reporting prior knowledge of status, efforts are still needed to maximize linkage. We will do this through linkage case management, and use of community ART initiation.

FY 2018 data show low linkages to ART services for HIV-positive KP in councils that did not implement community ART. It has been observed that community enrollment and ART initiation of KP at the point of diagnosis greatly reduce barriers to enrollment in care. Data also indicates initiation and linkage rates have continued to increase from 79% in FY 2018 Q4 to 86% in FY 2019 Q1 among KP in councils with community ART. In COP 2019, with MOHCDGEC guidance, PEPFAR/T will scale with fidelity this best practice to all councils as an important addition to the community-based KP package of services, along with the BCPE model to maximize early linkage and retention to HIV care for the newly diagnosed KP/PP clients.

A major success of the national KP program is the revived commitment by the GOT to provide a comprehensive prevention, care, and treatment package for KP, recently including full rollout of PrEP and HIVST, as well as the identification of facilities with KP-friendly services. In line with GOT commitments, in COP 2019, PEPFAR/T will scale-up PrEP to nationwide with a focus on key and vulnerable populations including AGYW and discordant couples. PrEP will have a prevention benefit, while HIVST will help with the identification of KP and sexual partners of FSW that are reluctant to go for services because of stigma. The national PrEP program will provide a comprehensive portfolio of services in line with GOT guidelines. The program will provide flexibility so that people are able to choose and be supported in the use of other prevention strategies, should they decide to discontinue PrEP after starting. Linkage of HIV-negative individuals reached through index and community testing to PrEP will be gathered and documented as part of a prevention cascade.

PEPFAR/T and the GOT have developed national PrEP M&E tools and a database for reporting and have conducted PrEP TOTs for national facilitators. Annual targets have only been met by 61% due to delays in getting the protocol approved, with implementation covering only a five-month period. Approximately 84% of people who were offered PrEP agreed to start it between May and September 2018. While the FSW community showed a high degree of PrEP acceptability, continuation rates for PrEP were very low. To illustrate, the one-month continuation rate is 45%, and three-month continuation rate is 11%. PEPFAR/T will scale-up strategies to improve continuation rates. During outreach activities, clients who test negative are offered screening for PrEP as an additional prevention method. In addition, FSW located in brothels are targeted for PrEP, because they are more stable in their locations.

PEPFAR/T will continue using differentiated service delivery models for HIV case finding and linkages to treatment among KP/PP, which include self-testing, index testing, contact tracing, social/sexual network demand creation and testing, enhanced KP peer navigation/escorted referrals, and rollout of community ART initiation and refills for KP living with HIV. PEPFAR/T will continue supporting comprehensive service delivery that includes HTS, condom provision and promotion, ART, PMTCT, HIVST, and targeted community prevention interventions, including those that address gender norms and GBV. Additionally, PEPFAR/T will guide partners to conduct mapping of local CSOs 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 to enable increased access for MSM to services such as HTS and to link those found to be HIV-positive to ART services.

PEPFAR/T will continue advising the GOT on KP policy to ensure safe and appropriate access to services that adhere to international standards. As noted earlier, this will include the establishment of a national KP Advisory Committee comprised of KPs and KP organizations who will work closely with the GOT to ensure the health needs of KPs are met across the whole portfolio of HIV prevention and care and treatment activities. COP 2019 will fund the implementation of stigma and discrimination sensitization programming for healthcare workers and law enforcement. PEPFAR/T will engage KP groups in the design and implementation of these programs and will work with the GOT to develop a system for documenting and remediating instances in which policy and/or persistent stigma adversely impact access to HIV testing, linkages, treatment, and prevention. The GOT's KP policy explicitly specifies a policy of non-discrimination in health facilities. Likewise, the GOT sent a circular reminding facility staff that anal exams can only be conducted without consent when there is a court order. PEPFAR/T will further encourage partners to utilize safety and security toolkits for KP. These partners will also meaningfully engage with indigenous organizations for all programming, including monitoring the effectiveness of stigma and discrimination programming.

In COP 2019, PEPFAR/T 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 this vulnerable group.

4.2.3 VMMC

In Tanzania, the VMMC program is a priority in councils with low male circumcision coverage and high HIV prevalence, including DREAMS districts. The program will continue to be a priority for HIV prevention as highlighted in the Tanzania National Country Operational Plan for VMMC (2014-2017) and Health Sector HIV/AIDS Plan IV 2017. The priority age band for VMMC was

selected based on impact and coverage modeling data from Avenir Health, which 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 and target and impact projections for the VMMC program at the district-level with data disaggregated by five-year age bands.

In FY 2018, PEPFAR/T supported 4,286,297 circumcisions, and by end of FY 2019, the total number of VMMC performed is expected to be 4,428,513. Building on efforts from COP 2018, the COP 2019 strategy is to maintain high coverage among 10-29 year olds 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 2020 to reach and maintain saturation in all strategic councils (i.e., seven attained, 63 scale-up, and 16 sustained councils), targeting 805,053 boys and men.

Summary of VMMC Strategy and Direction in COP 2019

SNU Category	>80% coverage among 10-29 year olds	Total
Scale-up saturation	63	608,690
Sustained	16	127,309
Attained	7	54,033
Total SNUs	86	
Total target		805,053*

* Total includes military

According to the 2016-17 THIS, national male circumcision (MC) prevalence is near 80% among 15-29 year olds. The PEPFAR/T program is on track to reach the target of 90% MC prevalence among 10-29 year olds by 2020. However, as coverage increases, pockets of low coverage remain in the country. Coverage among 10-14 year olds is still low (59.3%, THIS 2016-2017), and program data continue highlighting the coverage gap in men older than 24 years and in highly mobile men and communities in which men's occupations are characterized by seasonality (e.g., men working in the agricultural and mining sectors, fisher folk). Low coverage for the older age band justifies the continuation of VMMC targeting adult men. The program will combine mix models for mop-up campaigns in the younger age band (10-14) in order to maintain high coverage of MC in priority districts. PEPFAR/T recognizes the challenges of reaching adult men as the program matures. Therefore, the use of data sources and GIS mapping is imperative to drive strategic planning of VMMC service delivery for scale-up in priority districts. PEPFAR/T will continue to focus on scaling up VMMC services among older males age 25-29 by addressing key barriers. These obstacles include economic constraints, emotional reservations, service delivery convenience, structural set-up of facilities, and traditional and cultural norms. The program will continue to use different communication and demand creation approaches, including human-centered design strategies, to attract more adult men and increase uptake of services. PEPFAR/T's demand creation efforts use client-centered approaches, such as age-specific SMS messages and interactive voice response (IVR) systems such as helpline services to target adult men 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 adult men, allow for separation of older men from younger men, include extended hours and moonlight services, and increase the use of male service providers. In addition, IPs will focus on seasonal preferences for older clients (i.e., May to August) and will scale-up provision of VMMC services

during this time. Lastly, the program will focus on workplace interventions tailored to fishing communities, mining areas, and refugee camps to capture adult men for VMMC services.

To improve program performance, quality, and safety in COP 2019, PEPFAR/T will focus on engaging local partners for service delivery, as it gradually transitions the program to local indigenous organizations for planning, management, ownership, and sustainability. The GOT will work in collaboration with partners to develop a sustainability roadmap as a guide to VMMC stakeholders that will emphasize local resource mobilization, human resource capacity building, and good governance for sustainable VMMC services. PEPFAR/T will support plans and efforts to ensure EIMC services are integrated in routine services offered at Reproductive and Child Health clinics. The focus for EIMC will include developing a national training package, providing EIMC technical assistance to some priority districts, and establishing EIMC quality improvement measures at all levels in FY 2020. PEPFAR/T will focus on strengthening the quality of services through continuous quality improvement (CQI) and external quality assurance (EQA) programs for better safety. Finally, PEPFAR/T will also implement WHO pre-qualified device driven MC for enhanced safety (e.g., Shang ring).

In COP 2019, PEPFAR/T will strengthen data quality, increase coordination, and improve sustainability of the VMMC program. While there has been considerable progress toward MC saturation, the VMMC program continues to need technical support, strengthening of data quality, enhanced partnerships, and better quality of both the adolescent/adult and EIMC programs. PEPFAR/T supports the NACP to monitor implementation of its standardized VMMC minimum package that includes HIV prevention counseling, STI screening, HTS, and linkages to care for VMMC clients. In COP 2019, PEPFAR/T will also continue supporting integration of VMMC in its youth and adolescent basic minimum package for HIV prevention which includes RH counseling, condom promotion, STI management/referrals, ART services, and psychosocial services. Lastly, PEPFAR/T will advocate for the allocation of resources for VMMC commodities and supplies in the Comprehensive Council Health Plans (CCHP) and the GFATM mechanism for sustainability.

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

4.3.1 Planned Policy Changes

For COP 2019, there are policy changes underway that will positively impact the PEPFAR/T program. In May 2019, the GOT aligned its ART same-day initiation guidance with WHO's, thereby reducing the time period to "within 7 days" instead of the current "within 14 days." This policy change supports the minimum requirement to scale-up same-day initiation, with goal of achieving >95% of patients on same day initiation (within 7 days). This is an area in which Tanzania has seen success, with well over 90% of people with HIV currently receiving ART within 7 days of diagnosis.

The GOT will allow lay cadres to conduct HIV testing as part of its effort to ensure that adequate human resources exist to close the HIV identification gap in Tanzania. Specifically, groups that will be allowed to conduct testing include CHWs, CDWs, CDOs, SWOs, HAs, VHWs, HIV HBC providers, and members of health facility governing committees.

The May 2019 GOT circular supports the roll out of community-based ART initiation and one-month refills. This will help to improve both linkage and retention, especially among KPs and other hard-to-reach populations.

The current GOT policy endorsing six-month prescriptions with three-month dispensing will be brought to scale at facilities nation-wide and has achieved the goal of reaching 60% of clients at the 241 priority sites by the end of April 2019, with the goal of also achieving >90% of eligible clients at all PEPFAR-supported sites by the end of September 2019. At the beginning of COP 2019, six-month prescriptions with three-month dispensing will be the standard of care for all stable clients. In order to transition towards the global standard of six-month dispensing, PEPFAR/T will work with the GOT to ensure that clients who have successfully gone through two-rounds of three-month dispensing begin to receive six-months' worth of ARVs at each appointment. This shift will happen nation-wide. To ensure success, PEPFAR/T will support supply chain and storage systems, provider education, and patient treatment literacy for this initiative.

Two important policy changes related to the supply chain have been agreed to in COP 2018 that impact program outcomes in COP 2019. GOT will transition away from Nevirapine based regimens for pediatric HIV clients, which will include a transition to Lopinavir (LPV)/granules. The GOT committed to ensuring that all supply chain and quantification plans will be completed by April 2019, and PEPFAR/T expects to be able to provide LPV/granules to clients by September of 2019. Patients began being transitioned to TLD in Tanzania in March 2019. As part of the transition to TLD, informed consent will be conducted for women of childbearing age. At the same time, provider trainings and treatment literacy continue and the integration of family planning options, for those who choose them, are being strengthened. Uptake of TLD among women of childbearing age will be monitored closely to determine if any challenges arise. Women will be counselled on the use and effects of TLD and encouraged to make informed choices on TLD access, with or without family planning services.

Tanzania is currently awaiting final approval of the revised HIV law (expected in May 2019). The revision will allow for the scale-up of self-testing nation-wide. If the law is not changed by the end of the April-June parliamentary session, the GOT has agreed that the intervention can be rolled out fully in three of the ten regions where self-testing is currently being assessed.

As part of PEPFAR/T efforts to optimize PITC, screening tools, adapted from the Bukoba Combination Prevention Evaluation, have now been introduced nationally to ensure that only those at risk for HIV will be tested, making targeted HIV testing nation-wide policy and practice. PEPFAR/T is supporting printing and distribution of these revised HTS tools to facilities throughout all regions.

MOH policy in Tanzania requires non-discrimination for KPs in health facilities. The MoH disseminated a circular noting that forced anal exams may only occur with a court order. PEPFAR/T intends to ensure that MOI is engaged in this discussion, as well as CSO groups and other stakeholders to ensure that rights for all in need of HIV services are protected. Finally, PEPFAR/T will use FBO resources in part to promote non-discriminatory service delivery. To further emphasize their commitment to non-discriminatory service access, the GOT supports the establishment of a KP Advisory Committee comprised of KPs and KP organizations. This

Committee will work closely with the GOT to ensure that the health needs of KPs are addressed across the spectrum of HIV interventions in Tanzania.

PrEP is being removed from the existing protocol, and will be scaled up nationwide as a routine program activity. Results from the existing demonstration project will be used to inform a guideline revision by July 2019. Efforts to increase clients initiated on PrEP, including targeted expansion among AGYW populations will be implemented. PEPFAR/T will track and respond to retention data by sub-population to ensure that those most at risk of HIV and in need of PrEP are receiving and staying on PrEP for the period of risk. This will be supported through a targeted communications strategy, which will develop messages for key user groups such as AGYWs and FSW, as well as train providers on the importance of service delivery to these groups.

The biometric system will start with scaling up coverage for people on ART (including TX_NEW), with the goal of covering facilities that currently treat 80% of TX_CURR by September 2019. This will be conducted as a routine program activity. PEPFAR/T will work towards a national data system where the MOH is the custodian of data. CTC3 & DHIS2 achieves this goal. PEPFAR/T is in agreement and can tell partners that their performance will be based on analysis from CTC3 & DHIS2 given conditions outlined by PEPFAR/T are met, specifically that: 1) we concur that the required elements currently exist in the system; 2) a subset of USG staff have direct access to CTC3 and DHIS2 to ensure ability to monitor partner performance and to work closely with GOT on overall performance, both at a granular site-level; and 3) that when data needs arise that are not met by the system, those specific data can be collected external to the system until the system is able to meet those specific needs. These criteria should be able to be met by April 30, 2019.

4.3.2 Using Partner Performance to Inform Program Direction

Substantial changes were made to partner level targets and budgets for COP 2018 based on new epidemiologic data from the THIS 2016-2017. COP 2018 was the first year in which those data were used to inform partner targets and budgets. Prior to COP 2018, measurement of performance against target was severely hampered by targets that turned out in some cases to be vastly different than the updated burden estimates suggested. For example, partner performance in Dar es Salaam in COP 2017 appeared poor, but after the THIS, the estimated number of PLHIV decreased in Dar es Salaam by about 90,000, and we recognized that Dar es Salaam was one of just 4 regions in mainland Tanzania with an ART coverage exceeding 81%. On the other hand, in the regions around Lake Victoria, partner performance against target appeared relatively good. But, the THIS demonstrated that the burden of PLHIV was far greater in those regions than previously understood, which made achievements of those targets easier than would have been the case had targets been set with the true epidemiology known.

In COP 2018, targets were set entirely based on new Spectrum estimates, which were informed by the THIS 2016-2017. IM budgets were established based on the epidemiology, such that funds were aligned with the number of people already on treatment, and the number of people who needed to be added to treatment by that partner during the year. Throughout the remainder of COP 2018, partner performance will be measured against these updated targets, as well as other key metrics, and this will be used for future decision-making.

There are some examples where partner performance was used to determine partner targets and budgets, in spite of these large epidemiologic shifts. Two partners from COP 2017, THPS and PAI, underperformed even when the new epidemiologic data was taken into account, and they were no

longer partners for COP2018. One partner, AGPAHI, had an estimated increase in burden of 100,000 PLHIV in the 6 regions that it covered in COP 2017, compared to prior estimates. After a careful assessment of their capacity and performance compared to this large increase in estimated burden, we reduced their coverage to 4 regions for COP 2018. This will continue into COP 2019. For one partner, MDH, whose performance was excellent once THIS burden data were taken into account, we expanded their regions covered from 2 to 5. Early data from COP 2018 shows that their performance against target in those 5 regions is strong.

In conjunction with GOT and CSO representatives, the PEPFAR/T team accepted programmatic shifts proposed by OGAC to improve partner performance. Program activities in Tabora and Ruvuma (with the exception of VMMC in Ruvuma) will transition to higher performing partners. Several partners will be placed on performance improvement plans to ensure strategic programmatic areas are brought to scale effectively and efficiently, and that targets are reached. Non-military OVC targets will transition to the primary OVC partner, and community and facility partners will be streamlined in a total of 11 regions. DREAMS activities will be closely monitored to ensure performance improvements, and a new partner will be identified to take over care and treatment activities in police and prison sites.

Clinical implementing partners are only awarded a portion of their total COP approved budget at the beginning of the year. Additional funding allocations are provided based on performance and spending. If performance and spending suggest that awarding funds above and beyond the COP approved level is warranted, an OPU is submitted to OGAC. This approach will be used again in COP 2019.

4.3.3 Implementing Partners management to for program alignment and improvement

Details on the PEPFAR/T partner management strategy for optimizing partner performance are included in section 4.5.

For ensuring alignment with the PEPFAR strategy, we use several approaches:

- 1) Partners are included in the annual COP planning process, whereby they have the opportunity to hear feedback from meetings held with S/GAC and others, and have early opportunity to understand shifts in strategy that are required. In some cases, these shifts are immediate. For example, after returning from the DC COP approval meeting in 2018, we immediately had partner meetings and all-partner index testing training sessions with GOT so that the improved index testing strategy could be rolled out immediately.
- 2) Partner workplans are submitted annually and updated as needed when strategies change. This ensures that the written workplans that partners have agreed to implement are aligned with the most recent strategy decisions.
- 3) PEPFAR/T holds inter-agency PEPFAR Steering Committee meetings weekly. These are internal to USG, and we use these to review data and to rapidly share best practices or challenges being faced. When we identify a best practice, we work to scale that up across partners.
- 4) At the end of COP 2017 PEPFAR/T established a monthly data portal to review the progress of facility and community partners on a key sub-set of indicators more frequently. Monthly data review and discussions with partners allows for more immediate course corrections and site visit planning.

- 5) PEPFAR/T holds full partner management meetings quarterly, but also meets monthly with clinical implementing partners. This allows us to review their performance with them and to discuss shifts that are required.
- 6) PEPFAR/T holds all-partner meetings at least quarterly. At these meetings, the team announces any changes that affect multiple partners so that they can be implemented immediately, and low performing partners will be placed on performance improvement plans.
- 7) PEPFAR/T engages with GOT regularly. Starting in early 2018, the team began holding monthly meetings with GOT to discuss progress and to determine any shifts needed. At the Johannesburg Regional Planning meeting in 2019, the GOT and USG agreed to enhance this. Monthly meetings at the technical level will be held to review data and to discuss any actions that are needed. Quarterly meetings will occur at senior level to review progress and to ensure accountability. This updated process begins now. This will help to ensure that if GOT action is required or would be helpful to address challenges or to enhance performance, it can be done rapidly.

4.3.4 Evidence-based solutions to bring to Scale

Many of the evidence-based solutions that will be brought to scale in COP 2019 are described above in section 4.3.1. Additional evidence-based solutions that will be brought to scale that do not involve policy change include:

- 1) Rapid scale-up of index testing. Q3 and Q4 of 2018 have shown steady increases in both number of index positives and yield among adults. Some regions have seen substantial scale-up. For example, in Kagera, less than 1% of all HIV positive results came from index testing as of Q1 2018. By Q1 2019, this was over 20%. In this region, and in several other regions, we had been collecting data on the number of sexual partners enumerated per index case and the proportion tested. This facilitated identification of the modifiable gap in implementation. This practice is now being scaled-up country-wide.
- 2) TB preventive therapy scale-up will continue. A main barrier previously was lack of adequate supply, but this is now resolved. IPT initiation surged in the second half of FY2018 and in Q1 of 2019, and this will continue. Male identification strategies that have succeeded, including community-based testing for miners, clients of sex workers, fisherfolk, and other KVP. The index testing modality has also increased identification of men with HIV. Furthermore, site level data has shown that community-based male peer leaders supported by PEPFAR/T's social behavior change activity has contributed to an increase in male case finding at the facility. These activities will continue to be scaled up.
- 3) To improve retention, community tracking within 4 days of a missed appointment will be done. Innovative strategies already in place include the three-box approach, whereby a box exists for charts of people who are scheduled to come to clinic the next day, that day, or who have missed an appointment. There are several variants of this strategy, but the principle is being scaled-up nationally.

4.3.5 Plans to Ensure index testing scale-up and the right HTS Modality Mix

To ensure scale-up of index testing with fidelity, data are being collected from each facility, focusing on the largest facilities, about the number of sexual contacts enumerated per index client, the proportion of those who are tested, and the yield of that testing. This granular, site-level data allows us to identify the modifiable gaps in the index cascade in a given facility. Our

partners are already using this approach in some regions, and it is succeeding. This will be scaled-up country-wide. As part of the massive scale-up of index testing, PEPFAR/T will examine data results of the routine violence screening (conducted at every ART visit) to identify any potential increases in violence associated with index testing contact tracing.

Community-based testing will focus on index contact testing and key and vulnerable populations testing. Both of these strategies have seen substantial success, with quarter-on-quarter increases in HIV positive identification, and increases in identification of men with HIV.

Facility-based testing will always occur with pre-screening for symptoms and HIV risk, though all men >25 years who enter a facility can be tested, regardless of risk or symptoms. A national screening tool has been developed and approved and is now being implemented. PEPFAR/T will focus its facility-based HTS investments on the 241 facilities that account for 50% of TX_CURR, plus another 765 facilities that are both high-volume and high-yield. The BCPE approach will be implemented at all of these facilities, which has a demonstrated impact on increasing yield, and at times also increases the number of positives identified, when facilities had low testing coverage. GOT is de-emphasizing mass testing campaigns in favor of targeted testing using high-yield modalities.

PEPFAR/T will transition testing services at over 2,000 low-volume, low-yield facilities to GOT. Likewise, PEPFAR/T will transition PMTCT testing services in 8 regions to GOT. VMMC testing and other low-yield modalities will be transitioned to GOT nation-wide.

The above strategies focus PEPFAR T's testing investments on proven modalities well-matched to Tanzania's current gaps in identification and ART coverage. The strategies also increase the yield of each approach, even in non-PEPFAR/T supported testing settings.

4.4 Commodities

PEPFAR/T contributes with GFATM and the GOT to the total country needs for ARVs, rapid test kits, EID, and viral load commodities by providing them to the Medical Stores Department (MSD) for distribution. All products, with the exception of those for VMMC, self-testing, and recency testing, are distributed nationally based on consumption trends. VMMC, self-testing, and recency test commodities will be fully supported through COP 2019 and are provided directly to implementing partners providing these services. Through GFATM, PEPFAR, and GOT support, there are no commodities gaps expected during COP 2019.

The GFATM contribution to the HIV program for FY2020 is defined in the approved grant, which includes \$86 million for ARVs and \$19.5 million for lab supplies. Between the GFATM and GOT commitment to condoms and opportunistic infection (OI) medicines and PEPFAR/T support for commodities, there is no anticipated financial gap in these commodities.

The availability of TLD is a critical component of the TLD transition, which is rolled out in three phases based on level of facility. The transition plan is being accelerated to ensure that all sites are able to transition PLHIV by September 2019. This depends much on manufacturer's capacity to supply the global demand. With the current transition plan we don't foresee challenges, but if there will be manufacturing capacity issues there will be some effects. Tenofovir, Lamivudine, Efavirenz (TLE) is expected to run out April 2019 but with orders in pipeline, there will be enough

quantities to cover patients who will not yet be transitioned to TLD, those who will not opt into TLD, and those who will not tolerate Dolutegravir.

With agreed policy commitments which were made by GOT in the COP 2019 planning meeting in Johannesburg which includes elimination of nevirapine-based pediatric HIV regimens complemented by a transition to LPV/granules, six-month multi-month dispensing implementation nation-wide, self-testing roll out nation-wide (after passage of the HIV law) with an additional focus on higher learning institutions nationally (university colleges), and scale-up of PrEP, a need to revise quantification to inform these new requirements is a must. A revised quantification is ongoing in May 2019 which will inform new requirements and thus procurement.

In collaboration with GOT and other stakeholders, PEPFAR/T will support accelerated transition to pediatric optimal ART by ensuring there are enough commodities to support scale-up. Revision of guidelines and training materials to include optimal regimens as first line is in progress. Revised ARV quantification to inform transitioned commodities (Lopinavir granules etc) will be completed in May 2019 to allow for optimal regimens to be in country by August 2019, and an accelerated transition plan will start in September 2019.

PEPFAR/T supported the re-design of the supply chain system that focuses on increasing velocity and visibility in the supply chain. Increased velocity includes reducing the months of stock being held in warehouses by five months, and increasing the frequency of deliveries to facilities from quarterly to monthly. 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.

4.5 Collaboration, Integration and Monitoring

4.5.1 Strengthening Cross Technical Collaborations

In Tanzania interagency cooperation and collaboration is critical to ensure high performance of the PEPFAR/T program. Technical teams within the agencies operate through specific Technical Working Groups to foster constructive dialogues between agencies, stimulate innovation and enhance program standardization. At the management level, the PEPFAR Steering Committee provides regular opportunities to inform each agency of activities and initiatives to optimize efficiency across PEPFAR/T programs.

PEPFAR/T continues to engage the GOT in formal and semi-formal engagements. PEPFAR/T personnel are members of national technical working groups that convene to address program implementation and propose policy adaptations. Starting in FY2018 PEPFAR/T leadership has held monthly meetings with the Deputy Minister for Health and other senior MOH teams to track policy and performance. These meetings are transitioning to take place on a quarterly basis, and monthly meetings are being held between Agency Leadership and senior technical staff from both PEPFAR/T and the GOT. PEPFAR/T also is now engaging in monthly coordination meetings with UNAIDS, WHO, and GFATM to ensure that shifts in priorities are shared and program barriers are urgently identified and addressed in a unified and collaborative manner.

PEPFAR/T, the GFATM and the GOT work together to support the national HIV commodities supply plan. With respect to the implementation of community services, including those targeting KVPs, PEPFAR/T works closely with GFATM principal recipients (PRs) to geographically align partners and programs to prevent double funding.

4.5.2 Strengthening Partner Management

PEPFAR/T continues to strengthen approaches and processes to ensure highly effective, timely, and standardized partner management is in place to achieve COP 2019 targets and improve identified gaps. This process is data-driven and managed in two steps: 1) implementation and reporting; and 2) using data to improve performance. In FY2019, 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. Practices that were implemented and scaled-up during COP 18 will continue across all partners, nationally.

- 1) **Implementation & Reporting:** In COP 2019, PEPFAR/T will continue to use a comprehensive set of information to assess partner performance, paired with several key approaches to improving that performance. The assessment of partner performance starts with standard PEPFAR metrics (through the PEPFAR MER, quality (through SIMS), and financials (through outlays and budget analysis), all of which are currently available on a quarterly basis. Additionally, starting immediately after COP 18 planning was completed, PEPFAR/T implemented routine monthly reporting from all facilities covering 80% of TX_CURR on key strategies that were being implemented. We have used these data during the latter half of COP 2017 implementation and throughout COP 2018 to rapidly accelerate progress in these key priority areas. The precise data collected have been modified as needed over the past 9 months, but generally include index testing indicators, data on optimized PITC, data on policies reaching patients (proportion of patients receiving same day initiation, multi-month scripting, and IPT), linkage, retention, and viral load data. Upon return from Johannesburg in March 2019, we further enhanced this approach by adding more intensive review of selected data from under-performing facilities among the 241 facilities that comprise 50% of the TX_CURR in the country. This will be further enhanced by the GOT's commitment to activate the EOC for more focused, joint monitoring of activities at the 241 priority sites to ensure policy changes are reaching PEPFAR patients, and by the introduction of PIPs for partners that consistently fail to meet targets. PEPFAR/T is committed to transitioning to use of one data system with the MoH. As the GOT clinical care database reaches full implementation, the majority of these indicators will transition to being extracted directly from that system. Quality management and integrated analysis practices will be applied to identify facility and community sites that are under-performing, improve implementation fidelity and support achievement of outcomes to drive epidemic control. PEPFAR/T will use real-time, robust analysis of data to refine continuous quality improvement plans and identify successful facilitating factors that could be scaled up.
- 2) **Use of granular data to improve performance:**
 - a. **Regional Teams in COP 2018:** Immediately after the COP 2018 approval meeting in DC, USG "regional teams" were launched, whereby 11 regions were divided amongst 6 teams of USG staff, who were responsible for supporting those regions, with a focus on the facilities accounting for 80% of TX_CURR in those regions. These teams conducted multiple site visits to the regions and supported IPs in

accelerating progress. The teams were also responsible for SIMS visits occurring within their regions, thus providing greater continuity in their relationship with the regional and district partner and GOT staff. The GOT assigned 3 of its staff from the national level to join these teams and participate in site visits. Data were used to identify specific gaps both in region-level performance as well as facility-level performance, and technical assistance was provided to address identified gaps. In selected regions with especially large gaps in identification, this approach was enhanced with a long-term USG presence. Two staff were deployed to Mwanza for 1 month in November 2018, and 3 staff were deployed each to Mwanza and Kagera for 3 months starting in February 2019.

- b. **Expanding and enhancing Regional Teams for COP 2019:** The regional team approach has been successful and is being expanded. As of now, all regions in Tanzania have a USG staff-team assigned to them. Additionally, each one of the 241 high volume sites has been assigned to a single USG staff-member from their regional team. Partners have also assigned a staff lead for each facility. Granular data from each facility is reviewed regularly to measure progress against key goals. For example, for index testing, we measure the number of sexual partners enumerated per index case, the proportion of those who are tested, and the testing yield. These data, which identify specific, modifiable gaps, have been critical in achieving gains seen in some regions and will be critical for continuing rapid scale-up.
 - c. **Additional focus for under-performing sites:** High-volume and low performing sites will continue to be prioritized for SIMS visits, which will include tracking of remediation across all performance measures (program achievements, quality, and expenditure). Likewise, among the 241 sites, regular site visits will occur for those that are falling short of specific targets. When partner performance is of concern, PEPFAR/T management teams will increase the frequency of the reviews to weekly remediation actions and utilize benchmarks to monitor progress on a specified timeline.
 - d. **Addressing financial performance:** 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.
 - e. **Addressing overall partner deficiencies:** Formal Partner Performance Improvement 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 will submit reprogramming requests to ensure these adjustments are made in a timely manner.
- 3) **Ensuring excellent overall performance:** On a monthly and quarterly basis agency and interagency teams will continue to assess progress being made in 2019 to achieve targets overall and across sub-populations. The assessments will include analysis of performance against targets and investigate whether or not priority interventions are achieving expected results. The PEPFAR/T interagency team, along with the GOT, will continue to 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 quarterly in the POART. Immediately following the POART, PEPFAR/T will continue to meet with GOT, CSO and IP to discuss findings from the previous quarter and

agree on appropriate remedial measures. Agency and Embassy Leadership will also meet monthly with the MOHCDGEC leadership to review monthly data, policy implementation and address programmatic gaps.

To continue to foster a grassroots network of indigenous organizations and drive more local investment, PEPFAR/T will also engage with CSOs – both those receiving PEPFAR funding through sub-awards and those not receiving PEPFAR funds. This will include quarterly meetings and implementation of a Tanzania-specific CSO strategy to be finalized before COP 2019 implementation. The strategy clearly outlines PEPFAR T's CSO-engagement approach and includes 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 position CSOs to take increasingly larger roles in the implementation of PEPFAR/T 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. This will, in part, be achieved through the establishment of the KP Advisory Committee described earlier.

4.5.3 Improving Integration of Health Systems Interventions

In COP 2019, PEPFAR/T will continue to collaborate and coordinate with GOT to address key HRH gaps that stand as key barriers to fully implementing activities required for epidemic control. The investment and technical assistance to HRH has been targeted to improve the allocation and performance of service HCWs using both community and clinical site-specific service delivery data and alignment with GOT human resources processes for sustainability. Evidence-based approaches will be used to estimate the need for HRH support and the distribution there after based on performance.

For Laboratory services, PEPFAR/T will maintain certification and accreditation standards of 10 laboratories to meet the required operational standards while continuing to mentor 41 laboratories towards ISO15189 accreditation. The program will continue to expand the HIV proficiency testing program to 100% HIV testing sites for continuous improved quality of HIV testing services. In addition, the program will support training and certification of testers at all high volume PEPFAR/T supported sites.

PEPFAR/T will continue to support viral load testing coverage to ensure that all eligible patients receive at least one VL. In collaboration with health care providers and implementing partners, PEPFAR/T will scale-up VL demand creation activities; improve sample tracking electronic system using QR codes; and reduce lab results turnaround time through remote login laboratory request and use of the EID for VL testing in hard to reach facilities mapped in collaboration with GOT. To ensure utilization of viral load results by health care providers, PEPFAR/T will continue to support the national laboratory information system by linking viral load laboratory data to the CTC3 database for timely return of viral load test results and improve patient management along the continuum of health care delivery. In addition, PEPFAR/T in collaboration with GOT will support use of the LabEQUIP tool to review and strengthen the sample (VL, EID and TB) transportation system, hub and spokes allocation, equipment placement and laboratory supply chain system. PEPFAR/T will also support scale-up use of LAM Assay for TB screening of HIV clients with advanced HIV disease.

4.5.4 Improving Quality and Efficiency of Service Delivery

In COP 2019, PEPFAR/T will focus on supporting accelerated progress on same-day ART initiation (<7 days), multi-month prescriptions and task-shifting to nurses across PEPFAR/T supported sites, with ambitious targets for saturation of these interventions. PEPFAR/T 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 geographic expansion where appropriate to ensure rapid uptake of identified best practices; and monitoring impact of various lay cadres and peer support mechanisms on linkage, adherence and retention. Additional focus will be moving from three-month to six-month prescriptions and dispensing nationwide for clients who have successfully completed two rounds of three month dispensing. The ministry has developed a TLD transition plan that outlines TLD procurements and distribution that will be carried out in three phases. Phase one facilities have already started dispensing TLD. The phase two facilities are those that have ongoing training of health care workers and distribution of commodities. By the end of June 2019, all health care facilities will have capacity to transition and initiate PLHIV on TLD.

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. Once passed, there will be immediate roll out of self-testing nationwide. This will be in alignment with the national accelerated HIV testing strategy that will be outlined across the country.

4.5.5 Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control

Above-site and non-service delivery activities at the site level are the foundation of the PEPFAR/T program to strengthen the GOTs ability and long-term capacity to manage HIV response and ensure sustainability of investment made. Critical above-site programmatic elements include data systems and real-time data utilization, HIV-related surveys and surveillance systems, supply chain, HRH and competency-based skills building and knowledge sharing to support high quality HIV service delivery, laboratory, governance and information systems. Advancing domestic resource mobilization and the total market approach will also ensure utilization of GOT resources for greater shared responsibility to sustain epidemic control. In this regard, PEPFAR/T COP 2019 activities have integrated and aligned key functions of the HIV program for institutionalization into existing government systems.

In COP 2019, PEPFAR/T will continue to collaborate with other stakeholders to support identification, monitoring and evaluation of above-site investments to make a strategic pivoted shift in accordance with PEPFAR priorities to ensure the country is moving toward reaching epidemic control. Above-site level activities are mapped to key barriers through measurable indicators and linked to site level (service & non-service delivery) activities, and deliverables. This is reviewed using documented outcomes from implementation of COP18, Table 6, Sustainability Index and Dashboard (SID) results, MER, SIMS and other contextual information.

PEPFAR/T will continue to 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 and various stakeholders will review the same disaggregated cascade analyses and agree on joint solutions to reach the UNAIDS Fast-Track Goals while realizing additional budget efficiencies

PEPFAR/T historically uses a monitoring & evaluation tool/matrix known as Table 6 that identifies key barriers, above-site program areas, activities and links them to specific indicators and benchmarks (short, intermediate and long term). PEPFAR/T will make assessments for continued investments at the site and above-site, based on data from the current national level of ARV coverage, across age, sex and risk groups, as described in various sections of the document including section 6.

In addition, PEPFAR/T and the GOT are prioritizing health system interventions to better track clients across services, across sites and over time. This will ensure that people receive the services needed to stay healthy, and it will also facilitate accurate measurement of retention. PEPFAR/T and the GOT are working together to implement and take to scale a comprehensive unique identification strategy. The strategy includes a National Health Identification Standard (NHIS) and a new HTS register with improved identification fields aligned with NHIS. In addition, the strategy includes an immediate scale-up of biometrics in HIV C&T sites covering 80% of TX_CURR, and a National Health Client Register to support probabilistic matching of clients.

Finally, PEPFAR/T will continue to work collaboratively with MOHCDGEC and PORALG through the existing GOT platforms to ensure COP 2019 implementation reflects all relevant policies and guidelines regarding HIV/AIDS programming. Specific policy developments that support implementation include community outreach ART, completion of transition to TLD, differentiated service delivery including 6 month MMS, nurse-initiated management of ART, HIV case based surveillance (CBS), TPT for all PLHIV, completion of VL/EID optimization and deployment for community health workers for a task sharing policy. In addition, PEPFAR/T will continue to support GOT to adopt newer pediatric formulations of ARVs to improve clinical outcomes, scale-up of index and HIV self-testing and include HIV recency surveillance as part of routine program activities.

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 FY20) <i>HTS_TST</i>	Newly Identified Positive (APR FY20) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY20) <i>TX_NEW</i>
Total Men	1,279,731	121,173	115,357
Total Women	2,407,534	136,828	130,260
Total Children (<15)	497,444	13,598	12,946
Total from Index Testing	528,160	103,812	98,829
Adults			
TB Patients	54,633	4,805	4,565
Pregnant Women	946,037	21,004	19,954
VMMC clients	NA	NA	NA
Key populations	131,389	15,407	14,668
Priority Populations	184,304	3,502	3,334
Other Testing	1,493,519	99,384	94,614
Previously diagnosed and/or in care	NA	NA	NA

Pediatrics (<15)			
HIV Exposed Infants	68,139	1,610	1,530
Other pediatric testing	497,444	13,598	12,946
Previously diagnosed and/or in care	NA	NA	NA

Standard Table 4.6.2

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Councils					
SNU	Size estimate (10-29yrs)	Target -VMMC_CIRC (10-29yrs, FY 2019)	Current coverage (end of FY 2019) using National average	Target - VMMC_CIRC (FY 2020); 10-29yrs	Expected Coverage (in FY20) using National average
_Military Tanzania	-	15,021		15,021	
Biharamulo DC	68,562	18,645	85%	4,957	78%
Buchosa DC	-	-	-	12,496	79%
Bukoba DC	65,529	687	79%	10,777	78%
Bukombe DC	52,355	4,901	109%	3,702	78%
Bunda DC	-	-	-	13,634	100%
Chato DC	81,618	9,279	82%	6,347	78%
Geita DC	137,264	43,861	38%	21,156	78%
Geita TC	49,949	6,552	182%	8,462	78%
Igunga DC	89,818	4,655	96%	7,100	78%
Ileje DC	29,181	1,929	75%	5,851	78%
Iramba DC	51,814	14,295	39%	5,957	78%
Iringa DC	-	-	-	2,597	100%
Itilima DC	65,302	21,882	77%	8,399	78%
Kalambo DC	44,949	8,479	83%	8,490	78%
Kaliua DC	87,829	4,901	79%	9,532	78%
Karagwe DC	77,807	7,476	85%	5,073	78%
Kilolo DC	50,179	1,675	110%	3,436	78%
Kilombero DC	73,062	24,229	23%	20,246	78%
Kilosa DC	-	-	-	12,411	100%
Kwimba DC	85,680	2,689	88%	13,270	78%
Kyela DC	53,109	3,732	94%	6,193	78%
Kyerwa DC	72,451	24,449	53%	9,108	78%
Ludewa DC	30,744	1,886	123%	2,557	78%

Magu DC	65,395	2,661	104%	12,310	78%
Makambako TC	24,886	2,387	75%	2,432	78%
Makete DC	22,911	1,229	115%	1,523	78%
Mbarali DC	70,089	4,203	76%	13,203	78%
Mbinga DC	53,100	1,257	2%	41,683	95%
Mbogwe DC	43,044	14,052	99%	5,289	78%
Mbozi DC	106,688	6,772	78%	8,995	78%
Meatu DC	67,390	16,220	71%	7,517	78%
Missenyi DC	47,506	5,592	67%	7,198	78%
Misungwi DC	75,491	4,070	85%	11,533	78%
Momba DC	-	-	-	5,000	100%
Morogoro DC	-	-	-	12,457	100%
Mpanda MC	39,351	7,982	75%	5,342	78%
Msalala DC	55,445	17,805	35%	21,543	78%
Mufindi DC	57,161	626	129%	3,177	78%
Muleba DC	124,397	9,770	102%	7,395	78%
Musoma DC	47,120	10,530	26%	13,633	78%
Mvomero DC	71,611	18,772	26%	10,057	78%
Namtumbo DC	45,407	27,078	60%	10,813	78%
Ngara DC	70,377	26,962	83%	8,266	78%
Njombe DC	19,885	4,901	232%	3,500	78%
Nkasi DC	62,850	1,827	87%	12,064	78%
Nzega DC	96,796	3,042	97%	7,178	78%
Rungwe DC	55,713	9,632	79%	8,096	78%
Sengerema DC	73,220	4,225	92%	6,842	78%
Shinyanga DC	72,389	3,219	82%	12,562	78%
Shinyanga MC	43,980	582	83%	7,705	78%
Songea DC	-	-	-	12,822	100%

Songwe DC	-	-	-	5,000	78%
Sumbawanga MC	53,918	990	83%	11,896	78%
Tunduma TC	34,915	922	75%	8,873	78%
Tunduru DC	67,677	28,738	40%	13,740	78%
Ukerewe DC	78,134	11,518	78%	4,000	78%
Ulanga DC	-	-	-	15,032	100%
Urambo DC	44,218	1,351	102%	3,063	78%
Ushetu DC	59,224	10,642	20%	40,964	78%
Uvinza DC	-	-	-	10,302	100%
Uyui DC	85,966	4,446	81%	8,940	78%
Wanging'ombe DC	37,678	3,133	96%	5,277	78%
TOTAL	3,241,134	488,359		623,994	

Standard Table 4.6.3

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
PP_PREV	2,652,792	AGYW (15-19) 25% AGYW (20-24) 45%	529,288
KP_PREV	258,321	KP (FSW 95%; MSM 80%; PWID 90%)	157,645
KP_MAT	8,504	65%	5,505
TOTAL	2,919,617		694,368

Standard Table 4.6.4

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY20 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)
_Military Tanzania	-	315	315
Arusha CC	19,437	7,000	7,000
Arusha DC	6,822	2,756	2,756
Buchosa DC	-	11,029	11,029
Bukoba DC	15,758	5,224	5,224
Bukombe DC	17,566	2,323	2,323
Bunda DC	9,117	3,469	3,469
Busega DC	13,077	286	286
Chalinze DC	-	3,849	3,849
Chato DC	29,071	1,982	1,982
Chunya DC	21,283	5,356	5,356
Dodoma MC	11,264	8,857	8,857
Geita DC	62,558	25,249	25,249
Igunga DC	34,471	9,925	9,925
Ilala MC	81,094	30,755	30,755
Ilemela MC	18,313	5,215	5,215
Iramba DC	6,671	1,561	1,561
Iringa DC	20,198	7,012	7,012
Iringa MC	16,202	10,199	10,199
Kahama TC	19,902	29,066	29,066

Kaliua DC	34,221	2,308	2,308
Karagwe DC	18,259	3,068	3,068
Kibaha TC	4,846	4,429	4,429
Kigamboni MC	-	1,667	1,667
Kigoma Ujiji MC	16,715	4,756	4,756
Kilolo DC	17,032	7,317	7,317
Kilombero DC	13,671	3,567	3,567
Kilosa DC	15,669	1,458	1,458
Kinondoni MC	110,777	23,378	23,378
Kishapu DC	22,029	1,896	1,896
Kwimba DC	33,217	2,474	2,474
Kyela DC	15,529	27,369	27,369
Ludewa DC	14,999	3,201	3,201
Mafinga TC	5,570	452	452
Magu DC	23,614	1,975	1,975
Makambako TC	11,397	554	554
Makete DC	9,821	4,540	4,540
Masasi DC	3,494	1,036	1,036
Maswa DC	22,568	1,978	1,978
Mbarali DC	22,189	8,862	8,862
Mbeya CC	36,182	50,129	50,129
Mbeya DC	21,346	9,738	9,738
Mbinga DC	20,045	13,662	13,662
Mbinga TC	-	537	537
Mbozi DC	32,000	15,734	15,734
Missenyi DC	10,708	1,790	1,790
Misungwi DC	28,346	2,331	2,331

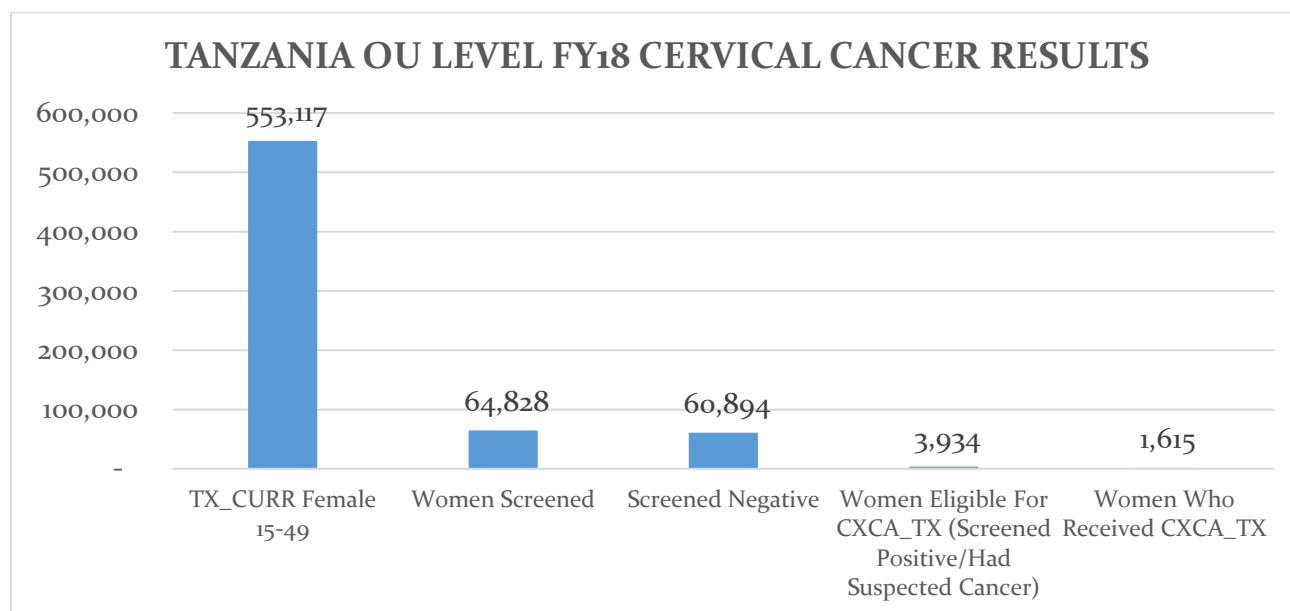
Mjini	367	337	337
Mkuranga DC	8,467	6,781	6,781
Momba DC	14,218	1,041	1,041
Morogoro MC	14,017	13,141	13,141
Moshi DC	17,826	14,432	14,432
Mpanda MC	-	2,565	2,565
Msalala DC	-	33,894	33,894
Mufindi DC	21,656	6,836	6,836
Muleba DC	29,833	53,919	53,919
Mvomero DC	10,232	1,628	1,628
Njombe DC	9,597	5,546	5,546
Njombe TC	14,672	5,553	5,553
Nkasi DC	11,267	2,834	2,834
Nyamagana MC	19,148	11,466	11,466
Nzega DC	42,487	13,000	13,000
Rorya DC	6,355	2,733	2,733
Rungwe DC	22,033	6,806	6,806
Sengerema DC	52,550	14,363	14,363
Shinyanga DC	27,269	43,764	43,764
Shinyanga MC	13,485	21,877	21,877
Songea DC	9,503	3,403	3,403
Songea MC	19,871	8,054	8,054
Songwe DC	-	1,835	1,835
Sumbawanga DC	11,709	10,285	10,285
Sumbawanga MC	8,311	6,302	6,302
Tabora MC	20,449	17,881	17,881
Tanga CC	18,991	5,363	5,363

Temeke MC	93,214	32,612	32,612
Tunduma TC	10,003	1,473	1,473
Tunduru DC	16,238	1,385	1,385
Ubungo MC	-	25,262	25,262
Ushetu DC	-	39,730	39,730
Uvinza DC	13,100	639	639
Uyui DC	34,589	2,644	2,644
Wanging'ombe DC	17,512	3,467	3,467
Grand Total	1,576,017	794,485	794,485

4.7 Cervical Cancer Program Plans

In FY2018, 321 sites offered cervical cancer screening and treatment services. 64,828 eligible women living with HIV aged 15-49 (11.7%) were screened (See Figure 4.7).

Figure 4.7



In COP 2019 it is expected that 50% of the eligible clients will be screened in facilities that contribute to 80% of clients currently on treatment. To achieve this goal all clinical partners will integrate cervical cancer screening for HIV+ women into routine HIV treatment services. A “screen-and-treat” approach will be implemented for the management of precancerous lesions to maximize opportunities for immediate cryotherapy. PEPFAR/T IPs will implement visual

inspection tests with 5% acetic acid (VIA) as a single-visit 'point-of-care' clinical screening test for early detection of cervical cancer and clients will be managed using cryotherapy and excisional treatment approaches such as LEEP. Women with suspected invasive cervical cancer will be supported for referrals or additional evaluation and treatment at established referral sites in the country. In addition PEPFAR/T IPs will also focus on capacity building among HCW in screening and treatment of cervical cancer. The Tanzanian National guideline advocates for screening for all eligible women for cervical cancer regardless of their HIV status. PEPFAR/T will provide clear instructions to IPs to focus their efforts only on women living with HIV.

4.8 Viral Load and Early Infant Diagnosis Optimization

Currently, there are 20 VL/EID testing laboratories and specimen collection and transportation is done through the hub and spoke system. Viral load capacity is now adequate to meet the needs of the country. Viral load coverage increased from 6% in FY 2016 to over 75% in FY 2018. All health facilities (spokes) have been mapped to a total of 309 hubs. PEPFAR/T will continue to support optimization of laboratory VL and EID testing services including improvement on specimen transport and results return system; testing machines acquisition and placement; commodities and supply chain management.

In collaboration with MOH, PEPFAR/T will monitor utilization of Point of Care Testing (POCT) for Viral Load, EID and TB testing in hard to reach councils and priority population. The POCT equipment will be placed strategically to complement conventional platforms in order to ensure reduction in turn-around time (TAT) for VL/EID and TB results leading to timely patient management.

PEPRAR/T will also continue to ensure that clients with high VL results receive adherence counseling, offered a second VL test, and appropriate action thereafter implemented as per the national VL testing algorithm. Technical assistance will be provided to Support and improve Laboratory information system (LIS), electronic sample referral system, and dashboard for VL, EID and TB, specifically, use of QR code technology to improve facilitate linkage of VL/EID lab results with patient-level CTC₃ database.

In COP 2019, Funds budgeted in the FAST for commodity procurement includes \$26,868,340 for procurement of VL reagents and \$3,319,062 for procurement of EID reagents.

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

5.1 COP 2019 Programmatic Priorities

Attained councils are geographic areas that have achieved $\geq 90\%$ 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 FY2020 will ensure that the country gets to 95/95/95 overall. Sustained councils are districts that have a lesser HIV burden and where fewer than 20% of all PLHIV reside. In COP 2019, PEPFAR/T treatment targets in sustained councils will continue to maintain a passive growth of 2.5%. Many of the attained councils are municipal councils in urban areas. We believe that many of these councils only appear attained, because people from surrounding councils seek care in these municipal councils. In Mwanza, for example, over 1/3 of people seeking care in Nyamagana Municipal Council have an address of residence in a neighboring council. Regardless of that, prioritized strategies implemented in the attained SNU will be different from what is implemented in the scale-up SNUs.

PEPFAR/T calculated the expected volume of patients needing the standard package of services in these areas by council and overall (Table 5.2.1).

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 19	Expected result APR 20
HIV testing (all populations)	<i>HTS_TST</i>	425,217	413,213
HIV-positive (all populations)	<i>HTS_TST_POS</i>	15,663	26,244
Treatment new	<i>TX_NEW</i>	20,646	24,786
Current on ART	<i>TX_CURR</i>	180,395	195,659
OVC*	<i>OVC_SERV</i>	170,094	161,308
Key populations	<i>KP_PREV</i>	18,863	18,867

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		Expected result APR 19	Expected result APR 20
HIV testing in PMTCT sites	<i>PMTCT_STAT</i>	306,024	216,389
HTS (only sustained ART sites in FY17)	<i>HTS_TST/HTS_TST_POS</i>	1,235,691/20,593	580,192/33,897
Current on ART	<i>TX_CURR</i>	192,711	269,624
OVC	<i>OVC_SERV</i>	7571	5,995

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

It is important to note that the 11 attained SNUs are all in densely populated urban areas, where HIV prevalence is higher, lack of knowledge of HIV status is common, and viral suppression is low (THIS, 2016-2017). 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. Recognizing that transmission of HIV in these areas could impact a large number of people quickly, the PEPFAR/T will continue to prioritize efforts in urban areas. 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 with fidelity. 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 at the facility upon consultation. The standard national clinical service package will be provided for PLHIV; this will include routine clinic visits, and the ARV treatment and care package. Essential laboratory services will be provided for PLHIV in terms of viral load testing to increase coverage.

PEPFAR/T will streamline its focus on community-index testing to reach key and vulnerable populations who don't typically seek services at health facilities due to fear of persecution or stigma and discrimination. HIV-testing as a gateway to prevention, rather than case-finding, will continue among adolescent girls and young women and in PMTCT settings. This strategy will apply to both attained and sustained councils.

For Attained SNUs, PEPFAR/T will streamline its focus in surveillance, program monitoring, and laboratory systems. PEPFAR/T will continue to monitor clinical services and retention as well as viral load suppression and suspected treatment failure. PEPFAR/T will continue to support ongoing surveillance activities to monitor new and on-going HIV infection, Limited demand creation and HIV-negative prevention, and continue outreach, prevention, testing, clinical services for key populations, including recency testing.

6.o Program Support Necessary to Achieve Sustained Epidemic Control

6.o Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR/T Tanzania COP 2019 program shifts and systems investments are focused on ensuring rapid progress in finding PLHIV, effectively linking them to care and keeping them on life-saving anti-retroviral treatment with the goal of improving the health of Tanzanians, reducing HIV-related morbidity and mortality, and breaking the chain of HIV transmission (U=U) to achieve sustained epidemic control. This will require wise use of data to measure progress and to guide real-time adjustments to ensure that the right strategies implemented through effective utilization of health workforce supported by training, mentorship and quality-improvement focused communities of practice are reaching the right people in the right places at the right time.

COP 2019 systems investments will focus on **addressing key systems barriers** identified which include the following:

- Parallel data collection between PEPFAR/T and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels
- Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities
- Inefficient systems and resources for distribution of commodities under new policies
- Inadequate number of competent HRH to deliver quality health services at service delivery points in priority scale-up councils
- Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce
- Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services
- Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale-up ART optimization, EID, self-testing, community ART, TPT, DSM, MMS, and other key strategies across scale-up councils and to reach key populations
- Lack of strategic engagement with the private sector for achieving epidemic control and shortage of market segmentation/total market approach
- Inefficient use of resources and weak public financial management (PFM) systems that result in low execution rates and poor matching of payments to priority services
- Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control

PEPFAR/T COP 2019 systems investments are strategically focused to support accelerated progress toward achieving epidemic control and build on foundational building blocks of prior years of PEPFAR investments. They are focused on increasing impact; optimizing alignment of above-site activities and partner management with site level implementation and strategic priorities to ensure key policies rapidly reach patients and maximizing return on investment with a total budget decrease of 45% from COP 2018 to COP 2019 include almost \$5 million reduction in SREs. The support for further HRH investments in COP 2019 to assist Tanzania to achieve its

ambitious targets, will depend on the HRH needs in terms of priority site selection and present PEPFAR/T priorities, considering various categories such as, high volume sites, identified treatment gaps, areas with high loss to follow-up (LTFU) rates, inadequate VL coverage, support for increased optimized PITC coverage, etc. PEPFAR/T will continue to use the Health Care Worker (HCW) inventory, which includes HCWs whom play a critical role in supporting the Government’s HIV epidemic control efforts. PEPFAR/T has been collecting and analyzing data on HRH investments since 2014, to guide determination and decision making for possible additional HRH resources, including proper allocation of health professionals. As shown in the figure, this includes consideration of support for cadres types according to level of sites (national/central, regional, district, facility, community) and financial support (monetary versus non-monetary), geographic shift, which reflects the need for absorption of available and developed existing capacity (including CHWs), should PEPFAR transition away over time. The main aim of the inventory and dashboard is to support robust stocktaking and analysis of investments in HRH staffing that can be utilized for PEPFAR/T performance monitoring, program planning, and reporting.

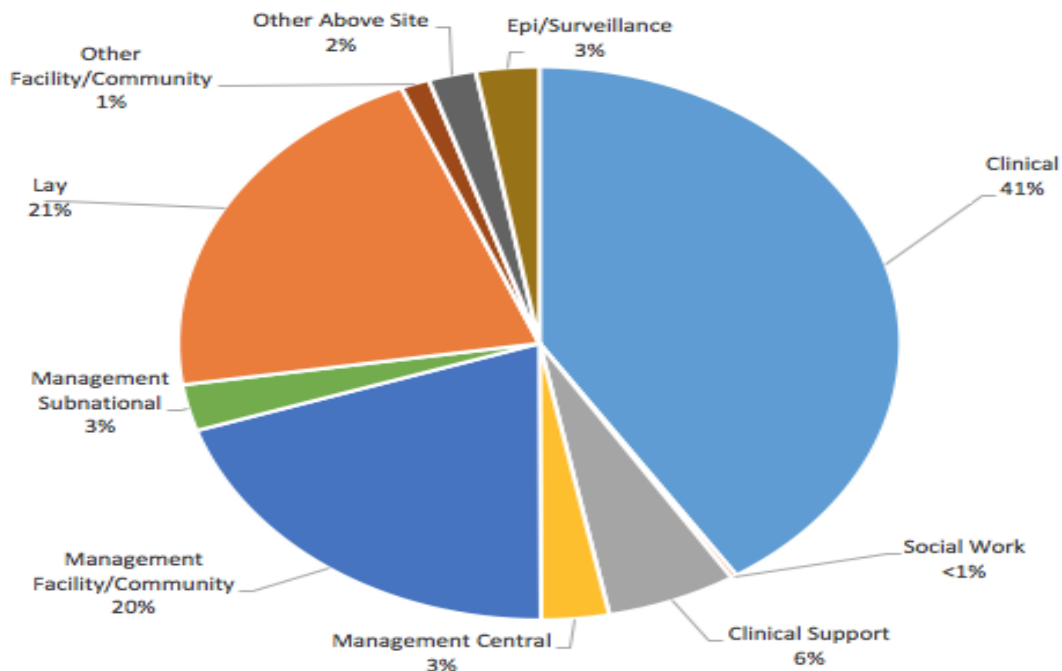


Figure 6.o PEPFAR Support- Health Workforce by Cadre Type, 2018

PEPFAR/T will also consider conducting a modeling and analysis of workforce requirements for maintenance of HIV services, to better determine the needs and any existing skill gaps. PEPFAR/T does not have a breakdown of cadres for COP 2017, because this data was collected retrospectively (kindly refer to the Table). Therefore, comparisons are extrapolated with figures from COP 2016 to date, of which there have no assigned targets, hence gaps cannot be determined. The HRH projections for COP 2019 as with previous COP planning, may shift depending on the actual needs identified by PEPFAR/T, implementing partners and NACP. The table below highlights the proposed projections in PEPFAR/T support for HRH by cadre.

Number of PEPFAR Supported Staff by HRH Category from COP 2016 to COP 2019

HRH Category	Number of Staff		
	COP 2016	COP 2018	COP 2019
Clinical Service Care Provider (clinical sites) including Lab	2,474	6,836	6405
Community Health Worker	4,561	17,851	9039
Managerial and Support Staff (non-clinical, clinical service sites)	1,099	1,209	846
Managerial and Support Staff (non-clinical, government sites)	89	98	110
Total	8,223	25,914	16,400

6.1 Information Systems and Data Use

PEPFAR/T has worked in unison with the Government of Tanzania to build, scale and support effective health information systems to increase data quality, the patient experience and provider effectiveness and to strengthen data utilization for public health action.

Access to real-time, accurate information about key aspects of program performance is essential to making the rapid progress necessary for Tanzania to achieve epidemic control. Additionally, appropriate information systems improve patient-level care and provider productivity and satisfaction. For these reasons, sustainable information systems for quality data use are critical areas of above-site investment for PEPFAR/T.

The table below highlights priority examples from COP 2019 Table 6 HIS above-site investments. It includes the barrier identified, key selected activities and benchmarks, and the status of achievements to date.

Table 6.1

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
<p>Data Alignment Parallel data collection impedes ability for PEPFAR and GOT to jointly analyze and use timely and accurate data to inform HIV program decisions and policy actions at national and subnational levels</p>	<p>GOT and PEPFAR agreement on data alignment vision, methods and data access and use.</p> <p>HIV Detailed report created in DHIS to strengthen coverage of PEPFAR indicators and disaggregates by extracting data from CTC3. PEPFAR Partner form created in DHIS and filled with PEPFAR Monthly data. USG accounts created for GOT DHIS2 access.</p>	<p>Activities Technical assistance and system development support for evolution of GOT DHIS to meet HIV reporting requirements, data alignment vision including automated HFR synch and DATIM data upload.</p> <p>Benchmark(s) 75% of all PEPFAR monitoring data sourced directly from GOT HMIS or CTC3/SHR dashboard by Sept 2020. All PEPFAR monthly and quarterly</p>

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
		reporting sourced directly from GOT HMIS by 2021.
<p>Client level data systems Tanzania HIV program requires client data systems that provide individual-level deduplicated information on a national cohort of diagnosed PLHIV throughout the course of infection to monitor epidemic trends, determinants of infection, and programmatic impact.</p>	<p>Dec 2017 = >75% treatment, 5% of positive identified within NACP Patient Monitoring System (PMS)</p> <p>Dec 2018 = >90% treatment, 11 % positives identified within NACP PMS for 2019 Q1.</p> <p>FASTA TZ remote check in pilot launched in August 2018, integration with CTC2/3 pending.</p> <p>Lab system integration with CTC3 ongoing.</p>	<p>Activities Evolution of client-level data systems according to data and service requirements.</p> <p>Benchmark(s) 40% of HIV-positive identified and 90% of treatment clients tracked and supported within client level electronic systems by September 2019. 50% and 95% respectively by September 2020. Unified solution in place and used by 200 high volume sites by Sept 2020</p> <p>30% coverage for SMS IEC or automated appointment reminders, and 20% of eligible clients using FASTA TZ for remote check in by Sept 2020</p> <p>Sample Referral System and CTC2/3 linked to track sample and return viral load results to facilities.</p>
<p>Connected and Harmonized Systems To address HIV data system requirements digital health systems need to be appropriately linked and compatible according to a national enterprise architecture and standards through national registries.</p> <p>The purpose of registries is to allow data to link together by allowing people and systems to refer to same data in the same way.</p>	<p>CTC3 / SHR: CTC3 dashboard being updated to support priority data use cases. Stakeholder consultation and requirements elicitation for next generation Shared Health record are ongoing.</p> <p>National Health Client Register (NHCR): Requirements approved by GOT, Software partner selection ongoing.</p> <p>HFR successfully supporting common references for facility based information.</p> <p>GoTHOMIS and eLMIS exchanged data successfully via Muungano Gateway and HIM. R&R data from GOTHOMIS has been pushed to both MUUNGANO Gateway and HIM.</p>	<p>Activities PEPFAR will support for Client Register, CTC3 and Shared Health Record, Health Facility Registry, Health Information Mediator and multi sector Muungano Gateway (PORALG)</p> <p>Benchmark(s) CTC3 / SHR: 95% of TX_CURR and 50% of HTS_TST_POS client level records within CTC3 or SHR by Sept 2020.</p> <p>Client Register: 50% TX_CURR and 25% HTS_TST_POS linked to client register by Sept 2020.</p> <p>Interoperability between PORALG information mediator, Muungano Gateway, and MOHCDGEC HIM, and related interoperability between GoTHOMIS, eLMIS, HMIS, and NHIF claims management by 2020</p>

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
<p>Unique Identification Strategy “To facilitate a longitudinal record for the diagnosed case across the course of HIV disease, HIV recent infection results should be linked to a secure unique identifier with ability to link across multiple HIV services delivery points”. (COP guidance)</p>	<p>National Health Client Register requirements including National Health Identification Standard (NHIS) formally approved by GOT.</p> <p>Partners currently rolling out new HTS register with improved identification fields aligned with NHIS.</p> <p>Expedited Unique Identification Strategy developed by GOT and PEPFAR including plans to scale-up Biometrics to 756 Care and Treatment sites (covering 80% of TX_CURR) by September 2019 and targeted initiation of Biometrics and use of full range of GOT approved identifiers in HTS sites.</p>	<p>Activities Continue evolution of Client Register for probabilistic matching. Expand paper and electronic systems aligned with NHIS and linked to Client Register Expand use of Biometrics for TX_CURR and HTS_TST_POS.</p> <p>Benchmark(s) 90% of TX_CURR and 50% of HTS_TST_POS linked to Client Register by Sept 2020.</p>
<p>Monitoring Morbidity and Mortality Monitoring and reporting of morbidity and mortality outcomes including infectious and noninfectious morbidity. To effectively achieve and maintain epidemic control the health system requires immediate strengthening of HIV tracking systems for LTFU outcome monitoring and strengthening national death registration with links to national HIV M&E system.</p>	<p>New Death Registration system supporting decentralized death registration with multi-donor collaboration resulted in scale-up of new death registration system across all councils in Iringa. Within 6 months, the system has registered and certified more than two-thousand deaths increasing certification level to 32% for the region.</p> <p>Birth Registration system has helped to improve the overall certification rate in the 11 regions to more than 80% in 2018 from less than 10% in 2012.</p>	<p>Activities Support scale-up of Death registration through PEPFAR regional partners and continue national TA support for integrating Death registration with HIV Patient monitoring system through client register.</p> <p>Support data quality of HIMS aggregate reporting and HMIS death register.</p> <p>Monitoring of follow up and tracing of lost clients through CTC2 and CTC3 upgrades.</p> <p>Benchmark(s) 100% of all PEPFAR supported sites accurately reporting deaths to GOT HMIS Death Reporting Systems by APR 2020.</p> <p>Expand death registration system to at least two additional regions.</p>
<p>Surveillance and Surveys to inform program and policy implementation A comprehensive surveillance system of general population (case-based and recency), embedded into the national HIV EMR, and key populations (IBBS) will monitor known and new cases to inform HIV programming and outbreak responses.</p>	<p>Recency Testing is preparing for national panel validation as well as trainings for .ab and health care worker and procurement of test kits. GOT and PEPFAR working on scale-up of recency in one region.</p> <p>IBBS and KP size estimations are underway on Zanzibar and mainland and results will inform the national consensus meetings and report writing.</p> <p>Case-based surveillance will be embedded within the advancement of the client-level</p>	<p>Activities Agreement with GOT that recency will be scaled nationally as a routine activity starting in Oct 2019.</p> <p>IBBS and KP size estimation on Zanzibar and the mainland will inform population size as well as HIV and STI prevalence.</p> <p>Benchmark(s)</p>

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
	data systems including availability of data for sentinel events.	<p>Recency Testing scaled in all high burden sites in all regions (80% coverage of TX_curr by Sept 2020).</p> <p>IBBS and KP size estimation results disseminated along with a national consensus document of population estimates and HIV prevalence for Zanzibar and mainland.</p> <p>Case-based surveillance analysis of sentinel events and routine dissemination of client-level cascade analysis for all regions.</p>

6.1.1 Information Systems and Data Achievements to date

PEPFAR/T continues to support sustainable and streamlined solutions to build and strengthen health information systems that increase the quality of data use to inform programmatic decision-making and support quality service delivery. The program has made strides to reach Tanzania’s HIS vision in the past fiscal year.

The GOT and PEPFAR/T have worked jointly to agree on a strategic vision for data alignment, including methods and data access and use agreements to align PEPFAR/T and national data to eliminate parallel reporting and reduce discrepancy between reporting mechanisms. For example, the GOT has strengthened coverage of PEPFAR/T indicators within GOT DHIS2 by adding a monthly HIV detailed form that includes data extracted from CTC3. GOT DHIS also hosts a PEPFAR/T partner form for PEPFAR/T monthly reporting, and the GOT has created USG accounts for DHIS access. PEPFAR/T is also committed to transitioning its quarterly partner performance monitoring to utilize an analysis of CTC3 data. This data alignment framework enhances transparency and sustainability between PEPFAR/T and GOT, will have tangible impacts in the reduction of the human resources used for data entry and ensures all stakeholders are using the same data for joint decision making. Furthermore, activation of the EOC will provide an opportunity for joint monitoring on progress of roll out of key, strategic program activities at the 241 sites as well as the chance for GOT capacity building on data analysis and use.

Tanzania is rapidly moving towards case base surveillance with advancements within the NACP Patient Monitoring System (PMS), a national HIV client-level data system. Data availability within CTC3 has increased dramatically as it now captures data from over 2200 sites, covering greater than 90% treatment clients as of December 2018, up from 75% in December 2017. PEPFAR/T and GOT are currently integrating the Lab Information System with CTC3 and partners are scaling up use of Count Test to capture client level data so that PMS will cover the entire HIV cascade. In addition, phased implementation of HIV recency surveillance is planned to better inform transmission vectors and possible outbreak investigations. To ensure these efforts are successful and interoperable, PEPFAR/T and GOT have worked in unison to develop plans for HIS infrastructure, registries and support services, such as the Client Register, Health Facility

Register, Health Information Mediator, the multi-sectoral data gateway and Unified Solution Hospital Management System. These efforts support the national eHealth HIS framework.

Unique identification of client level data is essential for effective, national case base management. The GOT and PEPFAR/T have developed a Unique Identification Strategy. This includes an ongoing, intensive biometric scale-up in 756 C&T sites to capture 80% TX_CURR, targeted scale-up of biometrics within HTS services where a hospital management system is available, and the development National Health Client Register for probabilistic matching according to approved National Health Identification Standard. The recently updated HTS tool allows for multiple forms of identification, such as phone number, voter ID and birth registration ID. The implementation of the Unique Identification strategy is expected to strengthen capacity to uniquely identify across services, across sites and over time.

To effectively achieve and maintain epidemic control, it is imperative to strengthen morbidity and mortality reporting for accurate LTFU outcome monitoring and to inform programmatic efforts to reduce HIV-related mortality. PEPFAR/T will support strengthening of system support for LTFU tracking. Current multi-donor efforts have invested in a decentralized death registration system which is showing demonstrable progress in one region.

In September 2018, the GOT passed an amendment to its Statistics Act. This amendment requires organizations and individuals to publish data that is sanctioned by the Tanzania Government National Bureau of Statistics (NBS) only. Further, the Statistics Act makes it a criminal offence to publish false statistics “that may result in the distortion of facts” and (contrary to the provisions of the Act) whereby such person will be punishable by a minimum TZS 10 Million fine and a minimum of 3 years prison sentence or both. The USG has expressed its concern that this amendment impedes freedom of expression and violates international standards on dissemination and use of statistics, as well as the Tanzanian Constitution. PEPFAR/T is closely monitoring how this development may impact the quality and use of health data in Tanzania.

6.1.2 Information Systems and Data Priorities and COP 2019 Activities

PEPFAR/T, GOT and relevant IPs have ambitious and streamlined plans to align PEPFAR/T and GOT data, and functionalize the eHealth and Unique Identification Strategy to best track the HIV cascade.

By providing technical assistance and system development to support the evolution of DHIS and meet PEPFAR/T HIV reporting requirements, the data alignment vision dictates an automated HFR synchronization with DATIM data upload in order to source 75% of PEPFAR/T data from CTC/SHR dashboard by 2020. The goal is for all PEPFAR/T monthly and quarterly data to be sourced from GOT system by 2021.

PEPFAR/T will continue to strengthen the national Health Information System infrastructure for improved data use, exchange and management and delivery of services. COP 2019 will support scale-up of the following national registries and services: The client register (CR) to support linkage and deduplication of client data, the shared health record (SHR) to strengthen the capture of HIV and other medical record, and the customization of the health information mediator (HIM) and multi-sectoral Muugano gateway to support data exchange across systems. CTC2/3 will also be integrated with lab systems.

Case-based surveillance will serve to improve systematic reporting of newly diagnosed HIV cases and allow for subsequent reporting of sentinel events by leveraging existing systems including NACP Patient Monitoring System (PMS) and building on platforms that are aimed at bringing together health information systems components to support interoperability across service delivery and administrative units. This will include PEPFAR/T and GOT scaling up use of Unified Solution eHMS to be operational in 200 high volume sites by September 2020. Combined use of eHMS along with data capture from paper registers aligned with identification standard will allow GOT and PEPFAR/T in COP 2019 to scale-up of a client level electronic systems coverage to 95% of TX_CURR and 50% of HIV-positive clients identified. Unique identification is essential to make these client level data systems possible. As the client register grows, continuous probabilistic matching for deduplication will be strengthened through utilizing paper and electronic systems aligning with NHIS and available biometric identifiers.

PEPFAR/T will continue to use mobile technology for patient tracking and retention. Text message reminders to follow up clients and electronic self-triaging systems by integrating with CTC2/3 dependent upon patient consent will reach 30% coverage for PMTCT, HTS and treatment services. To continue to leverage the private sector, PEPFAR/T will expand the Health Public Private Partnership activity by transitioning management to the GOT and integrating Health initiatives throughout the broader HIS approach. This initiative, under the leadership of NACP, facilitates the implementation and expansion of Fast Track ARV refills (FASTA) schemes for differentiated service delivery models.

Immediate efforts to strengthen LTFU outcome monitoring and national death registration will continue in COP 2019. This includes plans to support the scale-up the new death registration system to at least two additional regions and continue national TA support for integrating death registration within HIV patient monitoring systems through the client register. Additional plans include strengthening use of CTC2/3 to track mortality and LTFU to assure 100% of PEPFAR/T supported sites are accurately reporting morbidity and mortality data to the GOT HMIS.

6.2 Human Resources for health

In COP 2019, PEPFAR/T HRH investments are strategically focused on addressing HRH gaps and barriers to ensure that the right health workforce has the required competencies to deliver services to support high quality HIV prevention interventions and treatment services to improve the health of PLHIV and to support accelerated progress toward achieving HIV epidemic control. PEPFAR/T will continue to support investments geared towards increasing the quantity (number) and quality (competence) of health care professional cadres, to ensure a standard and appropriate skill mix, in alignment with health facility levels and national staffing norms.

HRH investments will continue to contribute towards the overall PEPFAR/T HRH strategy consisting of 5 objectives namely: (1) consider HRH capacity and needs (2) Develop site level supply strategies (3) Improve site-level recruitment, deployment and retention (4) establish sustainable financing of HRH and (5) improve site level HRH performance; and will be focused on the following priorities:

- 1) Support efforts to increase number (through hiring- monitored by the annual HRH_CURR indicator) of health care professionals with the required competence (through collaborative learning approaches; in-service training using ECHO, e-learning models) to

provide quality of HIV services, while also ensuring the GOT commits to absorb the PEPFAR/T supported HCWs, as part of HRH sustainability approach

- 2) Support improved retention, deployment and redistribution of health care workers (facility and community level) and ensure proper allocation of HCWs, including skill mix determination (using evidence based HRH tools such as WISN-POA-WAO).
- 3) Strengthen professional development (through CPD considering their respective career paths, & working with professional associations and professional councils/regulatory bodies to reinforce, sustain investments and maintain quality of HIV services)
- 4) Support advocacy for increased budget allocation (HRH financing) according to needs and HRH data utilization (supportive evidence). Increase use of data for decision making (e.g. epidemiological pattern changes, THIS, KVP studies), demographic profile, policy shifts, infrastructure changes (increasing number of health facilities/new site providing HIV services), to fully utilize already developed and integrated capacity of HCWs. This will include reviewing the HRHIS to capture indicators that will support the design of a HRH cascade.

For COP 2019, the specific key barriers identified as contributing toward the gaps are highlighted in the table.

Table 6.2

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
<p>Inadequate number of competent HRH to deliver quality health services for index testing, MMS, test and start, TPT coverage, etc. at service delivery points in priority scale-up councils</p>	<p>About 11,304.5 FTEs supported by PEPFAR through both financial (salary & stipend) and non-financial support.</p> <p>Draft National Health Sector e-Continuing Professional Development (e-CPD) coordination framework developed</p> <p>Training modules for mid-level cadres to undertake task sharing roles developed</p>	<p>Activities</p> <p>Strengthen, expand social welfare workforce and monitor performance including transitioning of workforce to Local Government Authorities (LGAs) in 84 councils</p> <p>Provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSMs, focused on adolescent and pediatric outcomes.</p> <p>Benchmarks</p> <p>Proportion of HRH direct support aligned to priority HIV program and regional strategies developed for effective transitioning of HCW</p> <p>35 high volume sites implementing an efficiency change and 60 HCWs</p>

		self-reporting increased competence (from baseline) in key HIV areas
Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	<p>Simplified Workload Indicators and Staff Needs (WISN) and Prioritization and Optimization Analysis (POA) used to distribute 6,180 HCWs.</p> <p>National Health Sector HRH requirement and recruitment plan 2018-2023 developed</p>	<p>Activities Improve HRH deployment at the central level- POSPSM- using WISN-POA-WAO (Workforce Optimization Allocation)</p> <p>Strengthen performance management of health workforce and develop customized retention packages in 185 LGAs, to retain health workers</p> <p>Benchmark At least 85% of approved permits are filled (recruited) in scale-up councils, disaggregated by cadre, with at least 85% of health care providers who report (deployed) to their post in scale-up councils are retained for one year</p> <p>Integration with and utilization of WISN+POA+WAO in POSPSM and HRHIS systems</p>

6.2.1. Human Resources for Health Achievements to date

In FY18, PEPFAR/T supported 4,825 graduates from pre-service education institutes, as part of the strategy to improve the country needs, and about 11,304.5 FTEs through both financial (salary & stipend) and non-financial support.

The MOHCDGEC launched consultations to formalize the CHW cadre in February 2018, and by October 2018, the schemes of service was approved recognizing them as a formal cadre, to allow recruitment of CHWs officially starting December 1, 2018. In addition, during the Joint Annual Health Sector Review Policy meetings held in November 2018, among the commitments made between the GOT and DPs for 2019-2020, was to ensure increase in deployment, retention, recruitment of skilled health professionals, including CHWs/Health Assistant -community cadre (HAs-C). In COP 2019, further engagement will be made with the GOT to utilize and absorb various trained and existing community level cadres in ensuring continuum of HIV care, to facilitate linkages between the facility and community. This will include cadres identified through the task sharing policy, and other specific lay cadres such as CHWs, CDWs, CDOs, SWOs, HAs, VHW, HIV home-based care providers to support provision of counselling and testing services, including self-testing. This will also involve various local community level Primary Health Care Committees for organization and coordination purposes, such as the Health Facility Governing

Committee, Village and Ward Development Committees, to ensure transparency and accountability of investments made.

According to the MOHCDGEC FELTP Strategic Plan 2016 -2020, it is estimated that Tanzania requires 225 epidemiologists (1 per 200,000 populations). However most trained epidemiologists are located at the national level, leaving approximately 55% of required positions vacant. This gap contributes directly to the inability to effectively monitor and evaluate ongoing HIV/AIDS programs or detect other priority diseases. As of February 2019, the FELTP program has trained 339 health care workers in Field Epidemiology and Laboratory management that are located in multiple regions and districts within the country, responding to public health emergencies, building and evaluating surveillance systems. For COP 2019, the FELTP graduates and residents will assist with conducting/supporting monitoring and evaluation of progress towards HIV epidemic control through real-time data analysis for public health action, data quality improvement, and HIV surveillance based activities, as an immediate initiative that started in COP 2018.

In July 2018, PO-RALG used WISN+POA analysis tools to distribute 6,180 HCWs to all LGAs and mentored them to use evidence based analysis to allocate these health workers to health facilities. 21 out of 93 LGAs that were assessed demonstrated application of WISN+POA tools for allocation of HCWs by 80% - 100%. This approach has been adopted by GOT and in COP 2018, WISN + POA will be institutionalized into GOT systems. In COP 2019, PEPFAR/T plans to upgrade the IT platform for institutionalization of WISN + POA + WAO into interoperable GOT systems including HRHIS, DHIS. This will include integrating WISN+POA to the Planning and budgeting system (PlanRep) for matching HCWs with council resources. The goal of continued use of the HRH tools are to inform deployment at the central level- Presidents Office Public Service Management (POPSM), to determine HRH needs at the facility & LGA level and provide analytics of HRH need and supply in relation to available resources.

PEPFAR/T's strategy to address maldistribution and misallocation of existing health workers, is implemented through a coordinated approach that engages POPS, MoH, PO-RALG and MoFP. These strategies are also in response to specific HIV policy and program requirements, i.e. Test and Start, DSM, self-testing and surge needs related to unique site level monitoring in scale-up councils to meet key targets.

6.2.2. Human Resources for Health Priorities and COP 2019 Activities

Based on the current COP 2019 priorities and the status of key HSS benchmarks and outcomes, PEPFAR/T will continue to focus on host country institutional development for HRH leadership, governance and management through COP 2019 activities. PEPFAR/T will ensure that at least 75% of HCW are retained for 1 year using the information available in the HRHIS to monitor progress. For COP 2019, this will be done through continued technical support to GOT (MoHCDGEC & PoRALG). PEPFAR/T will support the MOH in increasing recruitment, retention and allocation of health and social welfare workers at all levels based on the HRH strategy, using various approaches and models such as NIMART, DSM.

To improve HRH retention rates, PEPFAR/T will employ a combination of methods to ensure a decrease in vacancy rates through the various components of the HRH cycle. Facilities will continue to modify retention plans using key HR metrics on attrition rates, staff turnover, and

absenteeism. In COP 2019, PEPFAR/T will build on the previous HRH inventories to address the chronic HRH shortage for HIV service delivery through a local partner initiative that identifies innovative and sustainable solutions to HRH recruitment, deployment and transition to GOT public service. In addition, for COP 2019, PEPFAR/T will strengthen performance management of health workforce and develop customized retention packages in 185 LGAs, to support test and start and acceleration of differentiated service delivery models, acceleration of TPT services.

COP 2019 will continue to support mid and lower-level cadres through translation of the task sharing policy into operational practice, including supervision and mentorship, induction trainings for tutors in zonal health resource centers. Monitoring of trained HCWs as identified in the task sharing policy will be done through the USG supported-Train SMART tool. PEPFAR/T will support the development of monitoring and evaluation tools to guide implementation of task sharing and ensure compliance and quality control. The monitoring framework will utilize success stories, best practices for shared learning and guide decision making among key stakeholders with regards to PEPFAR/T priorities. In addition, PEPFAR/T will continue to support lay cadres in provision of HTS under the task sharing policy implementation and NIMART. This will include expanded task descriptor analysis for potential expansion/intensification of HCWs roles and tasks (e.g. nurses, lay cadres) in key HIV areas, to ensure effective utilization of available HCWs in terms of time and task management. This will also include proper allocation of available expert clients required for BCPE scale-up with fidelity, LTFU response, with possible modification and alignment to remuneration and job descriptions. PEPFAR/T will support the continued utilization of the Tanzania Nursing and Midwives Information System and a full roll out of NIMART. The support in COP 2019 for HRH will be pivoted according to needs projected from COP 2018, to assist GOT to achieve its ambitious targets, where shifts will be focused on scale-up districts identified by implementing partners and NACP for each facility and community site during COP 2019 implementation.

In COP 2019, PEPFAR/T will continue to work with NACP and other development partners to further identify and align with the HRH priority areas taking into consideration epidemiological and geographic shifts. The residents and graduates of the FELTP will focus on PEPFAR/T technical issues, programmatic challenges and shifts, as well as concentrate on supporting data quality and surveillance based activities as well as supporting utilization of EOC for real-time data analysis for public health action. PEPFAR/T will support the scale-up of virtual communities of practice through the expansion of Project ECHO Tanzania and continue to build on the established Centre for Distance Education (CDE) e-learning platform and HIV module development to strengthen implementation of key strategies. This will allow acceleration in the scale-up of DSMs, test and start by ensuring standardized training support to clinical mentors and expanding access to virtual learning support at site level. In addition it will strengthen capacity of HCWs for effective data utilization to support evidence-based decision making for public health impact at all levels of health systems contributing to ensuring high quality HIV service delivery through on-the-job, competency-based tiered field epidemiology training.

6.3 Laboratory systems

The national health laboratory system in Tanzania operates as a six-tiered network of health laboratories. It is comprised of a National Health Laboratory (National Health Laboratory Quality Assurance and Training Center), 4 zonal referral laboratories, 4 specialized hospital laboratories, 27 regional level laboratories, 130 district level laboratories and 583 health centers. In all of these

laboratories, PEPFAR/T supports scale-up of HIV viral load (HVL) for routine monitoring and EID services that include access, uptake, results return, and documentation of final diagnosis, sample transport networks and results return system using a spoke and hub system to transport the samples from facilities to testing labs. PEPFAR/T supports expansion of rapid test continuous quality improvement (RTCQI), EQA program and accreditation.

PEPFAR/T provides support to enhance public health laboratory diagnostic capacities and laboratory optimization for delivery of efficient and effective laboratory services and strengthen the quality, accessibility and sustainability of laboratory services in Tanzania.

The key systems gaps identified through SID 3.0, MER, SIMS for Laboratory support were low viral load coverage as per target set, and the majority of VL testing laboratories not accredited to International Standards ISO 15189. However, strategies are in place to maintain scale-up of VL/EID coverage mostly for the pediatrics and adolescents.

The table below highlights specific examples from table 6 of key above-site investments in laboratory services, the epidemic control or systems barrier (MER/SIMS/SID).

Table 6.3

Epidemic Control Barrier	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
<p>Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services</p> <p>Low viral load coverage</p>	<p>7628(78%) HIV testing points are participating in the EQA/PT program nationwide</p> <p>National VL testing capacity is 2.5M, which is adequate to meet FY20 targets. There is increase of VL tests from 96,000 tests in 2016 to 738,139(62%) tests in Q1 2019.</p>	<p>Activities Provide nationwide Lab TA support to expand the national laboratory capacity to administer and manage PT/EQA program (for HIV rapid testing, recency testing, VL/EID, and TB) and continue to improve laboratory Information Systems and optimization of dashboard for VL, EID, and TB; Scale-up the sample transport and referral networks (including electronic Sample Tracking System) to improving results turnaround time</p> <p>Benchmark At least 90% of labs participate and pass EQA; and there are no EID/VL service interruptions</p> <p>All patients on ART eligible for VL testing received at least one VL test per year.</p>

<p>Inadequate number of competent HRH to deliver quality of laboratory services</p>	<p>194 non laboratory HCW trained on HIV rapid testing and 179 assessed for competency</p>	<p>Activities Provide nationwide Lab TA support to scale-up continuous quality improvement of HIV Rapid Testing, recency testing including competency assessment and certification of testers/testing facilities;</p> <p>Support MOH to establish equipment Support MOH to establish equipment calibration center at the National HIV Reference Laboratory (NHLQATC) and Biosafety/Biosecurity trainings to ensure accurate and reliable laboratory results and safety;</p> <p>Benchmark At least 90% of sites providing HRT services implement the RTCQI and HIV rapid test testers deemed competent and certified.</p> <p>One equipment calibration center at the National HIV Reference Laboratory (NHLQATC) and Biosafety/Biosecurity trainings school established to ensure accurate and reliable laboratory results and safety;</p>
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6.3.1 Laboratory systems priorities and COP 2019 Activities

PEPFAR/T will focus on addressing the COP 2019 identified gaps to increase Viral Load (VL) coverage and quality of testing. This will be done through elimination of barriers that hinder scale-up of VL coverage and timely return of results for patient care, accreditation of Viral load testing laboratories to international standards ISO 15189, continue to improve laboratory Information Systems and optimization of dashboard for VL, EID, and TB and scale-up continuous quality improvement of HIV Rapid Testing.

6.4 Policies and Governance

Policies that are critical to reaching the country’s targets include those related to HIV self-testing and PrEP DSM, same day ART initiation and multi-month scripting of ART. Strategies alone, even the right ones, are not sufficient for success. Those strategies must be built on a solid foundation of political will and an enabling policy environment. Same-day ART initiation has

been scaled-up well, with over 90% of people starting ART in <7 days. On the other hand, multi-month scripting scale-up was only recently begun, with just over 30% of PLHIV receiving scripts of at least 3 months as of December 2018. Self-testing is not permissible under Tanzania's current HIV law, and the amendment of the law has been delayed. Finally, there has been systematic resistance to optimizing pediatric HIV regimens, which would improve viral suppression among children and adolescents.

6.4.1 Policies and Governance achievements to date

Following the release of the THIS 2016-2017, PEPFAR/T has supported GOT efforts to adopt new policies to increase identification, linkage, and retention. PEPFAR/T worked closely with the GOT to provide additional findings to support policy development and engagement with other stakeholders to develop a policy implementation plan. Test and Start has been approved and implementation started, Index Testing is being scaled up with a focus on fidelity with monthly monitoring implemented to track progress and implementation of 6 months multi-month scripting has been approved with 3 month dispensing. In addition, NIMART guidelines have been approved, trainings have been conducted and tracking of impact on initiation has been put in place. The GOT is moving forward with a plan to train and enlist lay cadres to support HIV testing activities. The eHealth Strategy and Digital Health Investment Roadmap documents have developed a GOT planned approach to establish a national health client register to support unique identification of clients across services and sites including the use of biometrics. Variables aligned with GOT standards have been incorporated into revised HTS registers and unique identification strategy including the use of biometrics has also been included in draft national case based surveillance guidelines. Throughout these policy processes the GOT has demonstrated an increased political will to promote client centered care. After the HIV law revision, self-testing is expected to roll out nationwide. Six-month dispensing will roll out for clients who have successfully completed two-rounds of three-month dispensing. PrEP will be moved from implementation under local MOH protocol to immediate scale-up and testing will be conducted in line with GOT policy and focused to targeted population.

6.4.2 Policies and Governance priorities in reaching and Sustaining Epidemic Control

Over the past 3 years, there has been policy development to support priorities that will lead to sustaining epidemic control. However, most recently (late 2017- 2018) there have been protracted decision making processes and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale-up ART optimization, EID, self-testing, community ART, TPT, DSM, MMS, index testing, and other key strategies across scale-up councils. PEPFAR/T has been working closely with the GOT to build on recent momentum in policy progress and articulate stronger commitments to implement policies in all service delivery sites. The USG will continue to hold regular meetings with senior Ministry of Health Officials to track progress in policy commitment, development and implementation, along with other key epidemic control priorities identified in COP 2019 guidance and program data, and on a quarterly basis will engage with MoH leadership (including the Deputy Minister of Health and the Minister of Health) to identify any challenges for action. In COP 2019, PEPFAR/T has revised the strategy in this area and will support national and sub-national structures including the RHMTs and CHMTs in translating policy guidelines into annual operational plans and provide continuous monitoring support for effective implementation.

In COP 2019 PEPFAR/T will provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSMs including, Test and Start, same day initiation, and 6 month dispensing in selected regions with 3 months dispensing countrywide. We will continue to strengthen capacity of the National PMTCT team to monitor eMTCT progress using new M&E systems and create a system that enables utilization of service level data in a real time to inform policy recommendations and resource prioritization at National and Sub-national.

Clinical HIV service delivery and M&E tools and approaches will be standardized for rapid cascading translation of policy into practice and support to MOH to develop guidance for increased access to HIV Self Testing such as use of automatic dispensers/vending machines in key hotspots and community locations.

For women, adolescent and pediatric care PEPFAR/T will support oversight and monitoring of rollout of the transition to DTG in women of reproductive age and adolescents, scale-up adolescent psychosocial support services and specialized services for pediatric and adolescent PLHIV. In addition, we will develop guidelines and SOPs for the rollout of pediatric ARV optimization, including support to strengthen and monitor clinical services for CLHIV using QI approaches and real-time data monitoring for programmatic action.

6.5 Financing

The ultimate goal of PEPFAR/ T's systems investment in finance is for Tanzania to support sustainable financing for epidemic control. Tanzania scored poorly in its sustainability profile in PEPFAR/T SID 3.0 because of challenges to ensure sufficient resources are committed and allocated to meet the HIV disease burden. Notable progress has been made as a result of PEPFAR/T investments. The national budget of Tanzania now includes funding for HIV/AIDS and increased avenues have been developed for public participation in budget formulation. PEPFAR support has strengthened public financial management and health facilities and local government authorities have increased transparency in budget planning and budget execution. There are enduring systemic weaknesses related to fiscal space- limited resource commitment and allocations for HIV from the Total Government Expenditure, and inefficiencies in the use of existing resources. In COP 2019, PEPFAR/T will target interventions that address insufficient domestic resource mobilization, poor technical and allocative efficiencies and weak insurance payment structures that contribute to inequities in service delivery.

The table below describes the key identified systems barriers related, results from the previous year's investments and some of the key activities planned for the future.

Table 6.5 Systems Barrier related to Financing

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control	PEPFAR through support to key IPs and local CSOs including the SIKIKA group, NACOPHA supported critical budget analytical and advocacy work in the country. As a result of these efforts- the	<p>Activities</p> <p>Support implementation of key components of the national health insurance</p>

	<p>GOT made the first-ever allocation for the purchase of antiretroviral drugs in FY 2016/17 of US\$4.6 million; and another US\$4.5 million was made in FY 2017/18</p> <p>GOT contribution for Medical Stores Department (MSD) has steadily increased over the past 3 years. Allocations have increased to the current level of TSH 272 Billion- which is the largest budget line item in the GOT Health Sector budget- primarily to cover the MSD debt and the in country distribution costs for PEPFAR donated products</p> <p>PEPFAR supported activities related to the national launch of the improved Community Health Fund (iCHF) – which will be an additional source of revenue for health. National training for ICHF implementation conducted through cascade trainings that focused on enrolment processes, patient management and provider payment methods; and linking insurance data systems with other data management systems.</p>	<p>strategy- in particular the iCHF program roll out - that offers essential benefit package to include key HIV/AIDS services.</p> <p>Increase domestic resources for HIV through the national insurance schemes by providing technical assistance to NHIF, in anticipation of the passing of the Single National Health Insurance bill</p> <p>Benchmarks Proportion of regions that implement improved insurance schemes to generate additional revenue for priority HIV services</p>
<p>Inefficient use of resources and weak public financial management (PFM) systems that result in low execution rates and poor matching of payments to priority services</p>	<p>Strengthened LGA and facility level planning, budgeting, accounting, and reporting which led to increased efficiency and accountability in resource management for quality HIV service delivery.</p> <p>PlanRep,- the GOT'S web-based tool for planning and budgeting, has been launched nationwide. Council level plans and budgets are done in accordance with the budget guidelines and ceilings issued by Ministry of Finance and Planning (MOFP). These practices are fundamental to PFM practices- which in turns increases efficiency in use of public resources.</p>	<p>Activities Increase efficient use of resources at the local level for HIV service delivery, through improved management of Direct Health Facility Financing and support for on time disbursements of resources from Ministry of Finance</p> <p>Improve efficient use of HIV resources by increasing budget execution levels of allocated HIV resources within the GOT national budget</p> <p>Benchmarks Percentage of approved budget transferred from national level to LGA Level</p>

6.5.1 Financing Achievements to date

PEPFAR/T's investments in public financial management over time has resulted in more efficient GOT systems for budgeting, disbursement, management and use of funds for HIV at all levels. The redesigned GOT planning system, PlanRep, includes service provider codes to track value for money and link expenditures to HIV service outputs. PEPFAR/T's support for the redesign and launch of PlanRep and the improved financial accounting and reporting systems (FFARS) led to improvements across all PEPFAR/T's scale up councils to develop, review and approve annual plans and monitor budgets through centralized and more efficient planning and financial systems. This improvement contributes to on-time report submissions and improved availability of quality budget information on HIV expenditures.

Technical assistance provided through PEPFAR/T resulted in a strategic purchasing agreement that shifted DFF for health basket fund from input-based to output-based payments. This achievement was the result of extensive dialogue between PEPFAR/T, the health basket fund donors in Tanzania and the Government of Tanzania. This reform increased the allocation of domestic funds for HIV services in council level health plans. It also improved the predictability and flow of funds from central to sub-national levels.

PEPFAR/T continues to lead strategic advocacy efforts among key stakeholders for supply chain targeted fund allocation in the GOT budget to mitigate challenges associated with ARV and commodity distribution.

6.5.2 Financing priorities and COP 2019 finance activities:

PEPFAR/T will continue to support and leverage the ongoing GOT financing reforms- including the Direct Health Facility Financing (DFF) to increase use of public finance for the HIV/AIDS response and also increase the efficient use of the existing resources. PEPFAR/T support over the past 3 years has contributed to small but incremental gains in GOT allocation to Health and HIV and has achieved improvements in public financial management, especially at the lower government levels – which is a key condition for the efficient use of public resources.

PEPFAR/T will continue support for the DFF- as a part of fiscal decentralization in the country - to refine DFF payments to the facilities and improve provider capacities to efficiently use these resources to deliver priority health and HIV services. Given the limited fiscal environment, PFM continues to be an area of focus for PEPFAR/T support- to address barriers that hamper HIV service delivery and improve overall efficiencies at the local council and facility level.

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.

PEPFAR/T will provide TA to the National Health Insurance Fund- as a purchaser for national health insurance. The ongoing work on the Single National health Insurance (SNHI) has made some strides with the expectation of the tabling of the SNHI before parliament during its session in April-June 2019. In addition- with the roll out of the improved Community Health Fund (insurance scheme for the informal sector)- PEPFAR/T will continue support to the regions and districts to ensure effective administration and management – and also expand coverage for People Living with HIV/AIDS (PLWHA).

6.6 Private Sector

Tanzania has an overall weak business environment due to increasing and constantly changing regulations. This negatively impacts the ability of the private sector to contribute to the HIV/AIDS epidemic. However, PEPFAR/T has supported small but focused activities that leverage private sector resources, expertise and networks to achieve epidemic control.

6.6.1 Private Sector Achievements to date

Some of the key private sector achievements over the previous years of investment are discussed below:

- *HIV Self-Testing Advocacy*: Two results are (a) TFDA, which has restricted registration of HIVSTKs in the country, has agreed to initiate registration of products by interested manufacturers while awaiting HIVST approval by Parliament and (b) the Office of PMTCT in MOHCDGEC is advocating internally for dispensing HIVSTKs through the vast Approved Drug Dispensing Outlets(ADDOS) network.
- *Condom Supply and TMA*: For a brief while socially marketed condoms are not available in the market place. At the time commercial suppliers reported a doubling of sales. This confirms studies that safe behavior, not price, is the determining factor for usage. This also reinforces growing acceptance by the GOT of the Total Market Approach.
- *HIV In-Service Training*: The GOT is disseminating an in-service clinical trainer curriculum, which was developed by the private health sector to upgrade and standardize HIV in-service and pre-service modules. GOT has initiated a process of empaneling health facilities as certified training sites.

Table 6.6 Systems barrier related to the Private Sector

Epidemic Control Barrier or Systems Gap Identified	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
Lack of strategic engagement of faith-based and private sector actors for achieving epidemic control and shortage of market segmentation/total market approach	<p>Established protocols and pilot self-testing and dispensing of Multi Month Prescriptions at ADDOs.</p> <p>Developed and implemented a total market approach TA to the public, non-profit, and commercial sectors for analyzing current and potential condom market segments and determining a national framework to expand commercial sector.</p> <p>In target LGAs increased channels and opportunities for private sector engagement regarding HIV services are both established and functional</p>	<p>Activities 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</p> <p>Support Total Market Approach of health products in the private sector</p> <p>Benchmarks Faith leaders and health facilities institute marketing strategies aimed</p>

		<p>at different socioeconomic status quintiles of target HIV and health populations</p> <p>Faith leaders and health facilities develop coordinated messaging that links faith community to faith-based facilities</p> <p>CSSC Faith-based secondary schools, health facilities, and their faith communities coordinate prevention of sexual violence programs</p>
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6.6.2 Private Sector Priorities and COP 2019 Activities

The SID 3.0 assessment revealed Tanzania has weak private sector engagement. PEPFAR/T will expand and leverage private sector resources for HIV response. PEPFAR/T will provide TA to private insurers that include HIV services within their benefits packages, these include: Jubilee Insurance; Resolution insurance; and AAR Insurance.

PEPFAR/T will advocate for increased empanelment of private providers who offer HIV services with the aim of extending affordable HIV/AIDS care insurance packages to customers who are able to pay for insurance. TA will be extended to private health insurers to improve their current HIV services coverage based on commercial costs of HIV basic commodities and services within private facilities. The expected outcome is for the NHIF and commercial insurers to increase the number of private providers empaneled to offer HIV services through complementary health insurance packages.

The lack of strategic engagement of the private health sector to achieve epidemic control will also be addressed through support to Christian Social Services Commission hospitals and schools as part of the FBO initiative. The highest tiers of Christian and Muslim leadership will guide local faith leaders and religious groups in creating demand for HIV services. Champions in the faith communities will then work with the CSSC healthcare network to reduce stigma, prevent gender-based violence, increase case findings among men and adolescents, and provide adherence support.

PEPFAR/T will continue to expand its total market approach and employ differentiated marketing and distribution strategies for condom distribution. 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, poor and hard to reach 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 rationalize the market for HIV prevention commodities is aligned with GOT's desire to mobilize domestic resources for increased self-reliance. PEPFAR/T will work with

GOT to increase uptake and utilization of condoms, achieve better targeting of public sector condoms towards populations of unmet need, install policies and guidelines that advocate for TMA and build the GOT’s stewardship capacity for the total market.

PEPFAR/T will revitalize employer/corporate engagement in HIV/AIDS by designing male centered approaches for innovative HIV messaging, testing ,enrollment, linkage and retention to care in collaboration with PEPFAR/T-funded IPs in priority areas outside of Dar as Salaam in male dominated industries such as transportation, minerals and mining, cement manufacturing, and fishing. These male-centered HIV service delivery models will increase collaboration between commercial firms and the more traditional PEPFAR/T-funded IPs and present innovative solutions that will contribute to targeted and focused testing and treatment programs for men.

PEPFAR/T will facilitate increased collaboration between government and non-state actors and the private sector. The more than 13,000 ADDOs, which are often the first source for medicines for populations in rural and underserved areas, can play a key role in dispensing of multi-month ARV prescriptions and providing assisted self-testing. The GOT’s Pharmacy Council, which is responsible for registering and supervising ADDOs, has been supportive of implementation research that will provide evidence for policy-makers for the increased role of ADDOs in providing HIV self-testing. The findings also will influence the revision of the national curriculum and training ADDO dispensers in counseling clients prior to self-testing. A change in GOT’s policy that would permit multi-month ARV dispensing and assisted self-testing at ADDOs would have immediate nationwide impact.

6.7 System Barrier 7: Supply Chain and Commodity Management

The availability and accessibility of life-saving commodities are the cornerstones of epidemic control and achieving the 95-95-95 goals. This is a major area of investment for PEPFAR/T, especially this year as the program implements the TLD transition and scale-up of pediatric ART 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.

Table 6.7

Epidemic Control Barrier	Current status (value from investment to date) (2018 Results)	Key selected activities and benchmarks (2019 Plans)
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<p>Inefficient systems and resources for distribution of commodities under new policy mandates e.g. TLD transition, DSM and test and start</p>	<p>New logistics system which incorporate TLD and other pediatric ARVs has been designed, SOPs drafted, training materials drafted, eLMIS reconfigured. Phase 1 roll out training started in November 2018 and will be completed in FY 2019.</p>	<p>Activities Support NACP and MSD to scale-up TLD regimen and move to optimal pediatrics ART</p> <p>Strengthen quantification processes to increase forecast accuracy and quantification adherence for all HIV commodities (ARVs, Lab Reagents etc.)</p> <p>Benchmarks Proportion of eligible patients transitioned into TLD</p>
<p>Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities</p>	<p>eLMIS integrated with DHIS2, MSD ERP, and GoTHOMIS-EMR with minimal loading in Health Information Mediator (HIM) in FY 2018</p>	<p>Activities Upgrade the electronic Logistics Management Information Systems (eLMIS) Open source to the latest version which includes capabilities to integrate with facility level data entry systems and links to HIM</p> <p>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)</p> <p>Benchmarks eLMIS information fully functional with the National Health Information Mediator (HIM)</p>

6.7.1 Supply Chain and Commodity Management Achievements to date

PEPFAR/T investments in supply chain capacity to date have resulted in improved efficiency and responsiveness. With support from PEPFAR, the GFATM and other stakeholders, Tanzania redesigned its supply chain system in FY 2018. The new design is now been implemented in Mwanza and Tabora zones, covering Mwanza, Simiyu, Shinyanga, Geita, Tabora and Kigoma regions, and will be rolled out in other regions in FY 2019. The new system will increase reporting frequency from quarterly to monthly. Similarly, deliveries to hospitals will increase from quarterly to monthly and health clinics and dispensaries will receive deliveries bi-monthly. Technical assistance and 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. Emphasis on having quality data has increased and gained interest within PO-RALG, and thus roll out of IMPACT to LGAs has been a success where Council and Regional Management Teams are oriented on understanding importance of quality data for

decision making the knowledge which is used to hold their facilities accountable. Roll out of IMPACT teams started in FY 2018 and will be completed in FY 2020.

6.7.2 Supply Chain and Commodities Management Priorities and COP 2019 Activities

PEPFAR/T team has developed specific measurable outcomes to address barriers associated with ARV and commodity management – including the TLD transition. 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, more 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.

Because TLD offers a pack size that lasts three months and six months, the transition to TLD provides an opportunity to expand multi-month prescribing for stable patients from two to three or six months. Availability of optimal regimens for pediatrics like Lopinavir/ ritonavir granules and tablets and DTG based regimens will ensure pediatric patients are getting more efficient regimens which will improve viral suppression. During COP 2019, barriers for TLD transition and transition to pediatric optimal ART regimens include the ability of global supply to meet demand for TLD and LPV/granules. PEPFAR/T is also working closely with stakeholders, including the GFATM, 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. 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.

As noted in section 4.4 on Commodities, a revised quantification is in progress to inform new requirements and, thus, procurement.

6.8 Surveillance, Research, and Evaluation (SRE)

In COP 2019, PEPFAR/T is proposing a total of three SREs (1 surveillance, 1 research, and 1 evaluation). The remainder of this section describes the SRE activities by agency; of which DOD proposes to implement two SREs (one evaluation and one research). CDC proposes to support implementation of one surveillance activity and USAID proposes none.

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. As per COP 2019 priorities on improving management of HIV advanced disease, this longitudinal assessment will help to understand the impact of co-morbidities on HIV outcomes over the long time. DOD will also conduct one research project 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. Viral suppression in adolescents is also a COP 2019 priority; thus, understanding facilitators and inhibitors to suppression is a key component of reaching epidemic control, and the study will be used to address systematic contributing factors to virologic failure in these age groups, through targeted interventions. 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 priorities of COP 2019.

CDC proposes one surveillance activity for COP 2019. The activity is completion of the *Bio-behavioral survey and size estimation among FSW, MSM, and PWID in mainland Tanzania* which will be initiated during COP18 implementation year. This surveillance activity is 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 2019 priorities to focus on key populations, and will improve and update Tanzania's data on KP, which is outdated. Currently, the GOT is using size estimations and HIV prevalence of key populations that were generated in 2012; further, the methodology used is not in line with the UNAIDS/WHO KP bio-behavioral guidelines for generation of population size estimates. The data will contribute to improve targeting to reach key populations and ensure sufficient programming per the number and HIV prevalence of KPs in the country.

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 2019. The team determined that the overall funding allocation by budget code and the budget code attribution by FTE are well-aligned.

There are currently 24 vacancies spread across three agencies (DOD: 2; USAID: 13; CDC: 9). Most of these are in the midst of the recruitment process, and it's expected that offers of employment will be extended during the 2019 calendar year. Some of these vacancies have been slow to fill due to the interruption in U.S. government funding at the end of 2018. WRAIR/DOD was awaiting allocation of additional office space within the Embassy in order to accommodate its two vacant positions of Deputy Country Director and Administrative Assistant. Now that space has been allocated, these positions should be filled by July 2019. The position of PEPFAR Coordinator in the PEPFAR Coordination Office will shift to a CDC-funded, direct hire position for three years as agreed upon with OGAC.

WRAIR/DOD will be adding two new positions: An M&E Officer and a Community Care & Treatment Officer. These will help strengthen participation in both intra and interagency spaces as well as enhance partner management. Eight of USAID's vacant positions are new positions that are being developed to assist in the local partner transition. Three of these are Program Management Assistants, three are AORs, one is a Lab QA/QI Specialist, and one is an HIS advisor. These new positions will further assist USAID will help implement a more stringent partner management strategy, incorporate more technical support for key program areas, and utilize program data in a more timely fashion. In addition to the vacancies listed above, pending final approval, USAID has been approved to hire an additional seven Program Managers who will be seconded to partners and/or MOH to support USAID's transition to local partners.

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) remains the same from the previous year, as does CDC's. DOD, Peace Corps and State also anticipate no changes in CODB from COP 2018. Note that 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 last fiscal year, an interagency working group focused on PrEP and self-testing was formed to focus on these two important initiatives, and in the current fiscal year, a working group has formed to focus on reaching men. New Cluster and TWG leads are also elected on an annual basis.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

COP17/FY18 Results

Scale Up Saturation & Attained				
Age	Sex	PLHIV	FY18 TX CURR	FY18 ART coverage
		1,248,171	872,717	70%
u1	Female	3,049	280	9%
u1	Male	3,165	275	9%
01-04	Female	12,206	6,636	54%
01-04	Male	12,669	6,636	52%
05-09	Female	11,327	6,636	59%
05-09	Male	11,728	6,636	57%
10-14	Female	14,378	10,635	74%
10-14	Male	14,488	9,728	67%
15-19	Female	31,371	13,628	43%
15-19	Male	18,838	7,577	40%
20-24	Female	63,633	35,997	57%
20-24	Male	32,199	7,268	23%
25-29	Female	88,179	66,021	75%
25-29	Male	46,908	17,641	38%
30-34	Female	102,771	90,217	88%
30-34	Male	57,226	30,027	52%
35-39	Female	109,670	95,485	87%
35-39	Male	65,507	39,091	60%
40-44	Female	101,812	59,311	58%
40-44	Male	66,247	59,311	90%
45-49	Female	75,870	59,311	78%
45-49	Male	56,524	59,311	105%
50+	Female	128,521	105,886	82%
50+	Male	119,885	79,175	66%

COP18 Expected Results

Scale Up Saturation & Attained				
Age	Sex	PLHIV	FY19 PLL TX CURR	FY19 PLL ART coverage
		1,248,171	1,082,175	87%
u1	Female	3,049	427	14%
u1	Male	3,165	441	14%
01-04	Female	12,206	8,424	69%
01-04	Male	12,669	8,441	67%
05-09	Female	11,327	8,347	74%
05-09	Male	11,728	8,361	71%
10-14	Female	14,378	13,052	91%
10-14	Male	14,488	11,952	82%
15-19	Female	31,371	17,198	55%
15-19	Male	18,838	10,865	58%
20-24	Female	63,633	43,905	69%
20-24	Male	32,199	10,895	34%
25-29	Female	88,179	78,643	89%
25-29	Male	46,908	25,147	54%
30-34	Female	102,771	106,103	103%
30-34	Male	57,226	41,085	72%
35-39	Female	109,670	111,839	102%
35-39	Male	65,507	52,722	80%
40-44	Female	101,812	74,030	73%
40-44	Male	66,247	74,442	112%
45-49	Female	75,870	71,744	95%
45-49	Male	56,524	71,488	126%
50+	Female	128,521	125,440	98%
50+	Male	119,885	107,186	89%

COP 2019 Targets

Scale Up Saturation & Attained				
Age	Sex	PLHIV	FY20 TX CURR (PEPFAR)	FY20 ART coverage
		1,248,171	1,282,067	103%
u1	Female	3,049	936	31%
u1	Male	3,165	966	31%
01-04	Female	12,206	9,963	82%
01-04	Male	12,669	10,049	79%
05-09	Female	11,327	9,763	86%
05-09	Male	11,728	9,838	84%
10-14	Female	14,378	14,931	104%
10-14	Male	14,488	13,827	95%
15-19	Female	31,371	28,859	92%
15-19	Male	18,838	22,229	118%
20-24	Female	63,633	52,211	82%
20-24	Male	32,199	24,160	75%
25-29	Female	88,179	89,828	102%
25-29	Male	46,908	38,219	81%
30-34	Female	102,771	118,908	116%
30-34	Male	57,226	51,197	89%
35-39	Female	109,670	124,879	114%
35-39	Male	65,507	62,228	95%
40-44	Female	101,812	86,219	85%
40-44	Male	66,247	83,545	126%
45-49	Female	75,870	83,654	110%
45-49	Male	56,524	82,362	146%
50+	Female	128,521	140,581	109%
50+	Male	119,885	122,717	102%

COP 2019 Targets by Region

REGION	PLHIV	FY20 TX CURR (PEPFAR)	FY20 ART coverage
	1,589,577	1,550,863	98%
Dar es Salaam	222,567	183,718	83%
Mwanza	77,762	119,568	154%
Mbeya	112,217	120,033	107%
Kagera	91,377	117,434	129%
Morogoro	84,639	63,378	75%
Tabora	67,843	69,319	102%
Tanga	70,404	56,483	80%
Dodoma	47,340	43,224	91%
Iringa	82,321	70,239	85%
Geita	57,293	59,639	104%
Shinyanga	55,164	58,468	106%
Mara	41,751	51,356	123%
Kilimanjaro	34,812	32,404	93%
Njombe	72,461	61,643	85%
Ruvuma	67,305	66,315	99%
Kigoma	32,502	32,356	100%
Arusha	38,609	29,159	76%
Pwani	61,477	50,819	83%
Songwe	41,694	43,731	105%
Simiyu	46,796	43,459	93%
Mtwara	50,940	31,168	61%
Singida	23,172	20,746	90%
Manyara	25,818	17,117	66%
Lindi	23,702	21,726	92%
Rukwa	26,860	28,738	107%
Katavi	20,479	19,950	97%
Mjini Magharibi	5,044	5,847	116%
Kaskazini Pemba	1,943	2,332	120%
Kaskazini Unguja	1,888	2,197	116%
Kusini Pemba	1,574	1,826	116%
Kusini Unguja	1,823	-	0%
_Military Tanzania	-	26,473	

COP 2019 Targets by PSNU Prioritization

PSNU priorities	PLHIV	FY20 TX CURR (PEPFAR)	FY20 ART coverage
	1,589,577	1,550,863	98%
1 - Scale-up: Saturation	1,087,196	1,090,002	100%
4 - Sustained	341,406	268,797	79%
7 - Attained	160,975	192,065	119%

COP 2019 Targets by PSNU

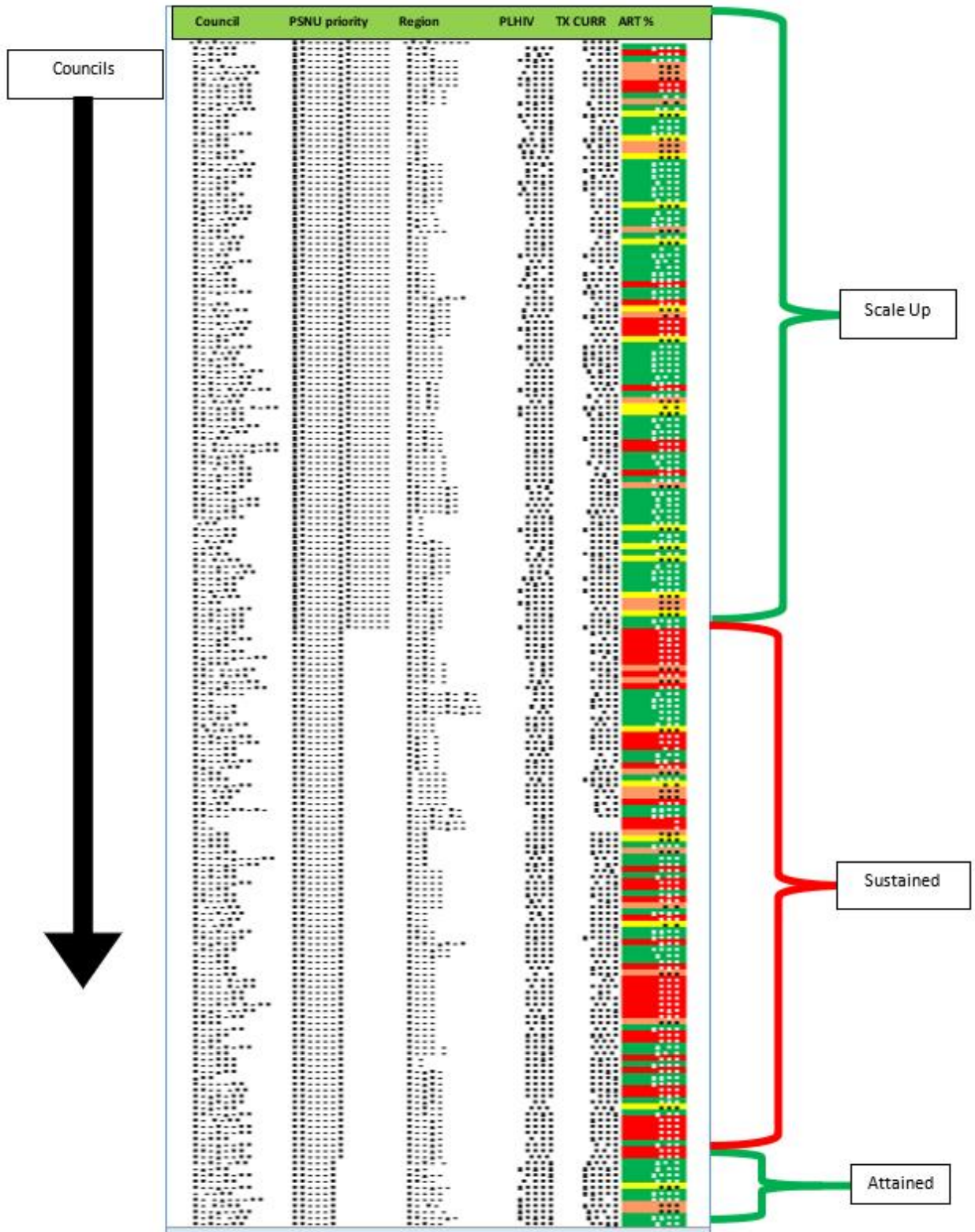


Table A.2

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization	Total PLHIV	Expected current on ART (APR FY19)	Additional patients required for 90% ART coverage	Target current on ART (APR FY20) TX CURR	Newly initiated (APR20) TX NEW	ART Coverage (APR 20)
Attained (N=11)	160,975	180,395	-	195,659	24,786	122%
Scale-Up Saturation (N = 97)* *includes Military as Scale up Saturation	1,087,196	914, 854	65,495	1,065,054	179,713	98%
Scale-Up Aggressive (N = 0)	n/a	n/a	n/a	n/a	n/a	n/a
Sustained (N = 87)	341,406	192, 711	76,519	269,624	39,405	79%
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)	1,589,577	1,287,960	117,529	1,530,337	243,904	96%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

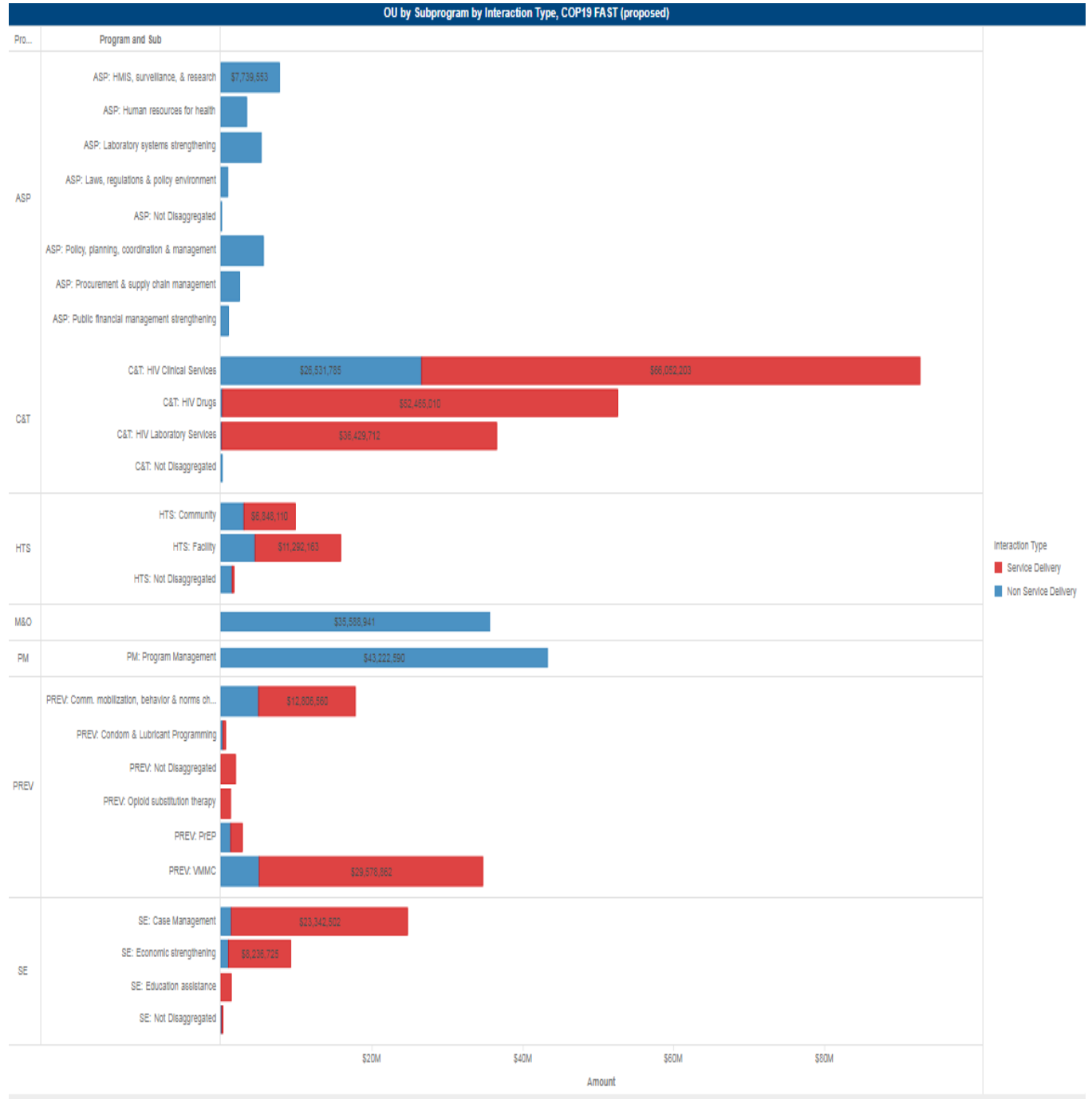


Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$117,628,726	\$291,956,265	\$ 409,584,992

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)	
PEPFAR Budget Code	Amount Allocated
CIRC	\$22,291,101
HBHC	\$9,528,043
HKID	\$18,440,029
HLAB	\$3,213,831
HMBL	\$50,958
HMIN	\$0
HTXD	\$39,669,661
HTXS	\$82,226,352
HVAB	\$4,854,606
HVCT	\$21,391,653
HVMS	\$14,854,146
HVOP	\$6,351,380
HVSI	\$8,045,042
HVTB	\$23,143,890
IDUP	\$2,107,139
MTCT	\$15,358,815
OHSS	\$9,890,133
PDCS	\$3,114,460
PDTX	\$7,425,025

*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

The primary input into the budgeting process was recent PLHIV and coverage estimates from the THIS 2016-2017 survey and updated projections from Spectrum. Adjustments were made to existing agency and mechanism level allocations according to shifts in the HIV treatment gap.

In addition, agencies and program officers consulted with expenditure reporting data, work plans, performance reports and S/APR data. Additional consideration was given to earmarks and expected cross-cutting attributions based on the Planning Level Letter (PLL) ceiling.

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 D– Minimum Program Requirements

The COP Planning Letter included thirteen “COP 2019 Minimum Requirements.” Our approach for each of these is described here. Working in collaboration with implementing partners and the Government of Tanzania (GOT), PEPFAR/T will closely monitor all of these issues throughout the current fiscal year including regular reviews of data and performance to ensure progress.

1. ***Adoption and implementation of Test & Start with demonstrable access across all age, sex, and risk groups. Tanzania has adopted a Test & Start policy, however, implementation of the policy nationwide is inconsistent, resulting in lower than expected progress towards TX_NEW targets. The team must work to minimize barriers to same day, same site ART initiation.***

Nationwide, the Test & Start policy is implemented at scale. PEPFAR/T monthly data shows that approximately 92% of clients are initiated on ART within 14 days of diagnosis, which is in line with the current GOT definition of “same-day” initiation. However, as of May 2019, the GOT released a circular to align with WHO guidelines to decrease this time period to seven days. In collaboration with the GOT, PEPFAR/T will continue to scale-up same-day initiation (at the 241 priority sites) with goal of achieving >95% of patients on same day initiation (within 7 days). This will be complemented by expansion of community-based ART initiation and one-month refills, which will help ensure clients who test HIV-positive at community levels will have easier access to same-day ART.

2. ***Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents. The team must work to increase access to HIV medical treatment optimized for specific subsets of the population (e.g. young people and men) and eliminate supply chain and other barriers to six-month dispensing.***

The current GOT policy endorsing six-month prescriptions with three-month dispensing will be brought to scale at facilities nation-wide with the goal of reaching 60% of clients at the 241 priority sites. The GOT and PEPFAR/T will be using the Emergency Operations Center, as well as monthly partner reports to monitor this progress closely. PEPFAR/T reached agreement with the GOT that six-month multi-month dispensing can be implemented at scale nationwide for clients who have successfully completed two rounds of three-month dispensing, and a circular was released in May 2019 to authorize facilities to begin. Along with improving HIV service delivery through MMS, PEPFAR/T with implementing partners, will scale-up successful models to reach men (e.g. men’s clinics, enhanced service delivery hours). To improve retention and viral suppression among adolescents, PEPFAR/T will strengthen adolescent friendly services, conduct site-level cascade analyses to assess timely identification of non-suppressed individuals and ultimately fast track adolescents to enhanced adherence counseling.

3. ***Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens. The team should continue to use remaining TLE stock and complete its TLD transition in COP 2019.***

In Tanzania, the first patients were initiated on TLD in, as part of the transition to TLD as the primary first line ARV regimen in Tanzania. Informed consent will be conducted for women of childbearing age, and efforts are underway to ensure access to family

planning services in this context. Preceding the initiation of patients in March, TLD stock was brought in country and clinical staff received training. PEPFAR/T is working with the GOT to ensure that sites at all levels have the supplies and training needed to enroll patients by September 2019. The GOT also agreed to transition away from Nevirapine based regimens for pediatric HIV clients, which will include a transition to LPV/granules. The GOT committed to ensuring that all supply chain and quantification plans will be completed by April 2019 and clients will have access to this regimen by September 2019.

- 4. *Scale-up of index testing and self-testing, and enhanced pediatric and adolescent case-finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established. With index testing integrated into national guidelines, the team should scale-up index partner testing and, even more critically ensure fidelity (i.e. prioritizing sexual and parenteral partners, biological children). Advocate in support of favorable HIV self-testing laws and policies.***

As part of PEPFAR/T strategy to reduce over-testing, efforts will focus on scaling up targeted testing strategies – such as facility and community index testing – with fidelity to ensure high yields with this approach. The GOT has agreed to bring self-testing to scale immediately upon approval of the revised HIV law, which is expected in May 2019. Plans to scale-up in 3 regions will be put in place should this be delayed. As part of PEPFAR/T efforts to optimize PITC, screening tools will be introduced to ensure that only those at risk for HIV will be tested. Community testing activities will focus on KVP, including adolescent girls and young women. PEPFAR/T will also be printing and distributing revised HTS tools to facilities throughout the regions.

- 5. *TB preventive treatment (TPT) for all PLHIVs must be scaled up as an integral and routine part of the HIV clinical care package. With isoniazid stocks in place, the team should ramp up TPT for all eligible PLHIV to improve TPT coverage.***

Clinical policies support the provision of TPT to PLHIV, supplies are available and staff are trained. Quarter 4 data from FY2018 and Q1 data from FY19 show substantial progress in isoniazid initiation. Partners are already working to scale-up TB preventative therapy and are on track to reach targets. The goal is to reach 100% of PLHIV receiving TPT by September 2019.

- 6. *Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. The team should continue to initiate same-day ART initiation and revise COP 2019 implementing partner (IP) work plans to reflect this minimum requirement.***

Through partner management, IPs are implementing same-day initiation for all eligible patients. PEPFAR/T and GOT will continue monitoring this initiative closely.

- 7. *Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services (ANC, TB, HIV testing, HIV prevention).***

The GOT prohibits user fees for all chronic diseases including HIV, TB, and MCH in both public and private services.

8. ***Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups. The team should maintain its scale-up of VL/EID coverage, particularly for those persons 20 years or younger.***

VL capacity is at scale and scale-up is underway for EID POC in SNUs with low volume EID and high burden of HIV among women. The goal is to focus on testing and decreasing the turnaround time of test results starting in the priority 132 SNUs and electronically linking laboratory VL/EID results with patient level (CTC3/2) database in clinics by September 2019.

9. ***Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. The PEPFAR/T team should work within active public health surveillance systems to collect data on subpopulation morbidity and mortality indicators.***

Efforts to strengthen the Death Registration and National System M&E are ongoing. PEPFAR/T supports the design of a death registry that links to the health sector client register to ensure information is documented in medical records and in the HIV patient monitoring system. The team is pilot testing a decentralized death registration system in Iringa through UNICEF. Efforts are also underway to strengthen the monitoring of patient outcomes (TX_ML). By September 2019, PEPFAR/T will leverage the on ongoing work of the global financing facility (GFF) to establish a national morbidity and mortality system that captures both facility and community level data that is linked to a robust HIV tracking system for LTFU outcomes.

10. ***Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17 with particular focus on adolescent girls in high HIV-burden areas, 9-14 year old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socio-economic support, including integrated case management. Improve on under-enrollment of <1 year olds in the PEPFAR/T program; increase enrollment of HEI via clinical entry points. Ensure all HIV+ OVC are on ART.***

PEPFAR/T has completed the Coordination with DREAMS and the alignment of OVC package (with targets set to consider the most vulnerable children). Targets will be rebalanced to focus on the 9-14 year old age bracket and test OVC with unknown status to ensure all HIV+ OVC are on treatment. The proportion of OVC with unknown status has decreased by 42% since FY2018 Q4 and February 2019. PEPFAR/T will address issues related to data quality and adherence classification; and implement escorted referrals and CCWs supporting linkage. The goal is to ensure that all OVC know their status and that a linkage system is in place for HIV+ OVC immediately.

11. ***Evidence of resource commitments by host governments with year after year increases. The team should work with the GOT to increase domestic resources to increase access to HIV prevention and treatment services.***

GOT acknowledges the sustainability requirements. Plans are being developed regarding the AIDS Trust Fund, HIV investment case, and commodity distribution. The goal is to ensure a clear understanding of existing commitments and create plans for scale-up by COP 2019.

- 12. Clear evidence of agency progress toward local, indigenous partner prime funding. Each agency should work with their HQ teams to ensure an increase of local and indigenous partners in COP 2019 and work towards a timeline for progress for future FYs.**

Each agency is working towards the global goal with new IMs planned accordingly. The goals are to increase funds to local/indigenous partners by 40% in COP 2019 and by 70% in COP 2020.

- 13. Scale-up of unique identifier for patients across all sites. Unique identifier has been incorporated into eHealth strategy; PEPFAR/T team to work to build on success of biometrics pilot in Zanzibar to expand to the mainland.**

The eHealth Strategy and Digital Health Investment Roadmap documents the GOT planned approach to establish national health client register to support unique identification of clients across services and sites including biometrics. PEPFAR/T will also explore integration of the National ID as part of this system. Variables that align with GOT standards are incorporated into revised HTS registers for future integration. Biometrics are included in the draft national case based surveillance guidelines and there is strong political will. PEPFAR/T reached agreement with the GOT that the biometric system should be used for HTS but for now can start with scaling at CTC to reach the goal of 80% of TX_CURR by September and the CTC portion can begin without a protocol as a routine program activity. The goal is to first initiate unique identification for treatment and second at testing points in order to reach 80% coverage for TX_CURR by September 2019. With respect to KPs, the biometric strategy will be rolled out for KPs only after discussions through the KP Advisory Committee to ensure safety of KPs is observed in data collection and storage and to ensure that the program does not lose the strides made to ensure that communities feel safe to go to the facility. PEPFAR/T will work with MOH to ensure that the necessary policies are in place to be able to ensure the human rights of people living with HIV are respected in the roll out and that the country has data protections for the data collected from PLHIVs.

APPENDIX E – Addressing Gaps to Epidemic Control including through Communities of Faith

PEPFAR/T will convene a meeting of the top denominational leadership (i.e. BAKWATA, Christian Council of Tanzania, Tanzania Episcopal Conference, Tanzania Interfaith Partnership) to educate the leadership on the epidemic, obtain their buy-in, and develop action plan that assigns implementation responsibilities. An outcome of the engagement will be to have the faith leadership embrace HIV as a winnable battle and understand how modern HIV treatment means long life. Their expertise in ensuring that HIV messages are incorporated into sermons, newsletters, etc. will be sought, particularly messages of hope and compassion, familial and community support, and commitment to adherence. Faith leaders at the local level will be engaged in assisted partner notification, in disclosure to prevent IPV, and promote adherence and VLS for all ages. Local faith leaders will introduce existing PEPFAR/T-funded implementing partners and their sub-partners to lay leaders of church/mosque activities, especially those that engage youth and men. IPs will work with HCWs/HBC from facilities and trained personnel from faith and FBO entities on partner notification, follow-up on stable patients and screening for TB/STI/HIV symptoms.

FHI 360/Tulonge Afya will be consulted to consider refinements to existing messaging appropriate for churches/mosques with particular attention to HIV testing with a linkage to retention (Test & Start, U=U) to find men and messaging aimed at both faith/traditional leaders and faith followers about sexual violence and HIV risk faced by 9-14 year old adolescents. Other materials will be reviewed for adaption to Tanzania such as those produced under *Families Matter*, *Parenting for Lifelong Health*, *Coaching Boys into Men*, and *SASA! Faith and No Means No*.

While obtaining support at the top tier of the faith community is an essential first step, ensuring that increased demand is met with comprehensive services at the third tier community level. PEPFAR/T strategy is to approach the epidemic response from two directions—through faith structures and networks and through the Christian Social Services Commission hospital network, which is the most impactful private sector health facility network in the country. Senior health facility managers, governing boards, and CCT/TEC leaders of the CSSC network will reinforce their mandate to serve health needs without discrimination in regards to religion, economic status, or personal characteristics. CSSC will reach out to its faith structures in the community and provide more comprehensive services at the facilities. CSSC will engage with its secondary schools and seminaries, capitalizing on the ubiquitous presence of mobile technology to reach young people. The CSSC healthcare network will be assisted in addressing the lack of government support for treatment of OIs in CSSC facilities. CSSC will also be assisted in ensuring that they will become financially self-reliant in maintaining the epidemic response in light of anticipated reduced government support.

Tables and Systems Investments for Section 6.o

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Unicef	ASP: Laws, regulations & policy environment	Non-Targeted Pop: Not disaggregated	\$ 200,000.00	Assessing impact of policies and regulations on HIV	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP17	COP19	90%
USAID	Unicef	ASP: Policy, planning, coordination & management	Females: Young women & adolescent females	\$ 200,000.00	National strategic plans, operational plans and budgets	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP19	90%
USAID	Unicef	ASP: Policy, planning, coordination & management	Females: Young women & adolescent females	\$ 250,000.00	Oversight, technical assistance, and supervision to subnational levels	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP19	COP20	90%
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 834,920.00	Training in supply chain systems	Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities	COP19	COP20	6

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 250,476.00	Supply chain infrastructure	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP20	eLMIS information functional with the National Health Information Mediator
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 250,476.00	Forecasting, supply chain plan, budget, and implementation	Inefficient systems and resources for distribution of commodities under new policy mandates, eg TLD transition, DSDM, and test and start	COP18	COP19	100%
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 292,224.00	Supply chain infrastructure	Inefficient systems and resources for distribution of commodities under new policy mandates, eg TLD transition, DSDM, and test and start	COP18	COP19	80%
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 375,714.00	Supply chain infrastructure	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP20	60%

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Guidehouse LLP	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 150,000.00	Laboratory infrastructure	Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services	COP18	COP19	Optimization software exercise completed and 100% of recommendations implemented
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 350,952.00	Supply chain infrastructure	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP20	80% availability
USAID	Guidehouse LLP	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	\$ 125,238.00	Supply chain infrastructure	Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities	COP19	COP20	25%
USAID	Abt Associates Inc.	ASP: Human resources for health	Non-Targeted Pop: Adults	\$ 281,250.00	Institutionalization of in-service training	Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	COP17	COP19	# new nurses in private hospitals trained as clinical trainers in use of HIV and TB rotation modules=15 # new private hospitals empaneled as approved clinical practicum sites=15
USAID	FREEDOM HOUSE INC	ASP: Laws, regulations & policy environment	Key Pops: Not disaggregated	\$ 200,000.00	Information and sensitization for public and government officials	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP17	COP19	2

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	FREEDOM HOUSE INC	ASP: Laws, regulations & policy environment	Key Pops: Not disaggregated	\$ 104,000.00	Assessing impact of policies and regulations on HIV	Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach	COP17	COP19	12
USAID	TOUCH FOUNDATION, INC.	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 337,500.00	HRH recruitment and retention	Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	COP19	COP20	Integration with and utilization of WISN+POA in POPSM systems=Yes Integration with and utilization of WISN+POA+WOA in POPSM systems=No
USAID	Palladium International, LLC	ASP: Laws, regulations & policy environment	Non-Targeted Pop: Not disaggregated	\$ 220,000.00	Assessing impact of policies and regulations on HIV	Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control	COP19	COP19	10
USAID	Abt Associates, Inc.	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 800,000.00	HRH recruitment and retention	Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	COP18	COP20	70%
USAID	Abt Associates, Inc.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 1,000,000.00	Service organization and management systems	Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control	COP18	COP19	90%
USAID	Abt Associates, Inc.	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	\$ 675,989.00	Training in public financial management strengthening	Inefficient use of resources and weak public financial management (PFM) systems that result in low execution rates and poor matching of payments to priority services	COP18	COP19	88%
USAID	Abt Associates, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 1,240,000.00	HMIS systems	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP19	90%

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Abt Associates, Inc.	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 200,000.00	HRH recruitment and retention	Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	COP18	COP19	70
USAID	JSI Research And Training Institute, INC.	ASP: Policy, planning, coordination & management	Priority Pops: Not disaggregated	\$ 200,000.00	Service organization and management systems	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP17	COP19	90%
USAID	JSI Research And Training Institute, INC.	ASP: Human resources for health	OVC & care givers: Not disaggregated	\$ 300,000.00	HRH recruitment and retention	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP18	COP19	85%
USAID	T-MARC TANZANIA	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	\$ 50,000.00	National strategic plans, operational plans and budgets	Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach	COP19	COP20	2 new products introduced to increase sustainability of TMARC in provision of HIV prevention
HHS/CDC	MANAGEMENT AND DEVELOPMENT FOR HEALTH	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 473,100.00	HMIS systems	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP17	COP21	a) 95% of CTC client data in CTC3/SHR b) 50% of C&T clients records linked NHCR c) 50% of HTS_TST_POS in CTC3/SHR d) 25% of HTS client records linked to NHCR. e) 75% of C&T client records have Biometric ID

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	National Institute For Medical Research	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 320,956.39	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP17	COP21	a) < 200 discrepancies between HFR and DATIM sitelist. b) < 20 facilities with no MOH ID in DATIM. c) Shape files available on HFR portal for download by all stakeholders. d) Updated council level for boundaries as of 2019 and ward level boundaries as of 2018 .
HHS/CDC	National Institute For Medical Research	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 344,758.80	Laboratory infrastructure	Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services	COP16	COP20	Atleast 75% of labs participate and pass EQA; and there are no EID/VL service interruptions
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 228,000.00	Institutionalization of in-service training	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP17	COP20	15% of high burden sites supported by DE center in learning
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 418,000.00	Training in coordination and management of health systems	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP16	COP20	35 high volume sites implementing an efficiency change 60 HCWs self-reporting increased competence (from baseline) in key HIV area (e.g. in HIV case findings, MMS, SDM delivery) 20% of high-volume facilities in at least three regions of Mwanza, Kagera and Dar es salaam implementing DSDMs tailored to children and adolescents 50% of high-volume facilities reporting

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Unicef	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 184,980.00	Vital registration systems	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP21	1) 15 High burden councils, or councils with high loss to follow up initiate use of death registration systems. 2) % of deaths captured monitored against expected number of deaths within initial councils and regions. 3) 50% of all deaths identified through HIV treatment follow up are confirmed with death reporting from GOT death registration system in 5 councils who first initiated death registration..
HHS/CDC	Unicef	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 160,316.00	Clinical guidelines, policies for service delivery	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP16	COP19	1.Improved EID coverage to 90% at 2m of age 2.75% of High volume sites impement adolescent psychosocial support services 3.Improved HVL suppression to 90% among ped/adolescent population
HHS/CDC	Management Sciences For Health, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 541,666.67	HMIS systems	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP16	COP20	a) 95% of CTC client data in CTC3/SHR b) 50% of C&T clients records linked NHCR c) 50% of HTS_TST_POS in CTC3/SHR d) 25% of HTS client records linked to NHCR. e) 75% of C&T client records have Biometric ID

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Management Sciences For Health, Inc.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 208,333.33	Service organization and management systems	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP16	COP20	At least 50% of priority SNU and all PHIs use dashboards from DHIS2 to triangulate star rating scores and services outcomes
HHS/CDC	Management Sciences For Health, Inc.	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 250,000.00	HRH recruitment and retention	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP17	COP20	A reduction in vacancy rate to 45%
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 500,000.00	Surveillance	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP19	Consensus national meeting and report on estimates on key population size and HIV prevalence
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 870,370.37	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP21	75% of all PEPFAR monitoring data sourced directly from GOT HMIS or CTC3/SHR dashboard.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNIVERSITY OF MARYLAND	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 522,222.22	Clinical guidelines, policies for service delivery	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP19	COP20	1.All high volume facilities use Mother child cohort registers, 2.Screening tools of Post ANC1 HIV testing,SOP of Post ANC1 testing are in use to all PEPFAR supported sites 3.Updated PLHIV tracking registers are in use to all supported sites
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 150,000.00	Clinical guidelines, policies for service delivery	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP19	COP19	Increased Retention to 75% At least 24,600 eligible clients on PreP At least 369,289 kits distributed (HTS_HVST)
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 850,000.00	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP20	Implementation of recency testing in regions that comprise of 50% of TX gap.
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 140,000.00	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP17	COP20	Annual support for maintenance of regional spectrum files

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: HMIS, surveillance, & research	Key Pops: Not disaggregated	\$ 300,000.00	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP19	Stakeholder engagement for and dissemination of key and vulnerable population including MSM, FSW, PWID including KP size estimations and HIV prevalence consensus activities.
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	\$ 850,000.00	Program and data quality management	Parallel data collection between PEPFAR and GOT, and different data systems including aggregate data reporting systems, supply chain, laboratory, human resources, and patient-level data systems impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels	COP18	COP20	1) 95% of SNU's report timely (high quality data) 2) Rolled out recency surveillance country wide and established mortality surveillance system
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 100,000.00	Institutionalization of in-service training	Inefficient HRH recruitment, allocation, retention and redistribution processes for existing health workforce	COP17	COP20	Mentorship package developed for guiding task sharing Monitoring guidelines and tools developed for task sharing 10% of high burden sites visited and mentored on task sharing and SDM per the policy
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 700,000.00	Lab quality improvement and assurance	Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services	COP17	COP20	75% of testing sites (Lab/POCT) implementing national QI Programs

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Policy, planning, coordination & management	Pregnant & Breastfeeding Women: Not disaggregated	\$ 200,000.00	Clinical guidelines, policies for service delivery	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP18	COP19	Increase Post ANC1 to 80% for alligible PBFW
HHS/CDC	OFFICE OF CHIEF MEDICAL OFFICER	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 100,000.00	Clinical guidelines, policies for service delivery	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP18	COP20	No child receive NNRTI regimen as treatment option
HHS/CDC	MANAGEMENT AND DEVELOPMENT FOR HEALTH	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 1,731,709.00	Lab quality improvement and assurance	Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services	COP17	COP20	All enrolled 9680 sites are participating in EQA/PT program, and pass to 90% and above. Atleast 80% of labs accredited to international/national standards and then maintenance of all accreditation standards <u>95% VL and 90% EID coverage</u>
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 100,000.00	Clinical guidelines, policies for service delivery	Inefficient systems and resources for distribution of commodities under new policy mandates, eg TLD transition, DSDM, and test and start	COP18	COP20	Evidence of use of national system for pharmacovigilance in 50% of high-volume facilities Full roll-out of pediatric ART optimization plan

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	TANZANIA HEALTH PROMOTION SUPPORT (THPS)	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 2,250,000.00	Training in laboratory systems strengthening	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP17	COP20	At least 75% of sites providing HRT services implement the RTCQI Atleast 60% optimization of Xpert machines use to do TB diagnose Biosafety and calibration center established TB LAM Assay is introduced as a targeted diagnostic assay for patients with CD4 < 200 or those seriously ill
HHS/CDC	MANAGEMENT AND DEVELOPMENT FOR HEALTH	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	\$ 1,793,333.00	Clinical guidelines, policies for service delivery	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP19	COP21	SOP and reporting tools developed 30% of eligible PLHIV clients received ARV resistance testing
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	\$ 283,000.00	Institutionalization of in-service training	Inadequate number of competent HRH to delivery quality health services for index testing, MMS, test and start, TPT coverage, etc at service delivery points in priority scale up councils	COP17	COP19	100% of the new policies (SDM, Self Testing, PrEP, Men) including S/APR program data implemented in the Military
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	\$ 220,000.00	Laboratory infrastructure	Inadequate laboratory capacity to administer and manage accreditation and optimization of essential services such as VL, EID, TB and referral services	COP18	COP19	1135(95%) HIV testing points participating in the EQA/PT program nation wide. At least 1078 (95%) of participating sites passing the PT At least 2000 (50%) testers receive EQA panels Zonal EQA distribution center functional

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	Prime Partner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Adults	\$ 642,480.00	Evaluations	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP16	COP21	Data collection on going
DOD	Henry M. Jackson Foundation For The Advancement Of Military Medicine, Inc., The	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Children	\$ -	Research	Protracted decision making process and weak implementation of key laws, policies, guidelines and procedures to facilitate rapid scale up ART optimization, EID, self-testing, community ART, TPT, SDM, MMS, index testing, and other key strategies across scale up councils and to reach key populations	COP18	COP20	Enrollment of study participants completed and data analysis done