Tanzania

Country Operational Plan (COP) 2021

Strategic Direction Summary

May 11, 2021

1.0 Goal Statement

Two years ago, PEPFAR Tanzania (PEPFAR/T) was in the throes of pivoting program activities based on findings from the Tanzania HIV/AIDS Impact Survey 2016-2017 (THIS). Transforming our understanding of the HIV epidemic in Tanzania, the survey showed that only 61% of people living with HIV (PLHIV) older than age 15 knew their HIV status. This indicated that finding and diagnosing PLHIV was a programmatic challenge. The THIS also highlighted that the geographic areas where PEPFAR/T had been focusing, were not actually the places with the biggest treatment gap. These findings triggered a programmatic overhaul. PEPFAR/T shifted activities to scale up index testing with fidelity, link clients and retain them in treatment, and shift national policies towards multi-month dispensing (MMD), community anti-retroviral therapy (ART), self-testing, and Pre-exposure Prophylaxis (PrEP) scale-up.

The result led to historic performance during FY19. Over-testing was reduced, and testing yield tripled. We also saw unprecedented treatment growth with Tanzania's NET_NEW. The program reached 73% community viral load suppression indicating vast improvements towards 95-95-95 targets. This was complemented by successful prevention activities. PEPFAR/T met its voluntary medical male circumcision (VMMC) and key and vulnerable population (KVP) program targets. DREAMS activities to reach adolescent girls and young women were expanded.

Although much of this success has been maintained into FY20, the impact of the COVID-19 pandemic on the PEPFAR/Tanzania program has been significant. Maintaining the safety of implementing partner staff, healthcare workers, and PEPFAR beneficiaries required that we pause and scale back many key interventions. Our COP21 plan will be focused on regaining program momentum to safely bring back to scale our client-centered services.

The core of PEPFR/T's success has been using the right data to identify gaps, and working with stakeholders, the Government of Tanzania (GoT), and implementing partners to tailor effective strategies to close those gaps. In this manner, we ensured that systems, including policies, were in place in support of programmatic best practices. In COP21, we will rely on the same approach and ensure that our success will provide a foundation to move us closer to 95-95-95 goals. This will include continued and specific focus on rapid acceleration of ART enrollment, ensuring optimization of ARV regimens for both pediatric and adult clients, and use of differentiated service delivery models. We will strengthen retention with the goal of further increasing community viral load suppression and morbidity and mortality reduction. These initiatives will be complemented by activities focused on preventing new infections. Conducting a second Tanzania HIV/AIDS Impact Survey (THIS 2.0) is also critical at this point in time. Updated THIS results will allow us to assess program progress and gaps to make the necessary adjustments to reach epidemic control.

In COP21, HIV case finding will continue to be emphasized. We will regain our momentum for index testing, ensuring that services offered are of high quality, non-coercive, and confidential. Results from ongoing index testing site assessments will inform quality improvement efforts. PEPFAR/T will ensure that civil society organizations (CSO) are engaged in guiding these activities. Continuing to work closely with civil society to roll out community-led monitoring efforts will also play a key role to achieve this goal. At the same time, we will further hone our PITC screening to ensure we are testing those most at risk. Expansion of self-testing nationwide

will also be prioritized. Integration of recency surveillance into routine HIV testing services (HTS), which was paused for most of COP20, will restart in COP21. This will inform refinement of case finding and prevention strategies throughout the year. All efforts will be complemented by efforts to address widespread stigma and discrimination that leads to fear of testing and reduction in service quality for people living with HIV. Involving people living with HIV/AIDS directly in anti-stigma and discrimination efforts will be by prioritized.

In the context of treatment, PEPFAR/T will build on current efforts to roll out 6-multi-month dispensing (6MMD). With the successful completion of the TLD transition, PEPFAR/T will collaborate with the Tanzanian Government to transition pediatric clients to DTG10. Efforts to strengthen linkage and retention to minimize patient loss will include a renewed emphasis on treatment literacy at facility and community levels. Community-ART enrollment and refills will continue for key and vulnerable populations and be expanded to the general population as part of continued efforts to decongest health facilities. Finally, efforts to strengthen pediatric case finding by leveraging the OVC program and optimizing pediatric regimens will help address this programmatic gap. PEPFAR/T will re-engage in conversations on diagnostic network optimization to ensure uninterrupted access to viral load testing. Refocusing viral load testing to prioritize high throughput platforms will enable PEPFAR/T to strengthen the viral load testing systems and minimize supply chain disruptions.

On the prevention front, continued engagement of the KVP Forum will ensure that KVP activities are being implemented effectively at the community level. VMMC activities will capitalize on a successful COP19/20 pivot to focus on older men by further strengthening innovative demand creation approaches to reach these men. COP21 targets have been adjusted to reflect the new PrEP implementation framework developed by the GoT and endorsed by stakeholders in May 2021.

Strategies alone, even the right ones, are not enough for success. Those strategies must be built on a solid foundation of political will and an enabling policy environment. Over the last three years, Tanzania has made great strides implementing policies on same-day ART initiation, multi-month scripting, and scaling up index testing among others. In COP21, the policy focus will be on scaling up PrEP and self-testing and supporting the roll out of Tanzania's unique identification strategy. Efforts will also be directed towards moving forward with nationwide 6MMD roll out and ensuring that supply chain policies are strengthened.

Wise use of data, with analysis down to the site-level, will be leveraged to rapidly accelerate progress. The Government of Tanzania (GOT), along with the United States Government (USG), remain committed to working closely together to review site-level data, to use those data for rapid action, and to continue its monthly review meetings chaired by the Chief Medical Officer. GOT and USG will continue to work side-by-side throughout this process to ensure that proposed policy changes quickly roll-out at facility and patient levels.

Due to prior PEPFAR/T investments in systems strengthening, patient-level data are now available for >90% of people covered by the program. These data are used to track program progress and accelerate implementation of key interventions such as isoniazid preventive therapy for tuberculosis prevention. The USG will continue to invest in GOT staff capacity to ensure effective use of data. The GOT and USG will build on existing site-level regional team and rapid-

response strategies to optimize partner performance at facility levels. Lower performing partners will continue to undergo intensive remediation and mentoring.

Above-site investments focus on supporting all of these priorities through supply chain strengthening to deliver life-saving commodities; 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, early infant diagnosis, and viral load monitoring; strengthening the Government of Tanzania financial management systems which provides a strong foundation of planning and costing of HIV/AIDS services; tracking expenditures and the different sources of financing for HIV/AIDS services to make the PEPFAR/T program more efficient; and institutional strengthening that will continue steps towards sustainability.

The GOT and USG continue to collaborate on Health Information Systems (HIS). PEPFAR/T supported the GOT National Health Identification Standard (NHIS) and a new HTS register that aligned with NHIS. In COP 21, PEPFAR/T will continue to work to input unique patient identification including biometrics into the national health client register to better track clients across services for improved retention.

Ensuring that the strategies continue to evolve to meet the changing needs of the epidemic, and that they are implemented in a person-centered manner, requires broad engagement with a wide range of stakeholders. CSO contributions have substantially aided progress including improving reach to key populations and reducing stigma. PEPFAR/T will continue this engagement in COP21. 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 are also key to success and PEPFAR will provide opportunities for regular engagement throughout the implementation year.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

According to THIS 2016-2017[1], the prevalence of HIV among adults aged 15-64 years in Tanzania is 5% (7% among females and 4% among males). UNAIDS Spectrum 2020 estimates approximately 1.74 million[2] PLHIV in Tanzania out of total population of 56,194,4483, with regional variations from 8,251 (Zanzibar) to 219,428 (Dar es Salaam)[4]. According to the THIS 2016-2017, 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 10-14 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 2020 model show that, the number of new HIV infections have been declining steadily over the years, from 81,793 to 80,523 between 2015 and 2016; and in 2018, it was estimated to be 72,547 while in 2020 was 68,000. Additionally, the total deaths for PLHIV has also been steadily declining, from an estimated 40,785 to 38,835 between 2015 and 2016 compared to an estimated decrease to 32,000 total deaths in 2020[6].

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) also 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).[7] 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 to 29 years (THIS, 2016-2017). In addition, COP20 coverage for KVP include expanding geographic and hotspot coverage of adolescent girls and young women (AGYW), female sex workers (FSW), MSM, and PWID to 30%; 90%; 85%; and 90% respectively.

THIS 2016-2017 data also showed that HIV prevalence varies by population in Tanzania. HIV prevalence is highest among females aged 40 to 44 years, at approximately 11% compared to 8.5%

[1] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[2] 2021 Spectrum estimates, 2020-point estimate
[3] To be cross-checked -National Bureau of Statistics (NBS) Population Projection, March 2020
[4] 2021 Spectrum estimates
[5] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[6] 2021 Spectrum estimates
[7] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

among males aged 40 to 44 years. According to the 2020 UNAIDS Spectrum Estimates, prevalence among adults aged 15 to 24 years is 2.9% (3.8 % among females and 1.9% 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 rates that are 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 2020 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. Building on COP20 Spectrum's use of auxiliary data sources and UNAIDS Naomi model's outputs, including point estimate uncertainty estimations and health seeking behavior variability for HIV positive clients across geographical areas of residence, Spectrum 2021 results show a shift of HIV burden among fewer regions compared to COP20 Spectrum files. Mwanza, Morogoro, Mbeya, Tabora, Iringa, and Ruvuma showed the highest net increase of estimated number of PLHIV compared to COP20 Spectrum outputs. Conversely, Kagera, Dar es Salaam, Kilimanjaro, Kigoma, and Mtwara showed the largest decrease in estimated number of PLHIV compared to COP20 Spectrum outputs. Notable decreases in PLHIV for PEPFAR/T's larger urban regions, namely Dar es Salaam, provide an indication of client movement outside of densely populated areas in response to COVID-19 fears. Throughout the latter half of FY20, PEPFAR/T continued to prioritize provision of safe and flexible HIV care and treatment services to ensure COVID-19 did not adversely affect PLHIV throughout the country. In COP21, targeted programming will continue to focus on the alignment of resources with the latest epidemiologic information.

For COP21, the Spectrum 2020 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. Spectrum District Estimate Tools included routine programmatic data for ANC attendance, VL suppression, national ART prevalence data among 15-49 year-old population from COP19 implementation, as well as granular program data in order to produce council-level age disaggregated estimates for the number of PLHIV. UNAIDS Naomi Model, newly introduced in COP20, was also utilized to produce more precise and accurate estimates of prevalence, ART coverage and incidence. This new model maximizes information used from auxiliary data sources (population–based surveys, geographical data, etc.) by jointly modeling HIV prevalence and ART coverage, and utilizing a model-based approach for reallocating ART patients across districts for clients seeking care outside of their districts of residence.[8] Through the inclusion of routine program data into the Spectrum 2020 model methodology denominators between COP20 and COP19 were slightly impacted, particularly for regions outside of the top 10 highest burden regions for which THIS was powered.

Similar to COP20, PEPFAR/T used the Spectrum 2020 estimates in the COP21 Data Pack, but adjusted TX_CURR targets by region accordingly, to align with triangulated THIS survey data and

[8] *UNAIDS Reference Group on Estimates, Modelling, and Projections- Next Generation Tools for Subnational HIV Strategic Information in sub-Saharan Africa Report and Recommendations*. (2019) (pp. 4–28). Glastonbury, USA.

programmatic knowledge. This approach guides the geographic breadth and scope of activities to sustain the progress made in COP19.

In terms of implementation of key policies, GOT initiated key policy revisions to move Tanzania closer to epidemic control through provision of updated circulars and revised National Guidelines for the Management of HIV and AIDS (2019) after the COP19 Regional Planning Meeting in Johannesburg. This included updating same-day ART initiation from 14 days to within seven days, implementing six-month multi-month dispensing (MMD), and the release of new HIV Testing Guidelines 2019. During FY19, GoT adopted and implemented differentiated service delivery models, including six-month/multi-month/and three-month dispensing of ARVs. Three month multi- month dispensing continues throughout the country, while six-month multi-month dispensing in Dar es Salaam, initially beginning in 2019, is still ongoing. However, additional plans for scale-up to other regions in COP20 has met delays due to COVID-19. Following the release of the January 2020 circular authorizing scale up of DTG to all PEPFAR supported facilities, GoT and PEPFAR's collaborative efforts to support accelerated uptake of optimized DTG- based regimens across all age groups has shown continued success, where almost 90% of eligible women of child-bearing age and adults were on optimized regimens by the end of COP19. The GoT has adopted amendments of the HIV and AIDS Prevention and Control Act (HAPCA) to allow for HIV self-testing in adults and lowering the age of consent for HIV testing from 18 to 15 years (approved in November 2019). Finally, the GOT is supportive of ongoing efforts to scale-up TB preventive treatment (TPT) to more than 75 % of eligible clients on IPT. PEPFAR/T aims to achieve 100% IPT coverage of all eligible clients during COP21 by working in close collaboration with the government to ensure a reliable supply of Isoniazid to increase the number of clients enrolled in and completing IPT.

To address gaps in HRH and supply chain, PEPFAR/T shall continue to support the implementation of the task sharing policy, in conjunction with the HIV differentiated service delivery model (DSM) roll out. In COP19, PEPFAR/T focused on 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 for Health 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 2020 and other data sources to triangulate information to effectively guide HRH investment based on needs.

Tanzania's gross national income (GNI) per capita in 2017 was $936[9], which indicates limited income to accommodate health expenditures. Tanzania's total health expenditure (THE) was 6.1% of gross domestic product (GDP) in 2015 and 11% of government spending in 2015[10], 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] World Bank national accounts data, 2017
[10] Health Policy Project, Health financing profile Tanzania, 2016

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 (%)		4.7		0.5		0.3		2.1		0.6		Not available		Not available	THIS, 2016-2017
AIDS Deaths (per year)	25,582		2,185		2,346		1,336		1,013		7,611		11,090		SPECTRUM, 2020
# PLHIV	1,742,506		54,800		56246		110,948		55,536		912,702		552,273		SPECTRUM, 2021
Incidence Rate (Yr.)		.2		Not available		Not available		Not available		Not available		Not available		Not available	SPECTRUM, 2020
New Infections (Yr.)	68000														SPECTRUM, 2020
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	91,000	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		5,313		5,200		3,819		3,184		18,929		32,764		The National Tuberculosis and Leprosy Program__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 Program__The 2016 Annual Report
% of Males Circumcised	Males 15-29yrs	80%			Not available	Not available			Not available	Not available			Not available	Not available	THIS, 2016-2017
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 (#)[11]	HIV Prevalence (%)	Estimated Total PLHIV (#)[12]	PLHIV diagnosed (#)[13]	On ART (#)[14]	ART Coverage (%)[15]	Viral Suppression (%)	Tested for HIV (#)[16]	Diagnosed HIV Positive (#)[17]	Initiated on ART (#)[18]
Total population	55,890,747	4.7	1,742,506	1,548,484	1,473,969	84%	91%[19]	4,914,010	183,000	269,002
Population <15 years	24,354,484	0.4	92,569	55,102	54,975	59%	72%[20]	482,842	7,570	6,761
Men 15-24 years	5,406,712	1.24[21]	57,141	39,282	36,433	64%	76%[22]	609,239	6,867	7,744
Men 25+ years	9,699,016	5.9%[23]	556,156	491,289	428,835	77%	92%	1,281,897	64,657	91,233
Women 15-24 years	5,475,698	2.28[24]	109,858	94,322	94,054	86%	82%	1,061,455	22,351	33,548
Women 25+ years	10,954,837	7.6%	936,868	868,489	859,662	92%	95%	1,478,577	81,655	127,799
MSM	49,700[25]	25[26]	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

[11] National Population Projection, Feb 2018
[12] SPECTRUM Estimates 2021
[13] NACP & PEPFAR Program Data FY19
[14] NACP & PEPFAR Program Data FY19
[15] NACP & PEPFAR Program Data FY19
[16] NACP & PEPFAR Program Data FY19
[17] NACP & PEPFAR Program Data FY19
[18] NACP & PEPFAR Program Data FY19
[19] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[20] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[21] SPECTRUM estimates 2019
[22] PEPFAR Program Data FY19
[23] SPECTRUM estimates, 2019
[24] SPECTRUM estimates 2019
[25] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.
[26] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

Priority Pop (Adolescent Girls and Young Women)	6,211,713	3.8[27]	Not available	236,045[28]	Not available	Not available	Not available	Not available	Not available	Not available
Priority Pop [29]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

[27] SPECTRUM Estimates, 2019
[28] SPECTRUM Estimates, 2019/ National Population Projection, Feb 2018
[29] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

Figure 2.1.3: Updated National and PEPFAR/Tanzania Currently on Treatment

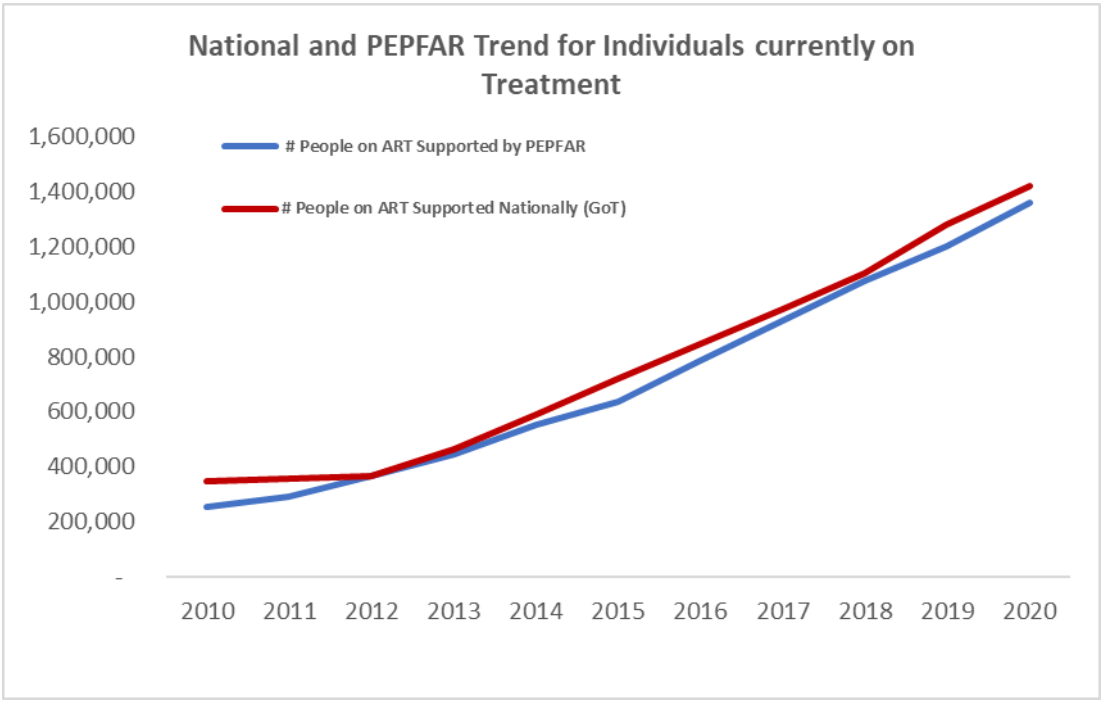


Figure 2.1.4: Updated Trend for New HIV Infections and All-Cause Mortality Among PLHIV

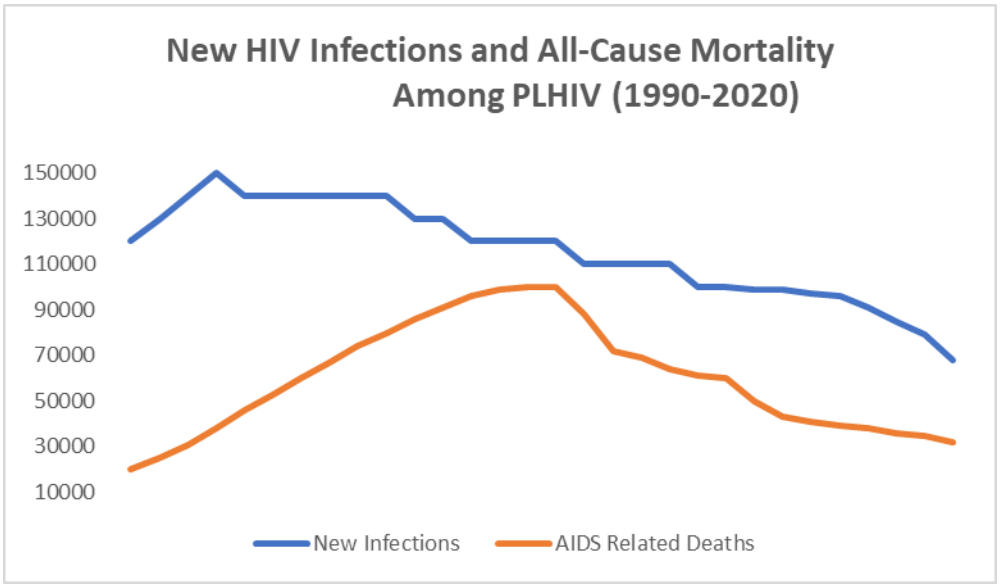


Figure 2.1.5: Progress retaining individuals in lifelong ART in FY202020

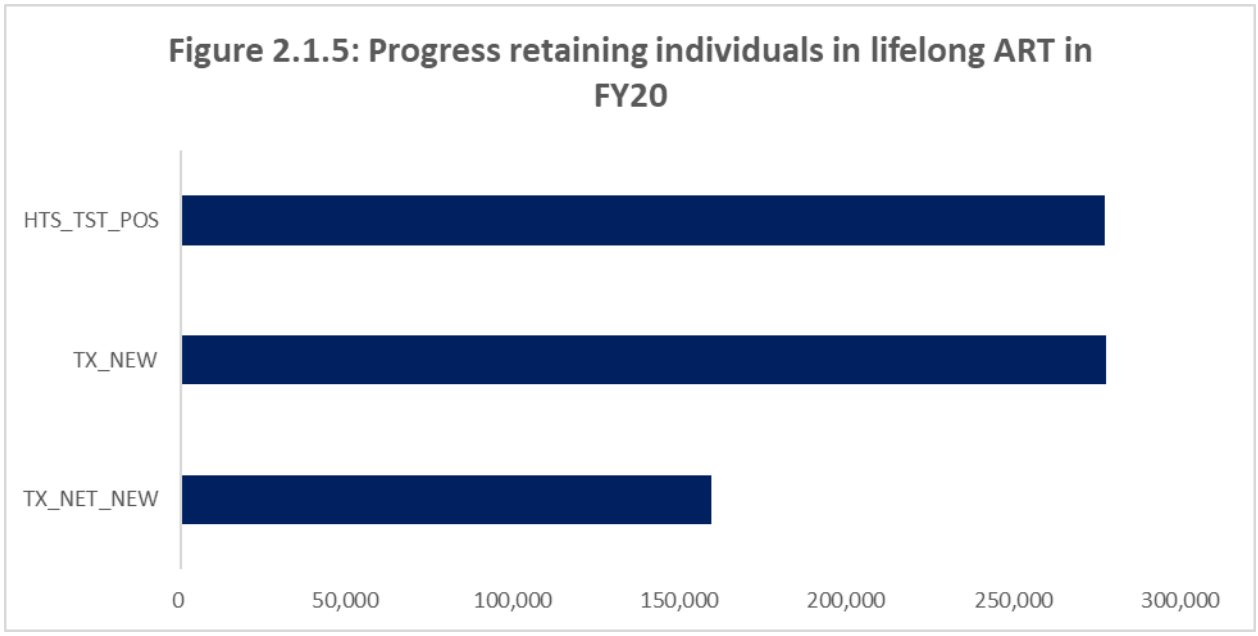


Figure 2.1.6: Quarterly Trends for clients lost on ART 2020Q1 to 2021 Q1

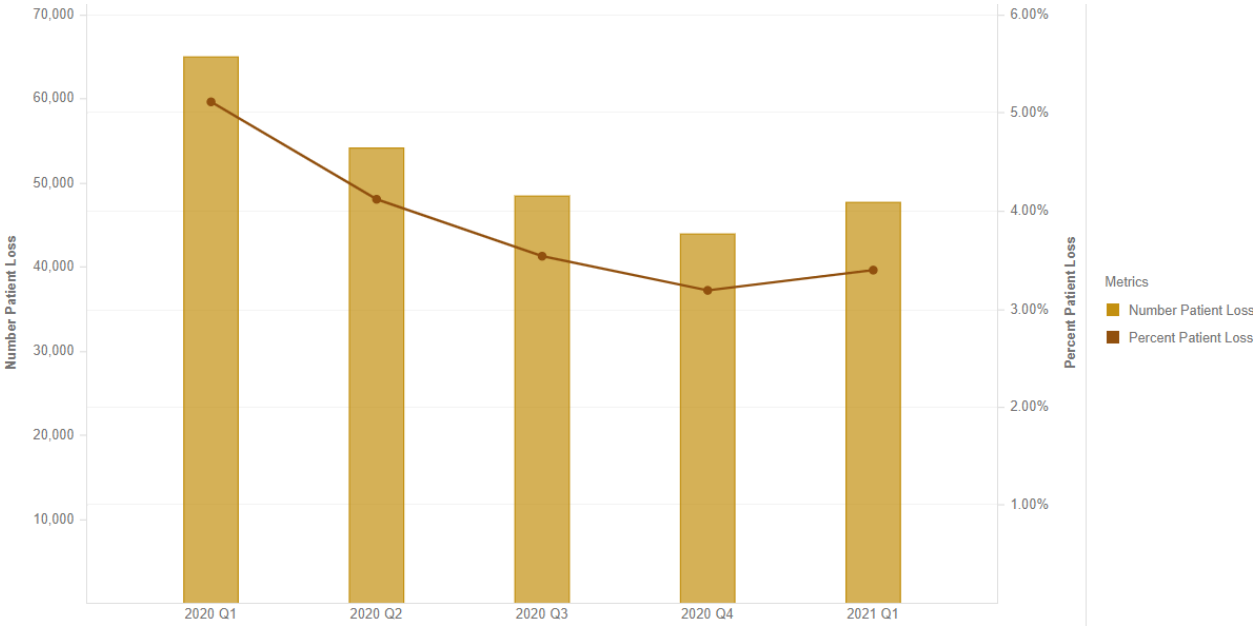


Figure 2.1.7: Disaggregated Proportion of clients lost from ART 2020Q4 to 2021 Q1

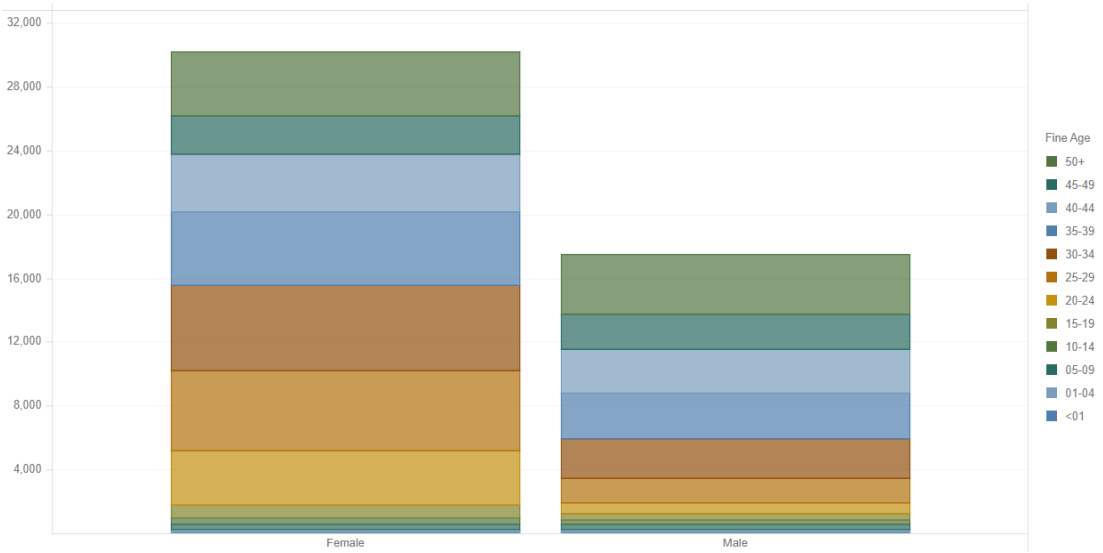
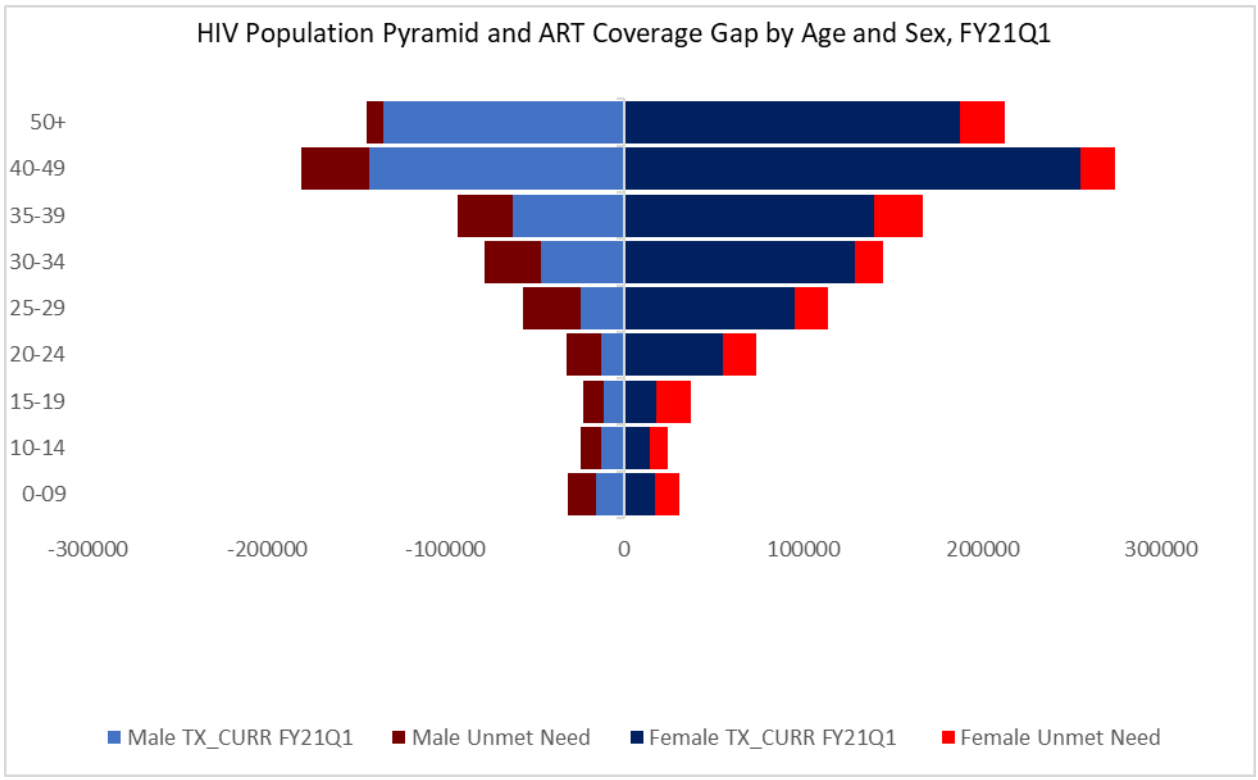


Figure 2.1.8: Tanzania Epidemiologic Trends and Program Response



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention
Beginning in COP19 Q1 and Q2, PEPFAR/T successfully introduced a variety of novel interventions to improve case finding, linkage, and retention. Key initiatives included acceleration of index testing at facility and community settings; optimized provider initiated counseling and testing (with a standardized risk assessment to determine eligibility); same-day ART initiation and linkage case management at facility and community settings; appointment reminders preceding clinic dates; same day tracking of missed appointments with community-facility collaboration for enhanced tracing of lost clients; and enhanced site-level use of data for continuous quality improvement focused on priority indicators.

The successes and experiences of implementation are being scaled up to smaller PEPFAR/T supported sites, while supporting sustained optimal performance at larger sites. Continued improvements in health information systems and utility of the national electronic reporting system, including adoption of a national unique identification strategy, will further facilitate scale-up of these client-centered strategies at all levels.

During COP20, PEPFAR/T, in collaboration with the GoT, will seek to leverage the U=U message to support and enhance retention efforts, medication adherence, and early initiation on ART. In addition, the U=U campaign will further be leveraged to combat HIV-related stigma. Anticipated community engagement activities carried out through implementing partners will include health education and promotion, dissemination of U=U materials, as well as policy and advocacy activities at the national, regional and district levels. U=U messaging will be disseminated and shared in clinical settings, via community outreach events, on websites, and social media platforms. Primary messages will include medication adherence, prevention of sexual transmission of HIV, viral load monitoring, staying undetectable, and other relevant prevention considerations. Additionally, PEPFAR/T will train and capacitate health care workers about U=U and how to communicate the message and support their clients living with HIV.

To close the gap in pediatrics, including improvements in early infant diagnosis (EID), we will implement a program-wide "sweep" to ensure all women living with HIV (WLHIV) have recorded HIV index testing of their children under the age of 19 years. Children of pregnant WLHIV will be a priority of the elimination of mother-to-child transmission (EMTCT) program. Two-month Early Infant Diagnosis coverage will be closely monitored at the site level for HIV-exposed infants. PEPFAR/T will also improve coordination between facility partners and the orphans and vulnerable children (OVC) program to strengthen pediatric HIV case management and continuity of treatment.

PEPFAR/T will also implement a modified "Operation Triple Zero" strategy to address retention and low viral suppression among adolescents and young persons. While HIV testing at the first ANC remains high in Tanzania, PEPFAR/T, in collaboration with GoT, will scale-up a risk screening approach to determine which pregnant women and breastfeeding mothers should be targeted for a serial HIV testing. GOT has developed a tool for screening that is currently under pilot and will be scaled-up as part of the maternal re-testing strategy. This approach will not only help identify additional WLHIV but will be critical to eliminating mother to child transmission in Tanzania. Further, pregnant women and breastfeeding mothers are prioritized among populations to receive PrEP for HIV prevention.

To improve retention in key and vulnerable populations, including men, PEPFAR/T will continue to implement the Bukoba Combination Prevention Evaluation (BCPE) linkage case

management model for new clients and returned clients who were lost from care. The National HIV service delivery model was updated in COP19 to include linkage case management (LCM) for 60 days following HIV diagnosis to support early retention and rapid progress towards viral suppression. Programmatic data indicate that risk of loss is greatest in the first six months of care. In addition, young adults (20-29 years old) are at substantially increased risk for loss. Based on these data, during COP20 PEPFAR/T will explore extending LCM beyond 60 days for at-risk individuals.

All PEPFAR/T supported community implementing partners will scale-up community ART refills by offering multi-month dispensing through mobile clinics. The reach of these mobile clinics will be further extended through use of motorbikes that can bring services to remote villages and settlements. Additionally, mobile pharmacies and motorbikes will be operated by trained healthcare workers (HCWs) recruited by the Regional/Council Health Management Teams. PEPFAR/T will scale-up the reach of the use of the text (SMS) reminder messages to reinforce appointment attendance. Furthermore, through the collaboration of facility and community implementing partners (IPs), specific focus will be to improve tracking of clients through community peers/volunteers.

The combination of targeted facility and community-based HIV testing, expansion of LCM past 60 days for high-risk groups, and the use of mobile differentiated service delivery models for community ART refills, together strengthen a client-centered model. This approach will aim to both facilitate improved diagnosis and viral suppression among underserved populations in Tanzania, including young men and KVPs, and alleviate the burden of expanded ART client loads on health facilities.

Gaps in the clinic-laboratory interface can also interfere in the delivery of timely and quality laboratory services, including early infant diagnosis and viral load testing. Specific challenges include inappropriate specimen collection, storage, packaging and transportation; incomplete documentation in test requisition forms; misidentification of eligible patients; missing and undocumented test results; and inadequate utilization of test results in routine patient management. To address the challenges, PEPFAR/T and GoT plan to improve training at the facility level, introduce monthly indicators tracking key components of the testing cascade and other indicators as deemed necessary, and strengthen the health information systems tracking specimens and test results. PEPFAR/T will also participate in a newly revived National Lab TWG, coupled with monthly supply chain meetings this forum will ensure minimal interruptions in the lab commodity supply chain.

For COP21 all retention activities highlighted above will continue, and PEPFAR/T will focus on assessment of any gaps at facility level for quality improvement. In COP21, PEPFAR/T will also support the GoT to transition the sample transportation and system to the parastatal Tanzania Postal Corporation. This will include strengthening the laboratory tracking system for samples and results. Use of key performance indicators will ensure quality and standardization of services. COVID-related program challenges in community case finding approaches will be addressed through maintained scale-up of index testing while cautiously observing COVID-19 prevention measures.

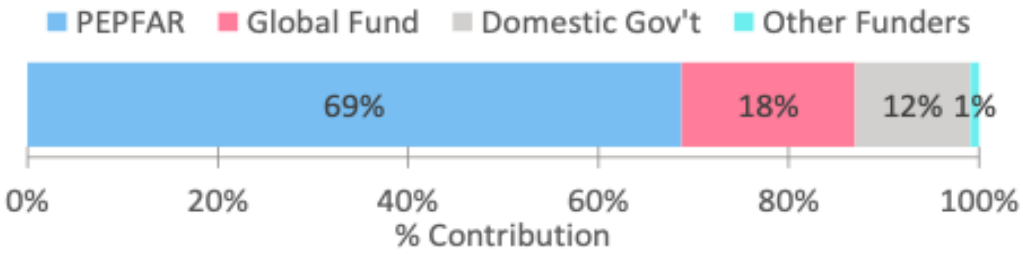
2.3 Investment Profile

The GoT aligns with the Fast-Track Targets and the Sustainable Development Goals (SDGs) and its commitment to end the HIV/AIDS epidemic by 2030 remains strong. Both the Tanzania commission for AIDS (TACAIDS) and the National AIDS Control Program (NACP)

have developed ambitious strategic plans with targets expanding ART coverage to 95% for all PLHIV by 2025 and reducing new infections to only 15,000 annually by 2023[30]. However, domestic financing remains a fraction of the total HIV spending. The Tanzania HIV and AIDS response is almost entirely donor funded. The major donors include the U.S. Government, Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund/GF), The United Nations Children's' Fund (UNICEF), and The United Nations Development Programme (UNDP). Although external contributions for the HIV response have increased since the publication of Tanzania's HIV Investment case 1.0 in 2016, domestic contributions have not increased significantly. Total HIV financing grew from USD 354.5 M in 2015 to USD 606.8 M in 2017. PEPFAR and the Global Fund accounted for 88% of financing in 2015 and 2016 and 90% in 2017. Several other donors and partners beyond PEPFAR and the Global Fund have provided small amounts of financial support and technical assistance.[31]

Table 2.3.1 Total Budget by Funder,2021

Funder	Total Budget	% Contribution
PEPFAR	$471.8m	68.7%
Global Fund	$125.1m	18.2%
Domestic Gov't	$83.3m	12.1%
Other Funders	$6.2 m	0.9%
Total	**$686.4 m**	



Source: HIV Resource Alignment,2021

In 2017, the estimated domestic contribution was USD 52.3 M, less than 10% of total HIV expenditure. Domestic resources have increased over time, from USD 36.8 M in fiscal year 2014-2015 to USD 52.3 M in 2016-2017, a 42% rise over the three-year period. Looking further back, from July 2011 to June 2014, the 3-year total funding was USD 78.7 M, and this increased to USD 138.8 M from July 2014 to June 2017. These contributions from the GoT are primarily in the areas of human resources, logistics support, and infrastructure, with relatively little spending on commodities. Although HIV financing trends in Tanzania were upward during 2015-17, the COP19 funding cycle was a 23% decline from COP18 to unsatisfactory country program performance.[32]

Tanzania has benefitted from increasing HIV expenditure over the past decade, but the low levels of current domestic financing present several challenges. The HIV response has a high dependence on external funding, but this external financing is likely to either stabilize or

[30] TACAIDS (2018). Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23
[31] (2019). Tanzania HIV Investment case 2.0
[32] (2019). Tanzania HIV Investment case 2.0

decline over the next few years. It becomes increasingly pertinent for Tanzania to identify new approaches to optimize the impact of the available funds given the likely stagnation at current levels for the HIV response in Tanzania. Domestic resource mobilization and optimization will both be critical determinants of the future of the response. Currently, the domestic funding is mainly for human resources, infrastructure, and program management, rather than for commodities and treatment, which is the largest program expenditure. Critical prevention services are also mainly financed by donors. Nevertheless, Tanzania is currently in the process of developing the proposal for the Global Fund funding request for the 2020 – 2022 allocation period, a total of USD 379,740,423 is allocated to Tanzania over the course of those three years (2021-2023). UNICEF and WHO are also expected to provide USD 776,564 for above site interventions such as health information system over the course of year 2020.

PEPFAR/T will continue to collaborate and coordinate with GoT and the Global Fund to address key human resources for health gaps that stand as key barriers to fully implementing activities required for epidemic control involving civil society on strategy and key activities. The investment will target allocative efficiency and improved performance of community health workers using evidence-based approaches to estimate the site level needs and client-centered approaches.

The budget split for commodities between PEPFAR/T and the Global Fund indicates one of the strongest areas of collaboration between the two largest donors for the HIV response in Tanzania. The Global Fund will prioritize ARVs and Laboratory commodities including RTKs while PEPFAR/T will also cover ARVs and commodities for PrEP, CTX, TPT, VL, VMMC, and recency tests.

Table 2.3.3 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	$13,000,000	$ 7,449,695	7	$ 19,100,000	Afya Endelevu, Digital Square, GHSC-TA,HRH,PS3
USAID TB	$6,500,000	$ 2,074,996	6	$ 11,755,000	Afya Endelevu, Boresha Afya Northern zone, Boresha Afya Southern zone, Police and Prisons, Afya Bora Mtoto Imara and Tulonge Afya.Imara-Afya Endelevu, Boresha Afya Northern zone, Boresha Afya Southern zone, Police and Prisons, Afya Bora Mtoto Imara and Tulonge Afya.
USAID Malaria	$42,000,000	$ 2,900,000		$ 11,680,000	Boresha Afya Southern zone, GHSC-TA, PS3 plus, Tulonge Afya.
Family Planning	$25,000,000	$ 9,550,000	8	$ 30,381,621	Boresha Afya Northen zone, Boresha Afya Southern zone, Digital Square, GHSC - TA,EpiC, PS3 plus, USESA and Tulonge Afya.
CDC (Global Health Security)	$2,000,000	$ 150,000	2		Co-funding is for FELTP
USAID (Global Health Security	$$1,150,000*	$650,000	2	$5,700,000	Boresha Afya Northern zone, GHSC - TA.

Peace Corps	2,836,300*	0	0	0	*Appropriated funds - $ 2,776,300 SPA funds - $ 60,000
Total	**$ 92,486,300**	**$22,774,691**	**25**	**$78,616,621**	

With the COP21 budget cut from COP20, PEPFAR/T capped its budget for ARVs and VL at approximately $95 million in order to preserve service delivery activities. The latest quantification review done in November 2020 indicated a total country commodity need of US$ 247 million while COP21 allocated amount for commodities is US$ 97mil. This necessitates a need for review of the budget split among the three key funders of the HIV program in Tanzania namely GOT and GFATM and PEPFAR, and these discussions have started and will continue in the coming months as the April 2021 quantification is finalized.

The Global Fund maintains the same level of funding as in previous funding cycle, dedicating 84% of its grant budget to commodities and PEPFAR dedicates 22% of its COP21 budget for commodities.

2.4 National Sustainability Profile Update

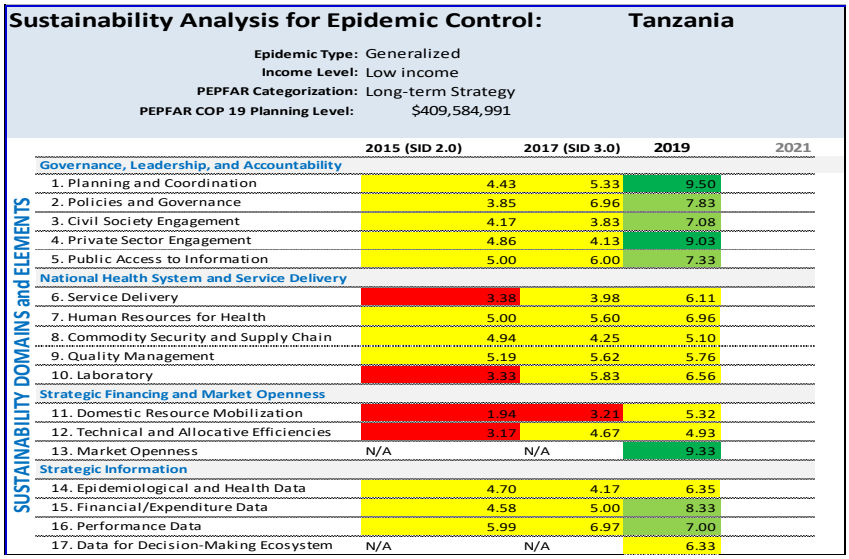
2.4.1 Tanzania Sustainability Index and Dashboard (SID) 2019 Overview

PEPFAR Tanzania completed the HIV/AIDS SID in 2019 as a routine assessment that happens every two years to characterize the country's sustainability landscape and to assist all HIV/AIDS stakeholders in making informed HIV/AIDS investment decisions. The SID 2019 findings will be used to assess above-site level budgeting priorities in COP21. As the SID is updated over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Based on a scoring system that generates responses to specific questions under each domain and element, with a possible maximum of 10 points, the SID assesses the current state of sustainability of national HIV/AIDS responses across 17 critical elements. The strongest scores are coded dark green (8.5- 10 points) which represents sustainability strength, while the next category is light green (7.0- 8.49) which signifies elements that are approaching sustainability, yellow scores (3.50-6.49) are representatives of areas of emerging sustainability, and red scores signify the weakest score (less than 3.5 points). The lower scores demonstrate areas of vulnerability that require continued significant investments, while the higher scores (light and dark green) demonstrate areas of improving sustainability - thus requiring limited investment. Tanzania's overall performance in the area of sustainability demonstrates that there has been improvement across all four domains as compared to SID 3.0 conducted in 2017 (Fig 2.4.1). However, most of the elements require host country ownership and investments to ensure the gains achieved can be sustained.

Tanzania has received substantial external financing for its national response to HIV and AIDS since the establishment of PEPFAR and the Global Fund. Cross-cutting investments from HIV funding sources have strengthened the health system. However, insufficient investments in HIV and the health sector, in general, have prevented Tanzania from reaching its full potential for sustaining the HIV national response.

Figure 2.4.1: Tanzania Sustainability Index and Dashboard (SID) 2019



Sustainability Analysis for Epidemic Control: Tanzania

Epidemic Type: Generalized
Income Level: Low income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 19 Planning Level: $409,584,991

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43	5.33	9.50	
2. Policies and Governance	3.85	6.96	7.83	
3. Civil Society Engagement	4.17	3.83	7.08	
4. Private Sector Engagement	4.86	4.13	9.03	
5. Public Access to Information	5.00	6.00	7.33	
National Health System and Service Delivery				
6. Service Delivery	3.38	3.98	6.11	
7. Human Resources for Health	5.00	5.60	6.96	
8. Commodity Security and Supply Chain	4.94	4.25	5.10	
9. Quality Management	5.19	5.62	5.76	
10. Laboratory	3.33	5.83	6.56	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	1.94	3.21	5.32	
12. Technical and Allocative Efficiencies	3.17	4.67	4.93	
13. Market Openness	N/A	N/A	9.33	
Strategic Information				
14. Epidemiological and Health Data	4.70	4.17	6.35	
15. Financial/Expenditure Data	4.58	5.00	8.33	
16. Performance Data	5.99	6.97	7.00	
17. Data for Decision-Making Ecosystem	N/A	N/A	6.33	

2.4.2 Sustainability Strengths

Out of the four critical SID 2019 domains and the respective elements, the *Governance, Leadership and Accountability domain* has scored dark green in two elements and light green in three elements. The *Policies and Governance* element within the *Governance, Leadership, and Accountability* domain demonstrated the greatest improvement by being scored at 9.50 points compared to 5.33 points in 2017. The documented improvements are largely due to recent developments across various platforms that have improved engagement and participation of Civil Society Organizations including strengthened involvement of civil society organizations (CSOs) and faith-based organizations (FBOs) in service provision, representation in policy decisions and accountability. Also contributing to the high scores were the adoption of key policies and guidelines through provision of updated circulars and revised National Guidelines for the Management of HIV and AIDS (2019) that happened after the COP19 planning meeting in Johannesburg, including review of same-day ART initiation from 14 days to within seven days, six-month multi-month dispensing (6MMD), and the release of new HIV Testing Guidelines in 2019. The GoT has also demonstrated strong political will by adopting the much-awaited amendments of the HIV and AIDS Prevention and Control Act (HAPCA) to allow for HIV self-testing in adults and lowering the age of consent from 18 to 15 years (approved in November 2019). Some critical areas that will require increased efforts and attention are the policies and guidelines to ensure legal protection for all key population groups. PEPFAR Tanzania has been working closely with the Tanzanian government to address challenges around this area using diplomacy and focused program implementation efforts.

The National Health System and Service Delivery, is another area of emerging sustainability that made substantial improvements in all the elements compared to SID 2017. This domain demonstrates an overall increased capacity of in-country service providers to deliver HIV services from the national level to the sub-national levels, with local experts leading in provision of technical support. The national supply chain system is showing some improvements. The holistic supply chain review conducted in 2017 showed the roadmap and responsibilities of each key player including the host Government, PEPFAR and the Global Fund. The country has also invested in task sharing to fill the critical gaps in HIV service delivery.

On the *Strategic Financing and Market Openness*, there are some improvements from SID 2017 due to the government developing a strategy to mobilize domestic financing through the AIDS Trust Fund (ATF) under the TACAIDS. SID 2019 had a new element; *Market Openness*, which has generally shown that there are no prohibitive government or donor policies for different stakeholders in provision of HIV services in Tanzania.

Other areas that demonstrated marked improvements included the *Performance Data and Financial and Expenditure Data* elements under the *Strategic Information* domain, which is aligned with increased GoT leadership through MOH and TACAIDS to collect HIV expenditure data and improved efforts to strengthen and harmonize information systems for data use and decision making. PEPFAR has continued to support the roll out of Direct Health Facility Financing (DHFF), Facility Financial Accounting and Reporting Systems (FFARS) that will strengthen the public financial management (PFM) to primary level health facilities (health center and dispensaries).

In addition, Activity Based Costing and management (ABC/M) that is being implemented in FY20 as a core component of PEPFAR's financial sustainability brings together elements of both financial and functional responsibility aiming at improving the efficiency, cost-effectiveness, and quality of HIV – related service delivery and broader health services.

2.4.2 Sustainability Vulnerabilities

The SID exercise also helped identify critical issues that require further investments and ownership to ensure sustainability. Within *Governance, Leadership and Accountability* domain, despite some improvements in engagement with CSOs, FBOs and private not-for-profit organizations, the private for-profit and private health services providers' engagement still needs further support and incentives to participate in the planning, coordination and implementation at all levels. Even though several coordination structures and mechanisms are in place, further investments are needed to strengthen their capacity, consistency in implementation, and accountability to HIV epidemic control initiatives.

Engagement with the private sector is an important element in sustainability of the gains. The policies and systems to engage with the private sector do exist in Tanzania, however the actual implementation is inconsistent across different intervention areas and geographic locations. TACAIDS creates an enabling environment by serving as a champion for multi-sectoral involvement in HIV/AIDS programming in the country. When considering the private sector within *the Governance, Leadership and Accountability* domain, the review team considered both the private, for-profit sector, as well as the private, not-for-profit sector. FBOs primarily fit into the latter category. Tanzania has made progress engaging with the private sector; however, this has disproportionately been dominated by non-profit entities, and the government provides more channels and opportunities for this engagement. For example, faith-based facilities can achieve certain criteria or standards that enable them to receive HRH and operational cost support through existing service level agreements. Such service agreements are not available in private for-profit entities which may only be eligible to receive some health commodities and reporting support. Deliberate efforts to engage with private for-profit entities are needed, especially because there is interest from within the private sector, but capacity is limited for most facilities.

In COP21, PEPFAR/T will continue to support and build on the progress made in COP20 by identifying potential private sector opportunities for complementing and strengthening the

local response to the pandemic including Total Market Approach (TMA) advocacy for HIV commodities.

Within the *National Health System and Service Delivery* domain, there is inadequate domestic financing for the procurement of ARVs, HIV rapid test kits (RTKs), condoms, and supply chain related costs. The *Commodity Security and Supply Chain* showed some improvements from SID 2017, however, the Holistic Supply Chain Review revealed weaknesses that require leadership, ownership, and continued investments by the government of Tanzania to reduce donor dependence. Despite ongoing efforts to cover the critical shortage of skilled health workforce, there is an overall low production, absorption, and deployment of health workforce to areas with critical needs. This area needs serious consideration and investment by all key stakeholders.

In COP21, PEPFAR/T will continue to engage all stakeholders, especially GoT, to optimize key HRH needs in order to sustain the gains amid disruptions to the health system and the healthcare workforce across the HIV continuum of care caused by COVID-19.

2.4.3 Funding for HIV epidemic

In COP21, PEPFAR/T's budget decreased by 9% compared to COP20. The Government of Tanzania continues to implement Global Fund grants and new grants were approved for the implementation period 2021 – 2023. In the Global Fund new HIV grants, Tanzania is receiving US$ 380,599,183 which is slight increase from previous allocation of US$ 371,092,337. 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**.** The national budgets do include funding for HIV/AIDS, but the overall ability to ensure that enough resources are committed to meet the needs in Tanzania remains a continued challenge**.** Only a small percentage of the national HIV response is financed with domestic resources. Data on government resources allocated to highest burden geographic areas are unavailable. ARV benchmark pricing is not applied by the government because of total dependence on the USG and Global Fund 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 it does not use data to strategically allocate funding and maximize investments.

In COP21 PEPFAR/T will continue to focus on increasing the transparency and accountability of investments made and advocate with the GoT for increased data sharing on performance, including financial information through resource alignment initiative for effective decision making.

2.4.4 Transition to indigenous partners

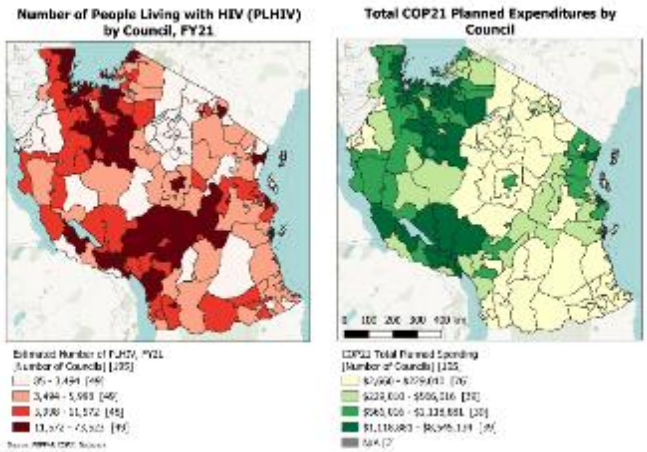
PEPFAR/T is committed to continuing and protecting the progress that has been made over the past 18 years in Tanzania. In COP21, USG agencies will continue to promote local capacity, development, and to responsibly transition to ingenious organizations that will effectively fulfill PEPFAR's mandate. 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 70% of funds transitioned to local partners in COP21. 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. In COP21, PEPFAR/T will build on the progress made in COP20 to appropriately contribute to the global goal of 70% of PEPFAR funds going 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.

2.5 Alignment of PEPFAR investments geographically to disease burden

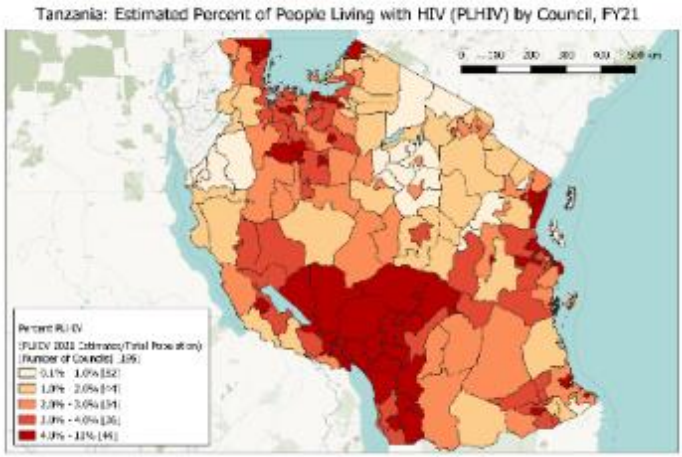
To determine if budgets appropriately aligned with HIV disease burden in Tanzania, COP21 planned spending was mapped alongside the most recent Spectrum PLHIV estimates. As displayed in Map 1, many PLHIV reside in the Lake Zone, the Southern Highlands, and Dar es Salaam. Therefore, a proportionate amount of the COP21 budget will continue to be invested in those geographic areas as it was in COP20

Map 1: Number of PLHIV by Council as compared to COP19 Planned Budget by Council



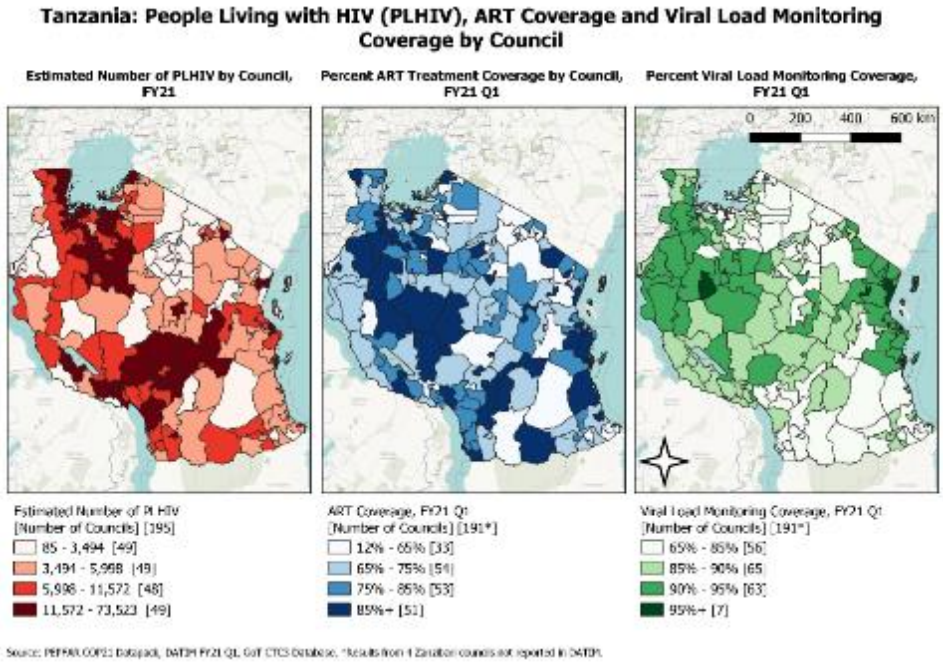
Map 2 displays PLHIV as a proportion of the estimated population from Spectrum models in each council., Councils in the Lake Zone, the Southern Highlands and around Dar es Salaam tend to have the highest proportions of PLHIV compared to total estimate population.

Map 2: Estimated percentage of PLHIV by Council



Map 3 displays the number of PLHIV, estimated ART treatment coverage, and viral load monitoring coverage at the council level. Councils with high HIV burden (within the highest quartile of PLHIV burden) also tend to have the highest ART coverage, as seen in the Lake Zone and Southern Highlands. This map also shows that the scale-up of viral load capacity in recent years resulted in clear improvements although COVID-19 has impacted continued progress over more recent months..

Map 3: PLHIV, ART Coverage and Viral Load Coverage by Council



Source: PEPFAR COP21 Datapack, DATIM FY21 Q1, GoT CTC3 Database. *Results from 4 Zanzibar councils not reported in DATIM.

Taken together these maps show that PEPFAR/T investments are geographically aligned with high burden areas as identified by the best currently available data. Nonetheless implementing a second PHIA will be a critical step for the program's success moving forward as this will be the only way of truly assuring that our investments are aligned with the areas of greatest remaining need.

2.6 Stakeholder Engagement

PEPFAR/T engaged external stakeholders to develop COP20 beginning in December 2020 when the COP21 draft guidance was 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-December 2020, PEPFAR/T leadership shared the COP21 timelines with all stakeholders - GoT (TACAIDS, Presidents Office Regional Authority and Local Government (PO-RALG), and MoHCDGEC), CSOs, and Development Partners. Stakeholders were requested to select representatives to attend the COP 21 Virtual Planning meeting, originally scheduled for March, 2021 in order to ensure their full participation in COP21 planning process. In mid-January 2021, the final COP21 Guidance and the Planning Level Letter were shared with all stakeholders.

During the week of January 25, 2021, PEPFAR/T held a COP21 Strategic Planning Workshop during which the COP21 programmatic, technical, policy priorities, various COP inputs, and tools were discussed. More than 200 stakeholders attended the meeting. The first two days of the meeting focused on discussion of minimum program requirements, GoT priorities, status

and plans for the new Global Fund award, and identifying important areas for subsequent discussion. The remaining days were focused on small group technical discussions to make strategic plans and decisions for COP 21 implementation. Time was dedicated to sensitizing participants on the COP tools, such as the Funding Allocation to Strategy Tool (FAST) and understanding results of the recent spectrum analysis.

During the COP21 planning, PEPFAR regularly engaged with Tanzanian CSOs to ensure their involvement in the planning process. Through a democratic process, CSO groups namely, Non-State Actors (NSA), Key and Vulnerable Population (KVP) Forum, NACOPHA, and the Adolescent and Young Adults (AYA) Steering Committee elected representatives to attend the COP21 Virtual Planning Meeting. CSO representatives came from KP, PLHIV, youth, and faith-based constituencies. The NSA also identified two additional representatives for a total of six.The CSO representatives worked with their constituencies to develop a presentation on COP21 CSO Priorities that was presented during the Strategic Planning Workshop in January. Based on the feedback provided, the CSO representatives continued to engage with their constituencies to synthesize their input into a "People's COP" document, which was shared in April 2021. This document was launched with stakeholders and ultimately formed the basis for their presentations and discussions during the Virtual Planning Meeting.

The GoT selected a delegation of twelve representatives to attend the Virtual Planning Meeting, including the Chief Medical Officer at MOH, several representatives from National AIDS Control Program (NACP), a representative from TACAIDS, and PO-RALG, with the Honorable Deputy Minister of Health as the head of the delegation. Several meetings were held with PEPFAR/T and GoT representatives to discuss policy and the minimum program requirements for COP21, and this was included as an agenda item at two of the regular monthly CMO meetings. In addition, one check-in meeting with all meeting delegates, called by Tanzania's Country Chair, and an in-country check in meeting was held with all delegates to review draft tools.

As the COP is finalized and throughout FY21 and FY22, PEPFAR/T will continue to engage CSOs, GoT, UN Agencies, and other stakeholders as key members of Tanzania's Development Partners Group on HIV/AIDS to collaborate on strategies that ensure Tanzania is on track to achieve epidemic control. The purposes of the monthly meetings between PEPFAR/T and the MoHCDGEC technical staff are to share and review monthly PEPFAR/T data, review policy adoption and implementation, and ensure implementation continues during COP20 and COP21. PEPFAR/T will continue regular engagement with the Global Fund in order to coordinate procurement of commodities procurement, supply chain coordination, and to ensure program activities are complementary.

3.0 Geographic and Population Prioritization

Table 3.1 below summarizes ART saturation and categorizes geographic areas accordingly. PEPFAR Tanzania has attained ART coverage in 11 Districts within 10 regions with a prevalence range of 3-10%. Almost all the 11 districts represent urban areas with high HIV prevalence. COP21 program planning will continue to prioritize these districts through ambitious targets in Dar es Salaam, the regions/districts surrounding Lake Victoria, and transportation corridors in the Southern Highlands.

According to the 2016-2017 THIS, of the 7 million men aged 15-29, 57% had received a VMMC, leaving a remaining gap of 1.7 million men to be reached. Since 2017, PEPFAR/T conducted more than one million circumcisions, reaching a national male circumcision (MC) prevalence

near 80% among men 15-29 years old. Despite this overall success, substantial geographic and demographic gaps remain -- Shinyanga and Simiyu (two regions adjacent to Lake Victoria) have MC prevalence of only 46% among men aged 15-29 years. This MC coverage gap is further compounded by the high HIV prevalence among fisherfolk in the Lake Victoria area (three times higher than the national prevalence). Factors affecting adult male uptake of VMMC services include distance to facility, lack of privacy due to structural set-up of facilities, economic constraints, emotional reservations, perceived irrelevance, and traditional and cultural norms. PEPFAR/T applied for, and was awarded, VMMC ambition funds in COP20 to close the MC gap in these regions. During COP19, the PEPFAR/T VMMC program transitioned to focus services on boys aged 15 years and older.

PEPFAR/T is currently operational in 197 councils in the country. COP21 plans will build on the programmatic shifts operationalized in NAOMI model estimates. 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.

Based upon progress made in service delivery during COP19 and COP20 and revised PLHIV estimates, in COP21, PEPFAR/T will continue to implement key interventions that will be prioritized in districts with greatest burden and gap in coverage. Although districts within Dar es Salaam, Lake Victoria area, and Southern Highlands have made significant progress in improved identification, gaps remain in ART coverage. Four of the five districts in Dar es Salaam have the highest PLHIV burden among scale-up districts and are being prioritized for enhanced activities in COP19 and COP20. Among the 35 districts within the Lake Region, seven districts (across four regions) maintain the largest unmet coverage needs and will continue to be prioritized for enhanced programming including KVP activities. Within the southern highlands, significant progress has been made and based upon COP20 targets, the 24 scale-up districts are on track to reach 90% ART coverage.

In COP21, PEPFAR/T will continue to prioritize case finding among men, KP, infants, children and AGYW. Following impressive progress made in reaching and surpassing the 90-90-90 goal of community viral suppression in COP20-Tanzania has embarked on the 95-95-95 goals with a focus on gaps that have been identified during COP21 FYQ1. The areas lagging behind are case finding in men, AGYW, infants, and children. PEPFAR Tanzania will enhance efforts to target men 15-49 years old in Dodoma, Kigoma, Kaskazini, Pemba, and Kusini Pemba regions which show the highest gap in treatment coverage for men. PEPFAR/T will continue to utilize the standardized, data-driven, male-centered service package that addresses the entire cascade across regions with highest gaps in finding men. In FY21, PEPFAR/T will continue supporting the scale-up the HIVST to cover all regions, targeting men, key and vulnerable populations.

PEPFAR/T plans to conduct the Population-based HIV Impact Assessment (PHIA) or THIS 2.0 during COP21, with attention to sufficiently powered estimates in identified key regions, to improve the regional level estimates.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP21	# Expected Current on ART (FY22)	# of SNU COP20 (FY21)	# of SNU COP21 (FY22)
Attained	225,680	199,270	11	11
Scale-up Saturation	1,214,880	1,058,054	98	98

Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	313,445	282,174	87	87
Central Support	N/A	N/A	N/A	N/A

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

Programmatic Priorities for Epidemic Control

In Tanzania, data from the 2016-2017 THIS demonstrated that gaps in case finding were large across all age and sex sub-groups and all geographic areas. At that time, only 61% of PLHIV knew their status countrywide, the lowest among all countries with substantial PEPFAR funding. During FY2018 and FY2019, the PEPFAR/T program made a strategic pivot to focus on identification of people with HIV, targeting efforts both geographically (e.g., the Lake Victoria area) and epidemiologically (e.g., sexual contacts through index testing). Despite reductions in identification efforts in FY20 due to the COVID-19 epidemic, during the first two quarters of FY2021, Tanzania added 108.631 people on ART treatment. PEPFAR/T achievements were attributed implementation of index testing, optimized provider-initiated testing and counseling (PITC), and targeted community-based testing approaches.

Although the gaps across the cascade are improving, there is still inequity by age and sex. To reach Tanzania's goals of achieving UNAIDS 95-95-95 targets, a combination of HIV testing services (HTS) approaches will be required. These include index testing and HIV self-testing to increase identification of PLHIV through client-centered approaches at facility and community-based settings. In addition, continued attention to pediatric identification efforts will continue, with an emphasis on testing of HIV-exposed infants and index testing of biological children of mothers living with HIV. Despite achievements to date and lessons learned, PEPFAR/T needs to continue working with MoH and IPs to optimize HIV testing and linkage to care for all people including young adults and KVPs. The most recent UNAIDS estimates show that the gap is largest among some sub-populations, especially children, adolescents, and men (Figure4.1).

Fig 4.1: ART Treatment Gaps as of December 2021

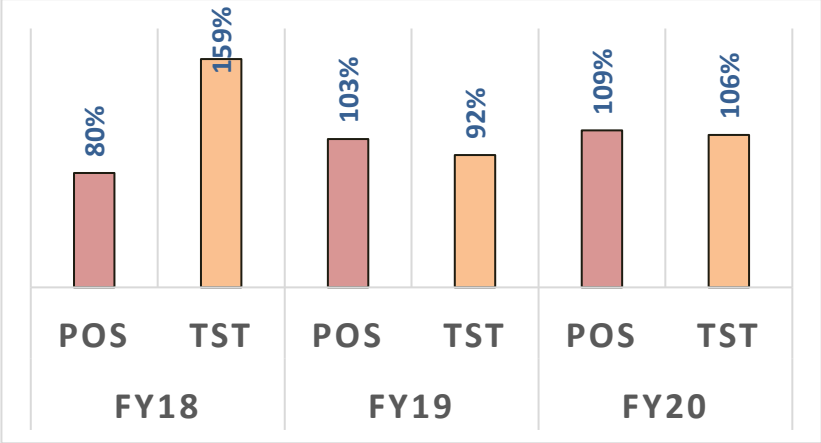
Age stratum	FY21 Q1 TX_CURR*		2021 PLHIV estimate (Naomi Model)		ART coverage	
	Female	Male	Female	Male	Female	Male
<01	170	156	1,438	1,481	12%	11%
01-04	4,745	4,469	7,888	8,123	60%	55%
05-09	11,930	11,288	17,985	18,447	66%	61%
10-14	13,976	12,984	22,448	23,021	62%	56%
15-19	18,079	11,430	37,776	23,175	48%	49%
20-24	54,865	12,633	73,908	32,773	74%	39%
25-29	94,894	24,421	114,013	56,837	83%	43%
30-34	128,807	46,904	145,083	77,990	89%	60%
35-39	139,303	62,207	166,863	93,378	83%	67%
40-44	140,612	73,529	154,445	95,721	91%	77%
45-49	114,463	69,282	120,311	85,055	95%	81%
50+	187,437	134,491	214,170	143,768	88%	94%
Total	909,281	463,794	1,076,327	659,768	84%	70%

4.1.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

The data from the 2016/2017 THIS showed that only 61% of PLHIV were aware of their status, presenting a key challenge to achieving the UNAIDS 95-95-95 goals. Following these findings, PEPFAR/T used a focused approach to align targeted and effective case finding strategies to improve identification. From COP19 and continued in COP20 planning, PEPFAR/T aimed to increase the quality and focus of the HIV testing, care and treatment services to identify, link and maintain clients in treatment services. To reach 95% treatment coverage, 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.

As a result of scaling up targeted testing by employing more effective identification strategies like index testing, optimized PITC, and focused community testing Tanzania changed the over-testing performance of FY18 for two years consecutively i.e. FY19 and FY20. The figure 4.1.1A below shows performance of testing and positive identification against COP targets for FY18 to FY20.

Fig. 4.1.1A:



For COP21, PEPFAR/T will continue to address the broad gaps in coverage across age and sex bands through enhanced, evidence-based implementation of four key aspects of client-centered HIV case finding approaches: index testing, optimized PITC, HIV self-testing scale-up, and client centered targeted community testing, including peer/social network testing (SNT) approaches for key and priority populations with focus in geographic hot spots on areas where new diagnoses are occurring. Special emphasis will be on ensuring safe and ethical implementation of index testing services, including adherence to WHO's 5Cs principles of HIV Testing Services for a client-centered, safe, non-coercive, private, and confidential service. Additionally, this will be informed by the index testing site assessment for safe and ethical index testing which started on October 2020 under GOT leadership and PEPFAR/T IPs facilitation. PEPFAR/T will ensure the involvement of CSOs in site assessment analysis and planning for any improvement actions required, including identifying health care worker training needs to address GBV. The tracking of quality implementation of index testing will include the use of established system of monitoring intimate partner violence and reporting of any related adverse events. Implementing partners will not be held to index testing targets set in the data pack. PEPFAR/T will also explore the use of index testing to trace clients defaulting

from treatment. Index testing could be used to link and re-engage known positive contacts that are not in care back into ART services.

As IPs address intimate partner violence (IPV), community and facility partners will strengthen the inclusion of gender -based violence (GBV) screening and response through PEPFAR/T support by rolling out GBV screening and referrals in HTS settings with a focus in councils shown to have higher risk. IPs will increase capacity of providers to effectively incorporate HIV testing messages, advocate for positive gender norms, and conduct GBV screening and response using the LIVES approach into testing and counselling sessions. IPs will ensure that each site has providers trained on how to enquire and respond to disclosures of violence using the LIVES approach. Partners will also work on improving the quality of post-violence care services. Trained providers will provide appropriate referrals to safe space/shelters and linkages will be created with support groups and legal services.

PEPFAR/T will continue to increase coverage and fidelity of safe and ethical index testing, optimized PITC using the national HIV risk screening tool, targeted scale-up of HIV self-testing and focused community based testing. In FY20 with the limitations of COVID19 PEPFAR/T demonstrated relative improvements in both the number of index positives identified and testing yield (see figures 4.1.1 B and 4.1.1C below),while the overall trend of absolute positive identification decreased from FY20Q3 after COVID19 was declared in Tanzania, index yield was kept above 20%.

Fig 4.1.1B: Trend of positive identification and index testing contribution overtime

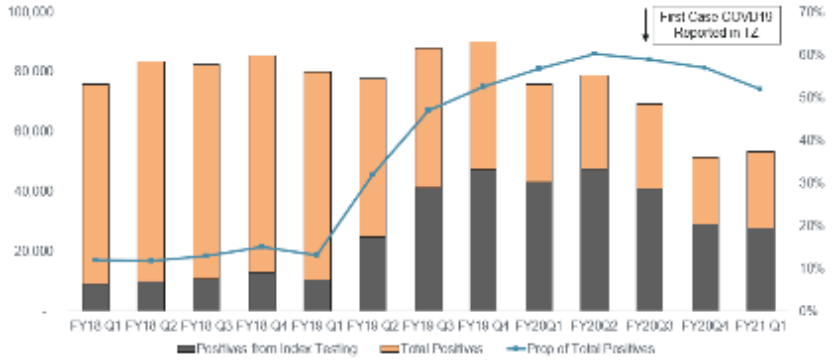
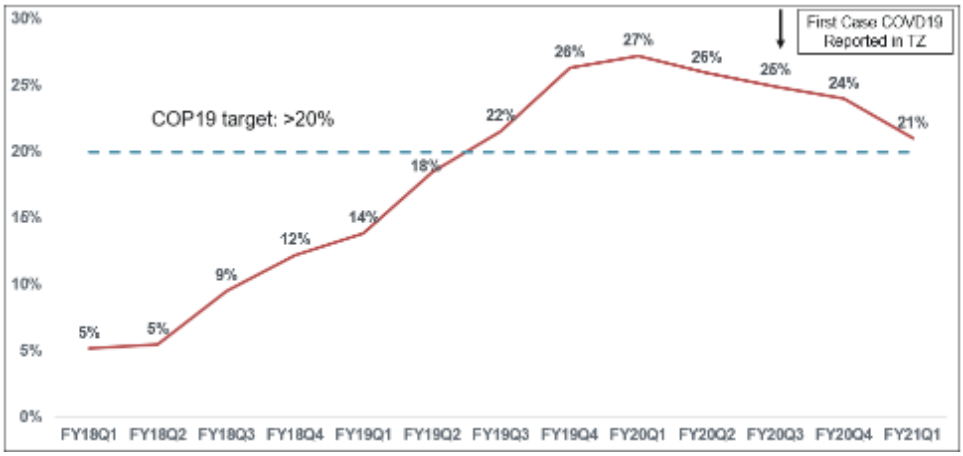


Fig. 4.1.1C: index testing yield trend



All PEPFAR/T supported sites continued implementing index testing, specifically focusing on the scale-up of assisted voluntary partner notification to support index client acceptance, elicitation of contacts, mapping and active tracking of contacts for testing, and linkage to care and treatment services for those who are diagnosed with HIV. At all sites, monitoring of index testing services provision was done throughout the cascade approach, i.e. data on the number of sexual contacts identified per index case, the proportion tested, and the yield was tracked to identify the facilities in which the greatest improvement were needed, and also to identify the specific gaps requiring improvement. This approach demonstrated success in improving results.

COP21 Identification Strategies with COVID 19 risk mitigation measures

- Client centered index testing in both facility and community settings while ensuring safety, non-coercion, privacy, and confidentiality measures are in place in the provision of index testing services
- Optimized PITC for increased yields, with focus in high-volume, high-yield facilities using the validated national HIV risk screening tool for each test taking place at OPD
- Targeted client centered facility-led community testing used selectively and tailored to needs of men and KVP, PP, and DREAMS
- HIV self-testing scale up country-wide

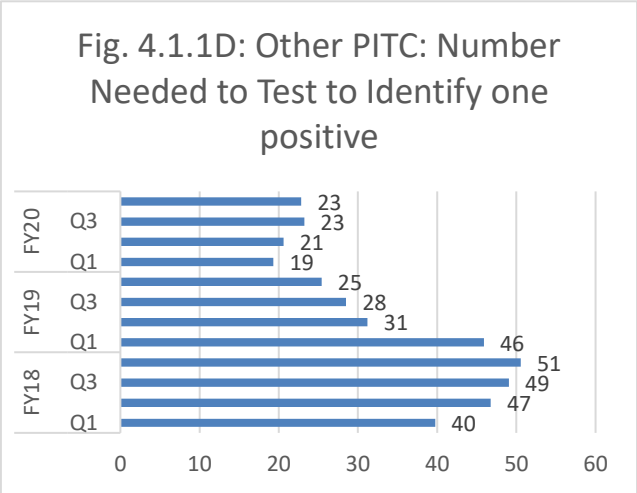
In COP21, the post-contact tracing adverse event screening for index clients will include physical and non-physical violence, undesired disclosure of status, identity, and conditioning of services on participation in index testing, and will be developed with input from civil society organizations. The site-level assessment tool of Index Testing Minimum Requirements will continue to be used to ensure sites are implementing index testing safely and ethically. Site level data from this assessment can be shared with civil society and other stakeholders. Sites will require remediation measures if they do not meet the minimum requirements. In such cases, index testing services at those sites should undergo further joint review. If verification of missed requirements is confirmed, PEPFAR will consider pausing index testing services until remediation measures have been completed. Alternative criteria could be developed with stakeholders, but will rely on joint decision-making processes and shared analysis of site-level data. Results of adverse event tracking will be monitored regularly along with performance against other indicators, triggering immediate action and reported in PEPFAR /T monthly reporting portal through partners, POART reviews as part of index testing progress assessment as well as MOH monthly HTS reports. National training curricula and monitoring and evaluation (M&E) materials for index testing (HTS registers including elicitation and adverse event reporting forms) have been developed and rolled out and include HIV self-testing and linkages to treatment.

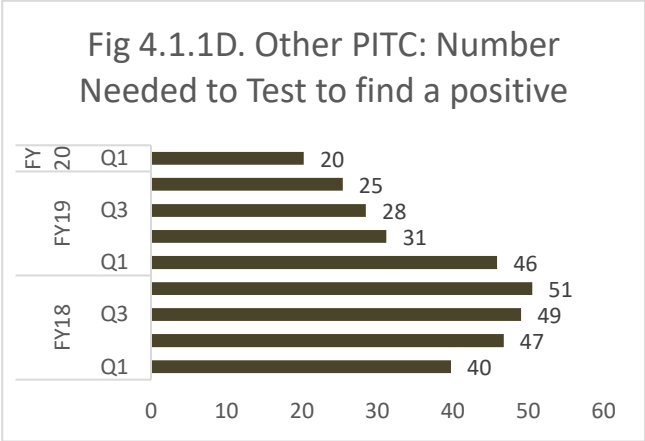
In COP21, for optimized PITC, PEPFAR/T will continue to strengthen the collaboration with the Government of Tanzania to ensure wider scale up of HIV risk screening for HTS among both adult and pediatric clients especially at medical outpatient department (OPD) settings and other testing within the facility serving general population. 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.

PEPFAR/T will continue ensuring the use of the national HIV risk screening tool across supported facilities. The result of this effort will be to continue to optimize yield for PITC in facilities that are PEPFAR/T supported. Compared to the FY18, the number of tests done at

OPD settings (Other PITC modality) decreased significantly. From the Figure 4.1.1D below, the number needed to test (NNT) to identify one positive has decreased from 51, which was the highest in FY18 Q4, to 23 in FY20 Q4. This is a substantial reduction of tests.

Furthermore, PEPFAR/T will intensify targeted client-centered, facility-led, community case finding strategies with high yield focusing on Key and Vulnerable Populations (KVP) in community settings. This will continue to be the key area for the KVP Advisory Committee involvement. In COP21, the program will also focus on testing of the KVP positive social network through social network testing. The program does not support non-KVP, non-index community, non-targeted campaigns and general population testing approaches. Client-centered, facility-led, community-based testing will focus on high-risk areas informed by mapping of KVP hotspots, concentrations of PLHIV and recent HIV infection surveillance data. These interventions will increase yield and will decrease testing in low burden areas. Data from PEPFAR/T community activities in COP19 demonstrated 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 benefits in closing HIV case finding gaps, it is especially important in finding men.



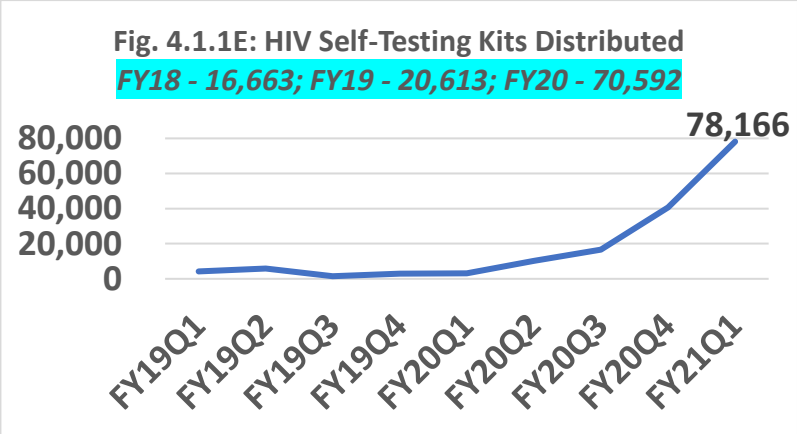


In addition, to effectively target client-centered, facility-led, community-based HTS activities, PEPFAR/T will continue to integrate nighttime and moonlight testing activities to better reach key and priority populations and communities surrounding KVP hotspots. These activities have been critical to Tanzania's success in meeting KVP targets. Implementing partners 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 continue supporting refresher trainings on the new revised HTS M&E tools and safe and ethical index testing training packages, 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.

For HIV self-testing, in COP21 PEPFAR/T Will continue working closely with the GOT to scale up HIV Self testing services in both community and facility settings with a focus on high risk and hard to reach populations like men. PEPFAR/T will also explore secondary distribution of HIVST through index testing activities as another way to reach men. Referring to figure 4.1.1

below, the number of kits distributed has been increasing progressively since 2018 when the program started in Tanzania. In FY20, the program distributed more than three times the number of kits distributed in fy19. In FY21Q1 alone the number of kits distributed, 78,166 exceeds the number distributed the whole of FY20, indicating the ongoing massive scale-up country wide.

Focusing on the cascade of HIVST services in FY20, nearly 80% of the kits have been distributed to females, primarily FSWs and AGYWs. Other groups reached include MSM, PWID, serodiscordant couples and other vulnerable populations. Over two third of the kits were used by the assisted method. Close to 90% of the results were returned with a positivity rate of 6%. 97% of the confirmed HIV positive clients were linked to ART services. During COP20 and COP21, with most of the policy and commodity barriers experienced before addressed, and the HIV self-testing implementation framework endorsed, PEPFAR/T will continue supporting the scale-up the to all regions of Tanzania, targeting men, key and vulnerable populations.



PEPFAR/T, in collaboration with GoT, will continue to support the client-centered, facility-led, community ART initiation and refills services for KVP (30-day prescriptions), in line with the new MoHCDGEC guidelines. We will continue strengthening and supporting PLHIV-support groups and networks to improve overall quality of services to increase continuum of treatment and achieve viral suppression for both adults and children living with HIV.

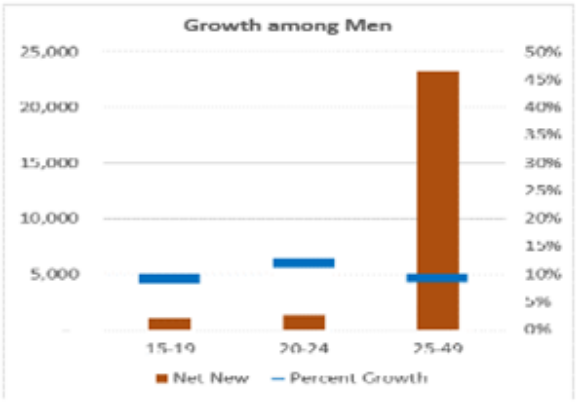
PEPFAR/T will implement the evidence-based linkage case management (LCM) model, assigning all newly initiated PLHIV to a PLHIV expert client for the first 60 days to support adherence to ART and promote early retention to care and treatment. In COP20 LCM was prioritized in all PEPFAR supported sites, and in COP21 will continue monitoring the program impact as we ensure fidelity of implementation across sites. Additionally, the emphasis will be on effective bi-directional referral systems, particularly for HIV-positive individuals, for increased access to care and treatment services, as well as for HIV-negative individuals to prevention programs that reinforce risk reduction. M&E efforts will be strengthened to effectively measure not only how many people have been referred from community to facility settings services, but also of those referred, how many have reached and utilized services. Sites and implementing partners will monitor data weekly and monthly and adapt the HTS program accordingly. PEPFAR/T will conduct analysis by population, sub-groups, age, and gender to understand program challenges in identification and use the data to improve client-centered targeted testing and linkage to treatment services.

Adult men

Based on FY20 Q1 program data, PEPFAR/T continues to struggle with identification of HIV-positive men and initiating these men on treatment. Currently, 33% of 2020 PLHIV estimate in Tanzania are men aged 15+ years where ART coverage has remained very low.

Finding men was a priority in 2020. However, identification of men decreased in terms of the number of new positives identified in 2020 (FY 20 Q1; 29,964 – FY 20 Q4 19,481), along with a decrease in testing yield from around 10% to 8%. This decrease could be due to the impact of COVID 19. Over 81% of the positives were identified through index testing services by FY20 Q4, which is evidence of the effectiveness of the strategies for identifying men through index testing. Despite of the decrease in HIV positives identified among men which has been highly impacted by the COVID19 situation, the data shows growth in TX_NEW resulted in the person-level benefit of increasing the number of men on ART. Figure 4.1.2 illustrates the NET_NEW for each male age group shown, and the percent increase in TX_CURR for the year.

Figure 4.1.2: Tanzania NET_NEW growth by age among men (FY20 Q1 to FY21 Q1)



PEPFAR/T will build on these index testing and community testing successes, rapidly improving index testing through partner notification services as an approach to increase identification of males. The community successes came mainly from KVP outreach activities. 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. In addition, PEPFAR/T will ensure all sites implementing Index Testing adhere and implement PEPFAR's minimum standards for Safe and Ethical Index Testing, providers trained and supervised on index testing procedures that include the 5Cs (Consent, confidentiality, counselling, correct results, & connection to prevention and treatment), IPV screening, AE monitoring, and ethics.

PEPFAR/T will continue to emphasize on the use of Social Network Testing as one of the new client-centered intervention targeting men. Complementing the index testing and HIV self-testing (HIVST) services, PEPFAR/T will scale up this modality especially among the KP, men and adolescents.

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 HIVST in male-dominated workplaces, both public and private.

PEPFAR/T's FY20 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 COP20 efforts to make clinics more "male-friendly" through extended operating hours, moonlight services, deploying male service providers, 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 SDM models that includes, multi-month prescriptions – including the new MoHCDGEC approach to providing six-month dispensing - and ART outreach services through facility community ART refills will continue and should help to improve retention by decreasing the need for monthly facility visits. Opportunities to expand community ART distribution and refills will be explored.

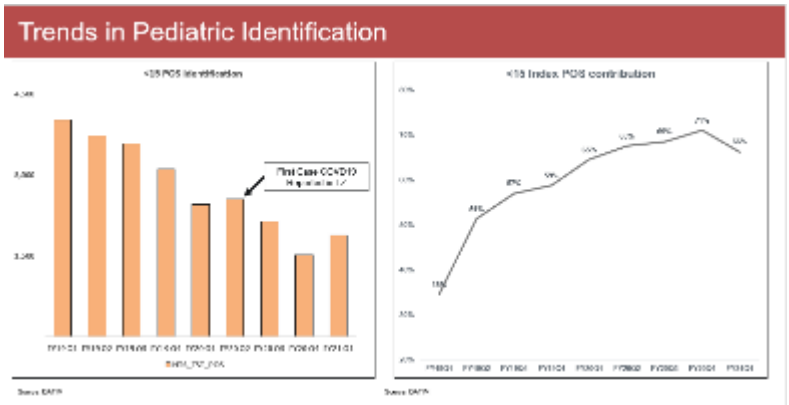
Adult women

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. Based on recent data, ANC coverage 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, PEPFAR/T transitioned PMTCT testing services to the GoT in 8 regions in COP 19. PEPFAR/T will continue to improve counseling to promote retention in PMTCT through same-day and weekly tracking of clients to ensure they are linked and maintained on treatment, 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 viremic 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/IPV screening services as part of these testing activities.

Pediatrics

The 2020 program data show major gaps in identifying pediatric populations living with HIV despite increase in yield of HIV testing and viral suppression. The overall strategy for addressing the gap in ART coverage in pediatric populations has four elements: (1) improving EID coverage, (2) index testing for all biological children of mothers with HIV, (3) OVC activities, and (4) risk screening for children from 2 years of age-14. Figure 4.1.5A shows the FY19-20 quarterly pediatric HIV case identification trend and index contribution.

Fig 4.1.5A: Pediatric case finding and contribution index modality to total Positive <15 years



In FY20 PEPFAR/T achieved 81% of EID testing coverage at two months, which is an increase from 72% in FY19. This great achievement was contributed by increasing the number of

facilities offering Point of Care Testing (POCT) particularly in hard-to-reach locations from 52 to 94; mentoring health care workers on collection of quality DBS samples and strengthening integration of EID testing within immunization clinics and during outreach services; peer mother initiatives have been implemented at facilities with high volumes of pregnant and breastfeeding women and on-the-job training has been conducted to improve documentation in mother-child cohort registers, HEI cards and individual electronic records.

PEPFAR/T is working to maintain all the approaches that worked in FY20 to ensure a systematic approach is used to identify all HEI through screening, use of immunization cards, and by ensuring an EID sample is collected at six weeks of immunization visit. PEPFAR/T will also work to monitor and improve the quality of EID samples. PEPFAR/T will continue to support local government authorities (LGAs) and IPs to ensure that all PMTCT sites are equipped to provide EID services and can utilize peer mothers to screen immunization cards to identify those eligible for testing and follow up mother-baby pairs. PEPFAR/T will continue to use local EID tracking registers at labor/delivery and ensure active communication between this department and the reproductive and child health clinic to report on the number of HEI live births for DBS collection.

Currently, Tanzania is using DBS for EID testing on Genexpert machines, and staff facilities are trained for DBS collection and sample management. Available standard operating procedures and guidance are for DBS samples. Given that Same Genexpert machines are targeted for EID, TB and VL (special groups), increased workload is likely to happen at some of these testing sites. DBS is the best option for now to ensure sample quality in case testing may not happen on same day or in case these may need to be transported to another sites. mPIMA for EID testing are available in four sites. PEPFAR /T is working with MOH/NACP to address reported unreliable support for mPIMA even within the existing few sites with mPIMA. However, the program believes that with existing capacity within conventional and POCT test options will be able to support EID testing for the country. 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. As part of COP20, PEPFAR/T will continue to ensure every biological child younger than 19 years of HIV positive mothers in care, traced, and offered testing. 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.

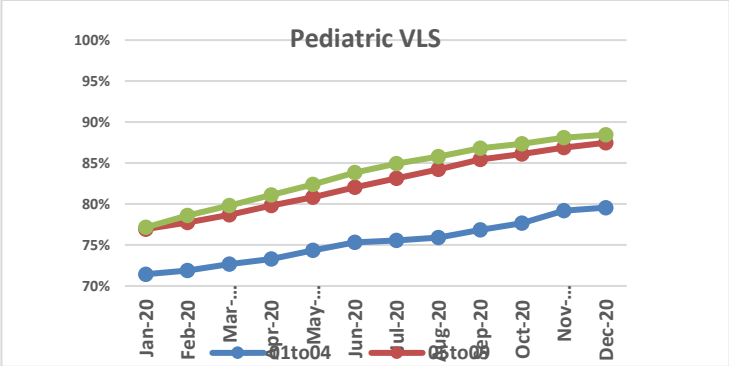
PEPFAR/T will enhance optimized PITC at inpatient, TB, and malnutrition wards and increase the use of risk screening tools in outpatient from years old children and follow the mother's risk and testing status for children under two. PEPFAR/T will strengthen pediatric and adolescent friendly services to improve retention and viral suppression. In addition, viremia clinics are conducted to address challenges faced by unsuppressed children.

Viral suppression is another key area of focus for children and adolescents. FY20 program data show improvement in viral suppression among children aged 0-14 years from 76% to 88% in 12 months, (Figure 4.1.5B) while noticing a slow improvement of VLS (71-80%) among 01-04 years of age. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T has reached more than 90% in ART optimization among CLHIV and resulted an improvement of viral suppression. The use of legacy regimen has decreased below 1%.

Tanzania is on track for pDTG 10 introduction and rollout. The pDTG 10mg is included in HIV/TB treatment guidelines.

Strengthening 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 for those yet to be transitioned.

Figure 4.1.5B: FY20 Viral Load Suppression among pediatrics



Focusing on cities with high burden

PEPFAR/T will increase the quality and coverage of HIV testing and care and treatment services in high burden cities as essential activities to reach epidemic control. Based on 2020 PLHIV estimate used for COP20 planning, seven metropolitan centers (Mwanza, Tanga, Geita, Tabora, Mbeya, Dar es Salaam and Njombe) were found to have high HIV burdens. Four of these cities – Dar es Salaam, Mwanza, Mbeya, and Tabora – are currently the focus during FY20 for 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-folks, 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 (social network testing) 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, as is being done throughout the country.

TB Screening with fidelity and Isoniazid preventive therapy coverage

Despite an increase in the number of PLHIV who screen positive for TB (13,379 in FY 19 to 19,270in FY20) the coverage of TB screening has decreased from 98% (FY19) to 92% in FY20 as well as low numbers of people diagnosed with TB (from 4,855 in FY19 to 4,408 in FY 20. Decrease in TB screening coverage has been significantly impacted by the COVID-19 pandemic which has caused few clients attending facilities and fear of HCW contracting the SARS-CoV2 infections. To address this, PEPFAR/T will strengthen TB screening with fidelity for case detection by focusing on screening quality improvement (QI) measures, on the job training for health care workers, supporting implementing partners with PPE for COVID-19 pandemic and close partner management on TB/HIV programming.

Whenever a person is identified with TB symptoms, that person will receive both HIV testing and TB testing (using the GenXpert MTB/Rif Assay). The goal of the country is to place two Gene Xpert machines per council, currently there are 26 councils without the machines, based

on the distribution of equipment, not all presumptive TB clients access the molecular TB diagnosis and this has been contributing to low numbers of people diagnosed. PEPFAR/T will optimize the use of GeneXpert machines forTB diagnosis among PLHIV by ensuring that service level agreement is signed for preventive maintenance of available machines and availability of Gene Xpert machine cartilages. This will ensure that 70% of presumptive TB cases are tested by Gene Xpert and in turn will increase the numbers of PLHIV diagnosed with TB.

IPT coverage increased 45% (FY19) to 70% (FY21), and IPT completion increased from 84% (FY19) to 90% (FY20). This completion success has been partly due to dramatic improvement in adherence to IPT, monitoring and proper documentation into the CTCs registers and CTC2 data base.

PEPFAR/T aimed to achieve 100% IPT coverage of all eligible clients during COP20. However, to date the proportion of eligible clients who have either completed a course of IPT or are currently receiving IPT is 70%. COVID-19 Pandemic has had a negative impact on initiation due to declines in patient volume at health care facilities and also clients and Health care workers were preferring for 3MMD in which TPT is not integrated. In COP 2021, PEPFAR/T in collaboration with GoT and implementing partners envisions to reach 100% of all eligible PLHIV on ART with TB preventive therapy, continue dialogue with the GOT to ensure a reliable supply of current regimen (Isoniazid) and introduce the new regimens recommendations, support efforts to improve quality of TB screening in CTCs – for increased presumptive cases rates, continue support for TB samples referral and continue emphasis on molecular diagnostic testing through Gene Expert machines.

On identification strategies, compared to COP20 in COP21 PEPFAR/T will focus on ensuring safe and ethical index testing by closely monitoring the IPV through the PEPFAR monthly portal, as well as establish a similar national monitoring system. Also, wider use of the national index testing adverse event investigation and reporting tool, to make sure that all the adverse event from the services provision are reported. Validation of the adult national HIV risk screening tool is another priority for COP21. And lastly, tracking the impact of HIV-self testing and implementation of the national HIV self-testing framework is another priority. For pediatric identification, in COP21 PEPFAR/T will strengthen mentorship to HCPs on quality DBS sample collection to reduce rejection rate. Also increase EID point of care from to from 64 in COP20 to 83 in COP21.

On continuum to care, evaluation of the scale-up model of LCM (60day follow-up) and extension to 6 months are new in COP21. In additional to that scale-up of community ART services across PEPFAR/T supported facilities.

On TB, In COP 21 PEPFAR/T support to the implementing partners on PPE for COVID-19 will bring back the TB screening coverage among PLHIV on track. Furthermore PEPFAR/T will work collaboratively with the GOT and implementing partners to introduce and scale up shorter TPT regimen as this will also increase the TPT achievement from the current 70% to above 85% and completion above 90%.

4.2 Treatment Continuity and ensuring viral suppression

During FY20, PEPFAR/T had a 12-month retention rate of 92.7% among established clients and a 12-month retention rate of 90.8% among new clients. Retention in both these groups has shown a consistent upward trend beginning in FY19 Q2. This improvement is the result of concerted efforts outlined in COP19 to address challenges with retention. Moving forward, specific changes to be introduced include scaling up successful strategies to all PEPFAR supported facilities in Tanzania and ensuring a client-centered approach that creates a welcoming clinical environment.

PEPFAR/T Treatment Continuity Response

All sites:

- Appointment reminders
- Multi-month dispending for eligible clients
- Same day tracking for missed appointments
- Enhanced community tracking through facility-community collaboration
- Site level indicators to improve appointment adherence and reduce recent loss
- Extend linkage case management beyond the routine 6 weeks for high-risk groups

To address treatment interruption among new clients, PEPFAR/T will continue to implement the Linkage Case Management (LCM) program and will explore extending LCM beyond the routine six-week period to up to 6 months for specific at-risk populations (i.e., adults 20-29 years old), so that newly diagnosed clients can be monitored to the viral suppression as a clinical outcome of interest. Sites now have access to a newly implemented electronic pharmacy system to track and record clients who attend for fast-track pharmacy pick-ups or in-transit refills at another facility – this will lead to more accurate reporting of clients currently on ART. Additional systems improvements, including the unique identification strategy, will help eliminate double counting of individuals who anonymously register more than once.

PEPFAR/T and GoT currently support multi-month dispensing to reduce costs and service waiting times to clients. Interruptions in TLD supply chain plans interfered with scale-up of six-month multi-month dispensing. Experiences gained from the initial implementation in Dar es Salaam region will allow swift implementation throughout the country upon receiving the required stocks.

Clients identified to have challenges in adherence to treatment, retention in care, and/or attaining viral suppression receive the necessary attention through designated days where the clinic is focused to address group and individual issues through enhanced adherence counseling coupled with peer support. These designated clinic days, coupled with greater frequency of visits, if feasible, or remote and virtual check-ins, if in-person visits pose a barrier, offer service providers the space they need to focus on special needs in order to identify and address unique, individual barriers in the spirit of client-centered care.

For adolescents and children, PEPFAR/T will 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 will include components addressing poor viral suppression, such as adherence counselling and ART regimen optimization. There will be tailored support to adolescents as they transition to adult care and treatment. Older adolescents participate in peer group sessions to share experiences during the transition to adult care. Health facility staff and community case workers provide enhanced monitoring and adherence support to adolescents experiencing challenges adapting to adult services. Where necessary these case workers also escort adolescents to clinic appointments. Health

facility staff provide disclosure counseling to adolescents, which is reinforced through psychosocial support that community case workers provide in the home.

To ensure viral suppression, PEPFAR/T will continue to support tracking of quality-of care indicators, supply chain management, and transition to optimized treatment regimens. PEPFAR/T will assist GoT in exploring point-of-care viral load to mitigate logistical challenges associated with hard-to-reach areas and long distances between facilities and testing laboratories.

PEPFAR/T will ensure accountability through real-time monitoring of monthly performance at the site level. The PEPFAR/T monthly indicators include treatment continuity and viral load suppression (among the priority indicators) for enhanced partner management. Through continuous quality improvement efforts, sites (with support from PEPFAR/T and local government) identify root causes contributing to losses or virologic failure and introduce changes that are tailored to the needs of individual clients. For treatment continuity, activities at the site level will continue to focus on improving capture of information needed to track patients, methods of attempting contact, and outcomes of each attempt. Additionally, monitoring of client experiences and quarterly reporting of findings through the community-led monitoring platform will further inform the development and implementation of workable solutions to improve retention and viral load suppression.

During COP21 PEPFAR/T focus will be on tracking scale up of DSD models by region and sub-population, enhance and scale up client led monitoring feedback to improve services and, to emphasize positive, empowering hopeful messages (benefits of viral load suppression).

To ensure treatment continuity for young adults, PEPFAR/T will support the implementation of tailored linkage and retention interventions by client/population through real-time data analysis, targeted case management approaches, and population-specific health education/literacy. PEPFAR/T will work to leverage MenStar approaches and utilize male peer-to-peer support and coach programs to enhance treatment linkage in men aged 25-39yrs.

During COP21, PEPFAR/T will work with the GoT on a plan to better utilize high throughput VL test platforms (Roche & Abbott) within the existing Laboratory Diagnostic Network to ensure efficiencies and uninterrupted HVL testing. Strengthening sample referral and transportation systems to ensure timely results return and utilization will be an essential step to this transition. Furthermore. PEPFAR/T will strengthen oversight and coordination for reliable supply chain systems which will include rolling out of the Global RFP. PEPFAR/T will continue to support multiplexing strategies for VL, EID and TB.

4.3 Prevention, specifically detailing programs for priority programming
a. HIV prevention and risk avoidance for AGYW and OVC
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.

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 with improved testing yields for AGYW and reaching the most vulnerable girls.

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), intensive peer and community-based outreach (age 15-24), and by adolescent friendly-trained health providers at health facilities. 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; 15-19 year ; and 20-24-year-olds. Girls are maintained in the program until they meet the established program completion criteria which typically takes about 9-18 months.

By the end of FY 21, it is expected that 91,919 new AGYW (age 10-24) will be reached with DREAMS primary interventions. These targets represent newly enrolled DREAMS girls, rollover girls who will be active but have not completed the program at Q4 and maintenance targets for saturated age bands. Approximately 70% of the total AGYW reached will also receive appropriate secondary interventions. The table below summarizes the DREAMS primary and secondary interventions:

Layering Table – Chart 1.1

Age Disaggregates	**9-14**	**15-19**	**20-24**
Population Description	OVC in- and out-of-school, lifetime experience of sexual violence, experience of physical/emotional violence in the past 12 months, history of sexual activity, alcohol use	Irregular condom use and multiple sex partners in the past 12 months; history of STIs, pregnancy, or transactional sex; lifetime experience of sexual violence; orphanhood; or out-of-school (never enrolled or dropped out); alcohol misuse	Irregular condom use and multiple sex partners in the past 12 months; history of STIs, pregnancy, or transactional sex; lifetime experience of sexual violence; alcohol misuse
Proportion of the Vulnerable Population*	73%	63-78%	79-88%
Primary Individual Interventions	• Education subsidies • HURU kits and curriculum (+ new modules on sexual violence prevention for 9-14-year-olds) • Financial literacy (BRAC model)	• HTS • Condom provision • Community-based HIV and GBV prevention (Stepping Stones) • Combination socio-economic approaches (Worth+ for all and enhanced economic strengthening package for most-at-risk)	• HTS • Condom provision • Community-based HIV and GBV prevention (Stepping Stones) • Combination socio-economic approaches (Worth+ for all and enhanced economic strengthening package for most-at-risk)

Secondary Individual Interventions	• Referrals to, or if clinical partner, provision of post-violence care, and HTS • Sexual Violence Prevention (IM Power/IM Safer) • Parenting and care giver programming (Furaha/Sinovuyu)	• Enhanced Economic Strengthening – (AVSI/WINGS) • Contraceptive method mix (initiation/refill) • Parenting and care giver programming (Sinovuyu/FMP) • Referrals to facilities for STI, TB, and initiation of FP, and ART services • PrEP (initiation/refill) • ART (initiation/refill) • Referrals to, or if clinical partner, provision of post-violence care	• Enhanced Economic Strengthening – (AVSI/WINGS) • Contraceptive method mix (initiation/refill) • Referrals to facilities for STI, TB, and initiation of and ART services • PrEP (initiation/refill) • ART (initiation/refill) • Referrals to, or if clinical partner, provision of post-violence care
Contextual Interventions	Influential men and women (all ages)		
	• Community mobilization and norms change using *SASA!* Package • Leverage DREAMS and OVC program to implement justice for children activities introduced through COP 19 Faith Community Initiative funds.		• *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

The layering table will be changed and adapted in COP20. In COP19, the OVC program began implementing 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 alongside a complementary parenting program, *Furaha.* In COP20, the complementary parenting program will move from a primary package intervention to the secondary package.

There will be changes in the economic empowerment activities for the upper two age bands. WORTH+ will still be offered to all DREAMS girls aged 15-19 and 20-24, and AGYW will also receive a start-up asset and/or matched funds. The start-up asset will be delivered after girls complete the WORHT+ curriculum and are starting their individual enterprises, and matched funds will be delivered after one year in order to help AGYW scale and expand their businesses. These additions will strengthen the AGYW's capacity to create sustainable businesses for consistent income.

A robust M&E system, the DREAMS Auxiliary M&E System (DAMES) is in place to assure DREAMS girls are receiving the primary packages as intended and relevant to her need. DAMES tracks each individual girl across the package of services using a unique identifying code. This increases PEPFAR/T's ability to provide programmatic oversight and assure the program is being implemented with fidelity across all partners. It provides a routine and standardize way for the partners and the interagency team track the layering of services at an aggregate level. In COP20 the DAMES system will be integrated to all community partners and improvements in the dashboard functionality will be made. Once integration is complete, PEPFAR/T expects the DAMES implementing partner to provide only maintenance of this

system. Long term, PEPFAR-TZ will work with the MOH to adapt DAMES into the government system and introduce it in the facilities.

In order to assess DREAMS reach, inform programming for potential expansion and utilizing funds in the most efficient way, the DREAMS team estimated the number of vulnerable girls in each SNU. THIS/DHS data were used to estimate the number of vulnerable girls in each DREAMS SNU. For the 10-14 age group vulnerability estimates are based on national level estimates of the percent of those out of school, married/sexually active before 15, or orphans. Regional level estimates of ever engaging in condomless sex or multiple sex partners in the past year were used to estimate the proportion of vulnerable AGYW aged 15-19 years in each district, and the results range from 63-78%. Regional level estimates of ever engaging in condomless sex or compensated sex in the past year were used to estimate the proportion of vulnerable AGYW aged 20-24 years, and the results ranged from 79% to 86%. These estimates were updated in September 2020 based on Data.Fi. Saturation denominators showed strong coverage in three of the operating SNUS, allowing the program the option to extend to new councils. The following table includes estimates of vulnerable girls from the original 8 SNUs and the 3 expansion councils agreed upon with OGAC, HQ counterparts, DREAMS-TZ and partners. These new councils are Nyamagana DC, Mufundi DC, and Mbarali DC.

Number of Vulnerable Girls and DREAMS Reach at FY_20 Table 1.2

PSNU	Age	HIV-Population	% Vulnerable	Number Vulnerable	Number of Girls Reached (FY_19 and FY_20)	Percent saturated at FY_20
Kahama TC	10-14	20528	73%	14985	5948	40%
Kyela DC	10-14	15768	73%	11511	5228	45%
Mbarali DC	10-14	20684	73%	15099	0	0%
Mbeya CC	10-14	26561	73%	19390	8982	46%
Msalala DC	10-14	22575	73%	16480	9569	58%
Mufindi	10-14	18073	73%	13193	0	0%
Muleba DC	10-14	46433	73%	33896	11336	33%
Nyamagama DC	10- 14	29121	73%	21258	0	0%
Shinyanga DC	10-14	30079	73%	21958	12666	58%
Shinyanga MC	10-14	13739	73%	10029	4649	46%
Ushetu DC	10-14	24900	73%	18177	7922	44%
Kahama TC	15-19	18527	78%	14358	9883	69%

Kyela DC	15-19	14120	71%	9969	2878	29%
Mbarali DC	15-19	16299	71%	11507	0	0%
Mbeya CC	15-19	30222	71%	21337	17428	82%
Msalala DC	15-19	17788	78%	13786	12229	89%
Mufindi	15-19	15143	63%	9570	0	0%
Muleba DC	15-19	37649	63%	23757	15037	63%
Nyamagama DC	15-19	29803	67%	19968	0	0%
Shinyanga DC	15-19	22332	78%	17307	9119	53%
Shinyanga MC	15-19	12476	78%	9669	6505	67%
Ushetu DC	15-19	18468	78%	14313	12675	89%
Kahama TC	20-24	16698	86%	14410	8323	58%
Kyela DC	20-24	11736	81%	9447	4145	44%
Mbarali DC	20-24	16025	81%	12900	0	0%
Mbeya CC	20-24	30002	81%	24152	17362	72%
Msalala DC	20-24	14475	86%	12492	9315	75%
Mufindi	20-24	12751	79%	10086	0	0%
Muleba DC	20-24	30570	85%	26076	24222	93%
Nyamagama DC	20-24	26856	88%	23741	0	0%
Shinyanga DC	20-24	18110	86%	15629	9595	61%
Shinyanga MC	20-24	11202	86%	9667	8223	85%
Ushetu DC	20-24	14422	86%	12446	12852	103%

In COP20, DREAMS will increase coverage in new and expansion SNUs by targeting 91,919 (27,608 rollover) 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. Since COP18 PEPFAR/T DREAMS Implementing Partners have been ensuring 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.

For an SNU to be classified as saturated it must reach at least 75% of vulnerable population in each of the three age categories targeted in DREAMS (10-14, 15-19 and 20-14). In COP19 PEPFAR/T estimated the number of vulnerable AGYW in each SNU. The table below highlights saturation targets for each DREAMS SNU (by age band).

DREAMS COP21 Targets 1.3

DREAMS Councils	Targets (10-24 combined)
Kahama TC	12101
Kyela DC	7777
Mbarali DC	15219
Mbeya CC	8859
Msalala DC	4961
Mufindi DC	16497
Muleba DC	24299
Nyamagana MC	23445
Shinyanga DC	12801
Shinyanga MC	4070
Ushetu DC	6223

DREAMS reaches the most vulnerable AGYW who may have increased susceptibility to experiencing violence. To help connect those experiencing different forms of violence to available resources and support in the community, in COP20 Implementing Partners staff involved in direct service delivery will also be trained on how to enquire about violence and offer first line support (LIVES) in response to disclosures of 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 to determine immediate intervention needs. PEPFAR/T will also significantly scale-up PrEP among vAGYW to support them to take control of their sexual health and reduce their HIV risk. There will also be an enhanced focus on reaching and improving access to services for both men and women under 30 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, Family Planning (FP), screening for gender-based violence (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 COP20, PEPFAR/T will continue to 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. PEPFAR/T is committed to working alongside stakeholders and the GoT to strengthen condom supply-chain and distribution systems to ensure condom availability at facility and community levels.

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 eleven 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 childbearing. 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 COP20, 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.

DREAMS will execute COP21 priorities with COVID-19 program adaptations developed through PEPFAR guidance and in-country innovations. Please note updated COP21 tables: 1.1, Layering Table, 1.2 Vulnerable AGYW Estimations, Reach, and Saturation, and 1.3 Targets. In COP 21 DREAMS plans to reach 136,253 girls, adolescents and young women.

In COP20, enhanced economic strengthening was rolled out in the 3 new councils with plans to phase into other the other 8 councils in COP21. For the 10-14-year-old age band, this will expand financial literacy using a contextually adapted model from BRAC to all councils and moving the intervention from the secondary to the primary package. For the 15-19 and 20-24-year-old AGYW DREAMS will also incorporate an adapted AVSI/WINGS model informed by the youth labor market assessment, to all 11 councils. This model places greater emphasis on entrepreneurship, business mentoring, and access to markets for DREAMS participants.

There are 4 COP21 strategies that address community engagement, program improvements and coordination and reaching the most vulnerable AGYW with the comprehensive DREAMS package. 1) DREAMS is revising the approach to mentoring in COP21 by incorporating the results from an environmental scan of mentoring conducted by a third-party organization and following PEPFAR/OGAC mentorship guidance. Some changes will include a more formalized approach to mentoring using standardized mentorship benchmarks, while other changes will be informed by the results of the mentoring scan; 2) Recruit more pregnant and breastfeeding AGYW into DREAMS from the facility and community settings, offering this vulnerable group the comprehensive suite of services and interventions. 3) Employ more DREAMS Coordinators and Ambassadors as needed to continuously improve the coordination of the Initiative at the regional and district levels while leveraging opportunities to engage the wider community. 4) Increasing PrEP uptake in DREAMS councils including demand creation, education, and initiation support.

Tanzania has 2.3 million OVC affected by HIV (MEASURE Evaluation, 2018). There are 65,702 children and adolescents living with HIV (C/ALHIV) who are on ART in 81 priority PEPFAR councils where the OVC program is implemented. The violence against children (VAC) study conducted in Tanzania (2009) showed that more than one-third (33%) of girls experience sexual violence. Early sexual debut is associated with exposure to violence, and childhood sexual violence is associated with increases in young adults' sexual risk behaviors. The goal of the OVC program is to prevent new HIV infections among at-risk OVC (in collaboration with DREAMS) and improve OVC and family well-being through improved access to and utilization of HIV/health, nutrition, education, protection, psychosocial, and economic strengthening services. The program contributes to the goal of HIV epidemic control by contributing to prevention of new HIV infections among children, adolescents, and young women; ensuring that all OVC know their HIV status or have been assessed for HIV risk; and ensuring that newly identified C/ALHIV are immediately linked to treatment and provided retention and adherence support; this contributes to reducing the pediatric treatment gap. In addition, OVC programming supports children and caregivers who are living with HIV through HIV-inclusive case management. OVC case workers help monitor child and caregiver retention and adherence, provide treatment literacy, and reinforce age-appropriate and positive family disclosure. Preventing and responding to sexual violence is an OVC program priority. 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.

As of Q4 of FY20, the OVC program has served 852,139 OVC and caregivers and enrolled 39,169 (62%) C/ALHIV on ART in OVC SNUs. This represents the OVC proxy coverage of TX_CURR <15 (94%) and TX_CURR <20 (63%). By Q2 of FY21, the program has enrolled 43,499 C/ALHIV on ART and about 11,750 HIV exposed infants. About 99% of children have known HIV status documented in their case file. In addition, under the faith and community initiative, the OVC program trained 16 PEPFAR implementers and ensured child safeguard policies are in place, conducted SVAC 101 TOT training for faith and community leaders and implementers, trained 65 high court judges, 154 magistrates, 16 public prosecutors, and 39 social welfare officers on justice for children, and have completed Coaching Boys into Men (CBIM) athlete's enrollment reaching a total of 86,626 athletes with 12 CBIM session ongoing. The OVC program has translated and integrated the three S/GAG modules (Healthy and Unhealthy Relationships, Making Decisions About Sex, and Sexual Consent) into the HURU program. Collaboration between OVC implementing partners, religious leaders, faith community, and other partners working in the community and facility have further enhanced opportunities for the OVC program to improve HIV case identification, treatment linkage, retention and viral suppression. The signing of memoranda of understandings (MoUs) between OVC and clinical partners has proved to be effective in identifying C/ALHIV for OVC program enrollment and linking them to HIV services.

In COP21, the PEPFAR/T OVC program will intensify its focus on prevention of HIV infection among children, reducing the pediatric HIV treatment gap, tracking viral load results and suppression for all enrolled C/ALHIV (in collaboration with clinical partners), addressing high rates of sexual violence among adolescents, and mitigating the risks faced by children of parents/caregivers with poor adherence to ART. The program will use an intergenerational approach to risk and resilience to serve 570,784 OVC under age 18 from 94 priority councils (of which 104,564 will be DREAMS AGYW 9-14 and 15-17 years. PEPFAR/T will also reach 153,702 OVC caregivers. The 570,784 target is distributed into OVC comprehensive targets of 338,289 (59.3%) OVC under age 18; OVC preventive targets of 127,931 (22.4%) for boys and girls aged 9-14 years in high HIV burden SNUs; and DREAMS OVC_SERV 10-17 years targets of 104,564 (18.3%). At least 90% of C/ALHIV on ART who are younger than 19 years of age in PEPFAR-supported treatment sites will be offered enrollment in the OVC program (a projected 64,554 C/ALHIV, or 96% of TX_CURR younger than 20 years of age will be enrolled in COP 21.

PEPFAR/T has adapted the stability benchmark for graduation that will allow more children to graduate from the OVC program. This created space to enroll C/ALHIV on ART into the OVC program. Recruitment of OVC into the comprehensive program will happen at ANC/PMTCT and CTC facilities. The purpose is to identify vulnerable children newly enrolled on treatment, infants of adolescent mothers who are lost-to-follow up in PMTCT, biological children of index adult clients, and other asymptomatic but undiagnosed children. Community-based case identification will prioritize OVC and adolescents who are highly vulnerable to HIV infection, particularly adolescent girls and children who have experienced violence. The OVC preventive program will target girls and boys 9-14 years in high burden SNUs using a school-based platform. The preventive program will implement interventions for prevention of sexual violence using evidence-based interventions IMPOWER/IM Safer which is adapted to COVID 19, and Coaching Boys into Men (CBIM.

The service package for a comprehensive program for children 0-9 years includes, among others: HIV risk assessment and referral to HTS; accompaniment for linkage to treatment; ART adherence and disclosure support; educational subsidies; Community Health Fund cards;

parenting support; economic strengthening village savings and loan associations and start-up kits for caregivers of CLHIV; nutritional assessment, counseling and support; and birth and insurance registration.

In COP21, the service package for OVC aged 9-14 will include: *"Furaha"* (translated Sinovuyo) for parenting and violence prevention; HURU in school HIV prevention plus S/GAC modules: *Health and Unhealthy relationships*, *Making Decisions about Sex*, and *Sexual Consent*; and education support and monitoring of school progression. Specific activities include prevention of forced, coerced, or non-consensual sex; linkage to post-GBV care and ensuring justice for children; IMPOWER, and CBIM. The service package for children aged 15-17 will include: *"Furaha"* parenting and violence prevention; adolescent sexual and reproductive health education; and education subsidy support and monitoring of school attendance and progression.

The OVC program will provide case management for all children and caregivers in the comprehensive program, including HIV risk assessment; treatment literacy; and VAC & GBV screening and referrals to comprehensive services. Other services delivered via case management include adherence support; active referral and linkages to HTS, CTC, post GBV care, justice for children, health and social protection; and family re-unification and support for at-risk street children.

DREAMS interventions are integrated within the OVC program and implemented as part of the OVC package in DREAMS' SNUs. The program integrates sexual violence messages into interventions for parents and caregivers. Emphasis will be given to ensuring that all programs dealing with children continue to implement and reinforce child safeguarding policies and procedures to prevent and respond to VAC and GBV and work with the justice sector to ensure justice for children.

Faith-based organizations are 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 religious leaders and faith communities to develop and disseminate messages on the prevention of sexual violence throughout their network.

In COP21, PEPFAR/T will ensure 100% of OVC active in the program have knowledge of their HIV status and have their HIV status documented in their case file. The OVC program will continue to use the OVC HIV risk assessment tool which has proven effective in targeting children at risk of HIV. Four questions in the risk assessment tool have shown potential to identify more HIV-positive children. These questions include asking whether: there is one or more PLHIV in the household (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%). PEPFAR/T will continue to conduct HIV risk assessments for all OVC with undocumented HIV status and document whether testing is not indicated or refer those at-risk for HTS (providing accompaniment by case workers, as needed). PEPFAR/T will also continue to strengthen and mobilize testing of biological children of HIV-positive clients (ensuring systematic assessment of 100% of HIV+ mothers and their children, in collaboration with clinical partners, for potential enrollment in OVC programming), particularly adolescent breastfeeding HIV-positive women, and scale-up testing children of HIV-positive FSW and women who inject drugs.

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 linkages will include community case manager training, capacity strengthening of LGAs, and community child protection committees. Continuous robust partner management, program monitoring, quality improvement, learning, adaptation, and operational research will all be employed to advance the evidence base on HIV risk and reduction among underserved OVC sub-populations.

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. MOUs between PEPFAR/T OVC, clinical, 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 to follow-up or missed appointments at facilities, and linking them back to care and treatment. MOUs will address critical issues related to referral protocols, case conferencing, shared confidentiality, and joint case identification. 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 SNUs. The OVC partners will also collaborate with demand creation programs to generate demand and increase uptake of HIV services among ALHIV and on delivering key messages to prevent sexual violence.

As of Q4 of FY20, the OVC program has served 852,139 OVC and caregivers and enrolled 39,169 (62%) C/ALHIV on ART in OVC SNUs. This represents the OVC proxy coverage of TX_CURR <15 (94%) and TX_CURR <20 (63%). By Q2 of FY21, the program enrolled 43,499 (66.2%) C/ALHIV on ART and about 11,750 HIV exposed infants. About 99% of children have known HIV status documented in their case file. In addition, under the faith and community initiative, the OVC program trained 16 PEPFAR implementers and ensured child safeguard policies are in place, conducted SVAC 101 TOT training for faith and community leaders and implementers, trained 65 high court judges, 154 magistrates, 16 public prosecutors, and 39 social welfare officers on justice for children, and have completed Coaching Boys into Men (CBIM) athlete's enrollment reaching a total of 86,626 athletes with 12 CBIM session ongoing.

In COP21, the program will use an intergenerational approach to risk and resilience to serve 570,784 OVC under age 18 from 94 priority councils (of which 104,564 will be DREAMS AGYW 9-14 and 15-17 years. PEPFAR/T will also reach 153,702 OVC caregivers. The 570,784 target is distributed into OVC comprehensive targets of 338,289 (59.3%) OVC under age 18; OVC preventive targets of 127,931 (22.4%) for boys and girls aged 9-14 years in high HIV burden SNUs; and DREAMS OVC_SERV 10-17 years targets of 104,564 (18.3%). The preventive program will implement interventions for prevention of sexual violence using evidence-based interventions IMPOWER/IM Safer which is adapted to COVID 19, and Coaching Boys into Men (CBIM).

b. Children/PMTCT

PEPFAR/T is working to substantially improve service delivery for children, especially EID at two months, case identification and viral suppression for children. Despite progress made in treatment growth, program data show major gaps in identifying, retaining, and virally suppressing pediatric populations. PEPFAR/T achieved 76% of the annual target for EID, with only 73% of HEI being tested for HIV by the age of two months. Based on FY20 results, 41,547 pregnant women tested positive for HIV, and 36,006 HEI were tested at 12 months. Of the

36,006. HEI, 538 (1.5%) tested HIV-positive, and 529(98%) were initiated on ART. Challenges contributing to this gap include, poor retention of mother-baby pairs, ineffective integration of EID in immunization platform especially with outreach program, erratic supply of commodities (DBS Kits, PoC for EID and lab reagents), missed opportunities to enroll HEI in the OVC program and receive support, especially adolescents and young mothers, and sub-optimal use of peer mothers to monitor and track clients lost to follow-up. PEPFAR/T will also explore secondary distribution of HIVST through index testing activities as another way to reach pregnant/breastfeeding women in PMTCT programs.

PEPFAR/T will continue to support LGAs and partners to ensure that all PMTCT sites receive capacity building on DBS collection, storage and packaging through onsite group mentorship and joint supportive supervision with regional and community health management teams across poor performing facilities. PEPFAR/T has also commissioned the Mother2Mother program to support MOH to develop a mother-mentor model to address stigma and community-based issues that lead to poor retention of mother-baby pairs. Furthermore, PEPFAR/T will scale-up the use of GeneXpert – near point-of-care (POC) – for EID testing to address challenges related to the long turnaround time and low EID coverage especially in hard-to-reach areas. Also, PEPFAR/T will strengthen integration of EID in immunization platform especially with outreach services. In addition to that PEPFAR/T will ensure constant availability of commodities by supporting R/CHMTs on how to forecast commodities and order timely. PEPFAR/T will continue to leverage the OVC platform to improve HEI referrals for EID and enroll mother-baby pairs for improved retention. The OVC program prioritizes enrollment of HIV+ adolescent mothers younger than age 19 with tracking of all mother-baby pairs via case management in order to improve EID at two months through final outcome. The OVC case management model will be used to develop quarterly care plans with mothers of HEIs during routine case management and household visits. The plan will ensure CCWs monitor schedules for HIV-positive ANC attendance, DBS testing for HEIs, and maternal HVL monitoring.

In COP21, PEPFAR/T will continue to scale up index testing as a key intervention to identify CLHIV. Through its "maximizing index testing" approach, PEPFAR/T will ensure all biological children of HIV-positive women are offered the opportunity to test and be linked to treatment. The OVC program will apply SOPs to strengthen OVC contribution to index testing with corresponding linkage to treatment. In doing this, PEPFAR/T will ensure standards of safety and confidentiality are adhered to through a structured mechanism. Optimized PITC will be modified to address findings from the validation of the HIV screening tool. All children below ten years old attending high yield entry points will be tested without screening and children above ten years old, including adolescents, will be screened for HIV testing. PEPFAR/T will strengthen pediatric and AFHS to improve retention and viral suppression. Viremia clinics will also include OVC case workers to address social economic challenges regarding unsuppressed children and ensure they are enrolled into the OVC program for support.

Viral suppression is another key area of focus for C/ALHIV on ART. Despite improvement in both viral load testing coverage and suppression, FY20 program data show 83% viral suppression among children age 0-14, which is below UNAIDS and PEPFAR target of 90%. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T is working to support GoT in transitioning out suboptimal pediatric regimens, including NVP based regimens. The OVC program, in collaboration with clinical partners, will track and support the transition to optimized ART among enrolled CALHIV, including DTG10 once available. PEPFAR/T has supported introduction of DTG 10 for children weighing over the age

of 4 weeks and 3kg and will continue to support rollout throughout the country. Site mentorship will be included to ensure service providers understand and are competent in ART dose adjustment and transitioning of regimens. To improve viral suppression, PEPFAR/T will also conduct site-level cascade analyses for timely identification of non-suppressed individuals and ultimately fast-track enhanced adherence counseling to C/ALHIV on ART and ensure that there is consistent supply of pediatric optimal regimen.

C. Key Populations

PEPFAR/T provides targeted interventions for KP and priority populations (PP), including female sex workers (FSW), men who have sex with men (MSM), transgender people, people who inject drugs (PWID), and at-risk individuals within these sexual networks. Activities reaching KP are implemented in all 98 scale-up councils, eleven attained councils, and nine selected sustained councils with known hotspots. In COP20, these councils account for 84%, 12%, and, 4% of KP_PREV targets, respectively.

Cumulatively for FY19, implementing partners reached 232,235 KP/PP with the core intervention package, which was 81% of the annual target. A total of 220,369 (94.8%) clients were tested for HIV during the FY19 reporting period, 32,602 (14.79%) were identified positive, and 29,252 (89.7%) were documented as linked to ART. While some of these "unlinked" persons may be clients who came for testing a second or third time without reporting prior knowledge of status, efforts are still needed to maximize linkage. PEPFAR/T will do so through utilizing proven best practices such as linkage case management, a strategy used to increase linkages to treatment, disclosure and adherence. This has proved to be effective through the Bukoba Combination Prevention Evaluation.

In FY19 Q2, index testing has been one of the main contributors to identify positives among KP. The temporary ban on index testing that was instituted in December 2019 has had an impact on the identification and yield among KP. At the time that this document was drafted, the PEPFAR/T team was in discussion with CSOs representing KP to address concerns raised around index testing practices and identify areas to further improve the quality-of-service delivery. After these important steps are taken, services may resume. Currently PEPFAR/T has indicators to track IPV on index testing services among KP.

In FY20, PEPFAR/T, in collaboration with GoT, has started the roll-out of recency testing to all testing points with the aim to understand the trends and sources of new HIV infections. This will help to identify new KP hot spots for prompt identification, enrollment, and monitoring.

D.

FY19 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 indicate initiation and linkage rates have continued to increase from 81 % in FY19 Q1 to 93% in FY20 Q1 among KP in councils with community ART. In COP20, with MOHCDGEC guidance, PEPFAR/T will continue scaling up ART provision in the community with fidelity to all councils as an important addition to the community-based KP package of services to maximize early linkage and retention to HIV care for newly diagnosed KP/PP clients.

In COP19, there has been significant improvement of the national KP program in Tanzania due to recognition by the GoT of the importance of providing a comprehensive prevention, care, and treatment package for KP. PrEP services are among the key components of this package. PrEP has been prioritized for groups of people who have substantial risk of acquiring HIV: serodiscordant couples; AGYWs; pregnant and breastfeeding women; MSM; transgender

individuals; sex workers; and PWID. The national PrEP program will provide a comprehensive set of services in line with GoT guidelines and circulars. The program will provide flexibility for clients to choose and be supported in the use of other prevention strategies. Clients will be counseled at PrEP initiation and can choose to discontinue PrEP after starting, though retention activities will aim to minimize client loss. The HIV-negative individuals reached through index and community testing will be linked to PrEP as part of the prevention cascade. In FY19, a total of 3,523 were PrEP_NEW females (101% of the annual target), and a total of 1,789 PrEP _NEW males (972% of the annual target) were reached. During the reporting period, FSW showed high acceptability of PrEP (51%), followed by MSM (26%), and PWID (11%). However, in FY20, the PrEP_NEW annual target has only been met by 8% due to a shortage of Truvada for PrEP clients in the country. The USG technical team is working with MOCDECH to ensure the program is well positioned to strengthen supply chain coordination, demand creation and monitoring in order to achieve the substantial increase in targets proposed in COP20 (180,000 PrEP_NEW).

In FY20, the GoT amended the national HIV testing law to allow people to test themselves for HIV. Under the new law, GoT has committed to scale up HIVST nationwide focusing on KP and sexual partners of FSW who are reluctant to go for services because of stigma and other reasons. In FY19, a total of 37,908 clients were provided with HIV self-testing kits. In COP19, PEPFAR/T, in collaboration with GoT and IPs, are comprehensively scaling up HIV self-testing in three regions, while in COP20 HIVST will be scaled-up countrywide including promotion of and linkage to HIVST through peers, community workers, and health facility staff.

PEPFAR has committed to ensure HIV services among KP do not put people at risk. PEPFAR/T acknowledges the need to take extra precautions with the information collected, documented, or stored in electronic systems. PEPFAR/T and GoT have developed national KP M&E tools and a database for reporting all KP services with unique identifiers and data protection with the aim of protecting vulnerable people.

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 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, in collaboration with IPs, will continue identifying local CSOs that will work with KP, especially PWID, FSW and MSM, in order to accelerate geographic expansion of services. The CSOs will be routinely involved in designing, implementing and assessing the progress of KP services in Tanzania. Through this approach, peers/seeds have been selected as key contacts to enable increased access for PWID, FSW and MSM, to services such as HTS and to link those found to be HIV-positive to ART services.

It is the policy of GoT not to discriminate against people seeking health services based on sexual orientation or other factors. In COP19, the MoHCDGEC underscored the importance of training facility HCWs and law enforcement officials on stigma and discrimination and comprehensive services among KPs. PEPFAR/T will continue to encourage partners to utilize safety and security toolkits for KP. PEPFAR/T will continue advising the GoT on KP policy to ensure safe and appropriate access to services that adhere to international standards. Also, PEPFAR/T, in collaboration with GoT and CSOs, have established a national KP Advisory Committee composed of KPs who will work closely with the GoT to ensure the health needs of

KPs are met across the whole portfolio of HIV prevention, care and treatment activities. In COP20, PEPFAR will continue to fund the implementation of stigma and discrimination sensitization programming for healthcare workers and law enforcement. In COP20, PEPFAR/T will continue engaging KP groups in the design and implementation of KP programs. Furthermore, in COP20, PEPFAR will scale-up the reach of the "U=U" (undetectable=untransmittable) message among KP.

Lastly, in FY19, PEPFAR/T provided medication assisted therapy (MAT) services to4465 PWID. This is 73% of the annual target (6097). Among those reached, 4175 (93.5%) were male and 290 (6.5%) were female. In the reporting period, Henry Jackson Foundation overachieved due to low target setting. However, in FY19, African Medical and Research Foundation (AMREF) reported only KP_MAT results for Zanzibar and did not include Tanga, which resulted in its underperformance of 15.7% of the annual targets. AMREF, in collaboration with CDC, will soon establish MAT services in Tanga. Moreover, MDH has opened two MAT clinics in Bagamoyo and Kibaha in order to increase MAT services among PWID.

In COP 21 PEPFAR/T will work to incorporate lessons learned from KPIF into ongoing activities and will continue to work with and support the KVP Forum. PEPFAR/T will continue supporting the scale-up the HIVST to cover all PEPFAR regions, targeting men and key and vulnerable population. Additionally, PEPFAR/T will continue to address challenges identified in index testing site assessments to ensure rights-based approach and incidents of IPV and GBV are reported. Refresher trainings for health care workers will be planned as needed based on the results of these site assessments. PEPFAR/T recognizes the importance of involving civil society organizations in this activity and commits to ensuring their participation. PEPFAR/T will scale up community ART initiations and refills and will work to improve tracking viral load suppression among KP.

Furthermore, PEPFAR/T will ensure biological children of KPs living with HIV are tested and if positive, linked to OVC services. PEPFAR/T will establish additional satellite MAT clinics to decongest current MAT facilities and increase MAT services among PWID. Once the PrEP implementation framework is signed by the GoT, PEPFAR/T will scale-up PrEP among KP groups. Preparations for the PrEP program are in place including supply chain, demand creation, and monitoring systems.

d. VMMC

According to the 2016-17 THIS, the national MC prevalence is nearly 80% among 15-29-year-olds. The PEPFAR/T program is on track to reach the target of 90% MC prevalence among the 10-29 age band by the end of 2020. However, as coverage increases, pockets of low coverage remain in the country. Program data continue to highlight 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 and fisher folk). Low coverage for the older age band justifies the continuation of VMMC targeting adult men.

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), Health Sector HIV/AIDS Plan 2017 -2022 and the proposed National Operational Manual for Sustainable VMMC 2020 -2024. 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. During COP21,

the Decision-Makers' Program Planning Toolkit, Version 2 (DMPPT 2) will be utilized as a monitoring and planning tool to estimate the coverage estimates and target and impact projections for the VMMC program at the district-level with data disaggregated by five-year age bands.

In FY20, PEPFAR/T supported 543,194 circumcisions, which accounted for 72.5% of the annual target of 749,356. The COVID-19 pandemic had a disproportionate impact on VMMC program performance due to reliance on campaigns at the community level and large outreach events. The total number of VMMC performed in COP21 is expected to be 429,628. Building on efforts from COP20 and the PEPFAR VMMC guidance, the COP21 strategy is to continue circumcision for males aged >15 year old men where circumcision coverage already exceeds 80% and achieve 80% coverage in councils where circumcision coverage is lower.

As noted, during the initial COVID-19 outbreak in Tanzania in FY20 Q2, all VMMC outreach campaigns and large demand creation activities were suspended. In FY 20 Q4 PEPFAR partially reopened services at static sites by ensuring adherence to PEPFAR COVID 19 prevention guidance. The program started to implement activities using no-contact and limited-contact demand creation approaches leveraging the use of technology (mobile platform) and interpersonal communication through community volunteer agents and popular opinion leaders. Services were limited to see a maximum of 15 clients or less per day. The program also integrated COVID-19 prevention measure in all static sites including: universal screening for COVID-19, reinforcing hand washing at the entry point, regular disinfection of working surfaces, maintaining social distance, and mask wearing for both clients and service providers to ensure their safety. In COP 21, PEPFAR/T will ensure VMMC partners continue to adhere to COVID-19 prevention guidance.

PEPFAR/T recognizes the challenges of reaching adult men as the program matures. In COP 21 PEPFAR/T will ensure all IPs adhere on the guidance on the age band to circumcise males aged 15 years and above. The guidance implemented starting from FY20 Q2 up to FY21Q1. During FY21Q1 the program has achieved 100% of the VMMCs only from men aged 15 years and above. PEPFAR/T is using 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 >15 years by addressing key barriers. These obstacles include economic constraints, emotional reservations, service delivery convenience, structural set-up of facilities, and traditional and cultural norms. Findings show older men prefer mobile vans, male service providers, and tents that provide privacy for stigma reduction. PEPFAR/T will use client-centered approaches to strengthen demand generation efforts in priority SNUs to target adult men ages 15+ with relevant information and support. These efforts will include: engaging women through DREAMS and PMTCT programs by providing tailored information about benefits of VMMC for women and their key role as mothers and partners; involvement of traditional circumcisers in demand generation to mobilize clients, especially adults for services; leveraging other HIV services to educate men on VMMC post-counseling, particularly in the context of index testing; PrEP and social network-based outreach; and distributing clearly written, attractive brochures and leaflets printed in Swahili, targeted to specific audiences, such as parents and partners. PEPFAR/T's client-centered approaches also include age-specific SMS messages and interactive voice response (IVR) systems such as helpline services, peer networking, promotion through satisfied clients and a focus on reaching female spouses and sexual partners.

In COP 21 PEPFAR/T is planning to implement Shang Ring device (SR) in some VMMC priority regions to increase service uptake among males aged 15 years and above. The SR pilot study conducted in Tanzania showed SR to have high acceptability to older males. In addition, the study suggested that the SR device is safe and acceptable for males aged 13 and older in Tanzania as COP 21 PEPFAR guidance emphasized. In line with WHO guidance, PEPFAR will work with the MOH on a roll out strategy.

PEPFAR/T will continue implementing user-friendly VMMC services tailored to ensure privacy for adult men, allow for separation of older men from younger men, extend hours and moonlight services, and use of the VIP VMMC services model targeting older men ages 25-29 years with a menu of premium options from which VMMC clients are allowed to customize how they wish to consume VMMC services, including flexibility for clients to choose the gender of the circumcising surgeons. In addition, IPs will focus on seasonal preferences and organize special campaigns to reach older clients and scale-up provision of VMMC services during this time. Lastly, the program will focus on workplace interventions tailored to fishing communities, mining areas, prisons, and refugee camps to reach adult men for VMMC services.

To ensure local ownership and sustainability of the VMMC program by local stakeholders, in COP21, PEPFAR/T will focus on engaging local partners for service delivery as it transitions the program to local indigenous organizations for planning, management, ownership, and sustainability. The GoT is working in collaboration with partners to finalize 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 is supporting the sustainability process to ensure VMMC services are integrated in routine services offered at all health facilities and the GoT has endorsed the use of reusable VMMC kits. During COP21, all MCs will be covered using reusable kits and ShangRing devices which PEPAR/T and the Global Fund is planning to implement in COP21. PEPFAR/T will work towards enhancing community and multi-sectoral engagement to increase service acceptance among older males by addressing myths, misconceptions and continued health education on benefits of VMMC through various platforms including: government, religious and local leaders' advocacy meetings, radio messages, and widely disseminated information, education, and communication (IEC) materials.

In COP21, PEPFAR/T will continue to 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 require technical support to strengthen data quality and set targets for VMMC in priority locations and populations using modelling tools and enhanced partnerships with UNAIDS and MOH.

PEPFAR/T will focus on strengthening the quality of VMMC services through (1) the introduction of the online VMMC training module (the Online Training Hub – OTH) for VMMC site managers, program coordinators and VMMC providers to refresh technical skills and empower site-level decision-making to increase yield and safety, (2) coordinated supportive supervision and mentorship, (3) ensuring the incorporation of continuous quality improvement (CQI) in VMMC program implementation by implementing partners working with RHMTs, CHMTs and facility level staff to secure facility-led QI processes with local managers and stakeholders, and (4) external quality assurance (EQA) programs for better safety including adverse event (AE) monitoring, prevention and management.

PEPFAR/T will continue to support the NACP to monitor implementation of its standardized VMMC minimum package that includes the following: HIV prevention counseling, STI screening, screening for HTS, HTS, infection prevention, linkages to care or PrEP services for VMMC clients, the timely identification and management of adverse events, and facility-led QI processes. In COP21, 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 work in collaboration with GoT to include commodities and supplies in comprehensive council health plans (CCHPs) and have VMMC services as part of insurance packages accepted by the National Health Insurance Fund (NHIF) for longer term sustainability.

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

In COP20, the GoT and PEPFAR/T continued to implement the recommended policy changes that were agreed upon to positively impact the PEPFAR/T programs. Many of the adopted policy changes were successfully implemented during COP20, including:

HIV self-testing. The Tanzania Parliament approved the law on self-testing in November 2019. Self-testing has been piloted in the three regions of Mwanza, Kagera, and Njombe. HAPCA amendment published in GOT gazette and regulations have been approved and incorporated into the HIV self-testing framework, and plans are to scaleup the self-testing program nationally. The GoT Medical Stores Department will manage the HIV self-tests storage and distribution to ensure quality and sustainability.

PEPFAR/T is working closely with the GOT to scale-up HIV self-testing. In FY20, the program distributed more than 70,000 self-test kits, which is three times the number distributed in the previous year. This exponential progress has continued through FY21Q1, with more than 78,000 kits distributed. In FY20, close to 90T of the results were returned with a positivity rate of 6%, and 97% of the confirmed HIV positive clients were linked to ART services. In FY21, PEPFAR/T will continue supporting the scale-up of HIVST to cover all PEPFAR regions, targeting men and key and vulnerable populations.

Use of Dolutegravir (DTG) based regimen. The use of Dolutegravir based regimens is now implemented in all facilities following the GoT circular that was released in February 2020. The DTG transition has moved quickly to overall coverage of 92% of all eligible clients (including 92% of all eligible women of child-bearing age) as of December 2020. With support from The Global Fund, the GoT has removed Nevirapine-based regimens from facilities and the GF has approved collection and destruction of legacy stock. PEPFAR will closely monitor destruction plan progress. Supporting an effective commodities supply chain, including coordinated commodities reporting, forecasting and quantification, remains as the pivotal step to ensure supply of life-saving drugs and attainment of 95-95-95 goals.
After being prequalified by WHO Tanzania is on track towards registration of pDTG10 in the country as the drug has been included in the drug list and the roll out plan finalized order placed anticipating to receive the first consignment by November 2021 or early 2022. In COP21 PEPFAR/T will continue its support on pDTG10 for children weighing over the age of 4 weeks and 3kg and rollout throughout the country.

OUs assure program and site standards are met.

Continuous Quality Improvement has been integrated into all PEPFAR-supported facilities and in line with national policies. CQI has also been incorporated into implementing partners work plans. Currently most quality assurance assessments and subsequent mentoring and supportive supervision are being managed virtually.

IPT scale-up. The scale up of IPT to eligible patients has improved significantly. The proportion of clients currently on IPT/TPT and those who have completed treatment is now at 69%. INH stock outs remain a challenge. To address this challenge, GoT and PEPFAR will target all eligible PLHIV, including children to complete IPT/TPT by the end of COP21. Cotrimoxazole, where indicated, will be fully integrated into the HIV clinical care package at no cost to the patient.

Targeted testing. Targeted testing has been implemented with fidelity to avoid over testing. The number of tests conducted has decreased while there has been a steady increase in yield of positives. GoT and PEPFAR will maintain targeted testing while ensuring consent procedures and confidentiality are protected and the assessment of IPV continues. All children under age 19 with an HIV-positive parent will be targeted for HIV testing.

PEPFAR/T is committed to ensuring that all index testing services are client centered. PEPFAR/T has demonstrated its ability to successfully scale-up index testing, and although performance was compromised in the context of COVID-19, PEPFAR/T is confident that the program can be brought back to scale in COP21. PEPFAR/T will draw on the core tenets of high-quality services, with an overall goal of ensuring that services are non-coercive, private, and confidential. PEPFAR/T will not be using targets to drive performance, but rather emphasize the importance of index testing to identify undiagnosed contacts. PEPFAR/T will continue to engage KP, including peer counselors, as a best practice, and will also continue to ensure that interested clients select their preferred notification method. Finally, PEPFAR/T is looking forward to collaborating with CSOs and communities to analyze and follow-up on results from the index testing site assessments to ensure that beneficiaries and potential clients are safe and services are confidential.

Facility-led, community-initiated ART. The policy on facility-led, community ART initiation has been successfully implemented; especially during the COVID 19 outbreak. Plans are underway to ensure all clinical IPs are implementing the facility community module of HIV services to ensure synergies and quality of care. PEPFAR/T continued to support decentralized drug distribution (DDD) for ART refills and other HIV care services including TB, TPT, FP, CECAP as well as VL sample collection. The facilities identify ART groups, satellite ART refill centers and ART outreaches to reach clients who have opted for DDD model. In COP21 PEPFAR/T is planning to scale DDD model to reach more clients particularly those in hard-to-reach areas and SNUs with high treatment interruption. PEPFAR/T will closely monitor facilities to ensure quality and proper documentation and activites are scaled up.

Preventing interruption in care among young adults

PEPFAR/T will continue to ensure retention of clients on ART by implement the 4-Tiered Retention Approach that includes:

- Tier 1: Client-centered services for all (appointment reminders, optimized treatment regimens-TLD transition and LPV/r for pediatrics, 6 MMD, and linkage case management)
- Tier 2: Loss prevention among those “at risk” for loss (same-day tracking by phone, 3 box approach, and data system lists)

- Tier 3: Intervening for "recently lost" clients (multiple phone contacts, community-based tracking)
- Tier 4: Understanding characteristics of those lost and targeting interventions to them.

Joint planning and execution of COP. There have been continuous monthly MoHCDGEC/PEPFAR joint technical meetings to discuss country progress towards the mutually agreed upon minimum HIV program requirements for COP implementation. These meetings will continue in COP21 and will be chaired by the Chief Medical Officer. The Minister of Health will chair the meetings on a semi-annual basis.

Pediatric case finding. The pediatric cascade (including case finding and service delivery) was identified as a priority for PEPFAR/T in COP20 and will remain so in COP21. From a case finding standpoint, early infant diagnosis programs have already shown great improvement from COP18 to COP20 through focusing on connecting mother-baby pairs using GoT registers and electronic health systems, although concerns about the transmission of COVID-19 among the community did result in a drop in case finding. PEPFAR/T plans to further strengthen the linkage between community and facility structures, particularly through the OVC program to ensure that pediatric case finding systems are fully implemented during COP21 to achieve the goal of full EID coverage for all HIV-exposed infants. In COP21 PEPFAR/T will scale-up the use of GeneXpert – near point-of-care (POC) – for EID testing to address challenges related to the long turnaround time and low EID coverage especially in hard to reach areas and strengthen integration of EID in immunization platform especially with outreach services.

In addition, pediatric case finding efforts are also impacted by index testing services for biological children of WLHIV. During COP21, PEPFAR/T plans to continue emphasizing that all WLHIV be routinely offered index testing services and that all eligible children be offered testing. Pediatric care will also be a priority as the program transitions to DTG based regimens. We believe that this transition will be crucial to addressing the larger issue of poor viral suppression among children and adolescents.

Optimized pediatric ARV. Optimized pediatric ARV regimen for children ≥ 20 kg is now continuing in Phase I, Phase II, and Phase III facilities as part of the transition to dolutegravir-based regimens. In February 2020, the GoT released a circular emphasizing this to be the preferred regimen. With support from The Global Fund, the GoT has removed Nevirapine based regimens from facilities and will move forward with a destruction plan. In preparation for COP21, preparations are underway to plan for a transition to DTG10 for pediatric clients weighing 20kg or less. As part of preparations, clinical guidelines will be amended and the product will be registered.

Lay/non-health HIV testing and counseling personnel. The GoT is currently not in support of allowing lay/non-health personnel to conduct HIV testing and counseling. Although there has been recent interest in expanding the scope of work for lay/non-health personnel after many years of advocacy, there is no indication whether this will include HIV testing. The GoT was examining availability and interests of existing unemployed HCWs and assessing how to cover the gap for personnel who will be performing HIV testing and counselling. PEPFAR will continue advocating for using lay counselors as self-testing agents. During COP20 discussions, PEPFAR/T also agreed to hire 5000 community workers to support important prevention and treatment-related demand creation activities. By the end of FY20 PEPFAR supported a total of 13,285 lay workers that work in both facilities and communities and is planning to maintain the support as we consult with GOT to expand their scope of work and optimally allocate lay workers on sites.

Six-month multi-month dispensing of ARVs. The GoT adopted and implemented differentiated service delivery models, including six-month multi-month dispensing (6MMD) and three-month dispensing. The MoHCDGEC approved the start of 6MMD in the Dar es Salaam region in March 2020 and 73% of eligible 6MMD clients received it by December 2020. Scale-up to all other regions are planned for FY 21 pending stock arrival in Q3 2021. Furthermore, plans are underway for decentralization of drug distribution scaled-up in the context of COVID-19.

PrEP. PrEP was initiated in Tanzania in the context of a demonstration project. Based on COP19 discussions with the GoT, preparations have been underway to scale-up PrEP nationally. At the end of 2019, the GoT agreed to the integration of PrEP as a comprehensive HIV service for KVP, including AGYW. Since that time, the nationwide scale-up of PrEP has been hampered due to the lack of a GoT sanctioned PrEP framework, which was ultimately endorsed by stakeholders in May 2021. Signing of the framework is anticipated to coincide with COP21 approval. At the beginning of 2021 the GoT announced that due to concerns that the PrEP implementation framework did not adequately consider the cultural and social context of Tanzania, it would be revisited. At the time that this SDS was drafted the GoT had not yet finalized a national PrEP implementation framework nor had it released a circular that would empower facilities to implement the framework and roll-out PrEP. GOT has committed to finalize/sign the implementation framework and demand creation materials in May 2021 to begin scale-up of PrEP. PEPFAR Tanzania's vision for PrEP in COP21 will ensure this essential prevention intervention reaches populations at high risk for HIV including key and vulnerable populations, AGYW, and pregnant and breastfeeding women. For AGYW, PrEP roll out will be prioritized in DREAMS PSNUs and other geographic areas with similarly high AGYW HIV burden. PEPFAR/T will intensify demand creation activities for awareness and promotion of effective use and retention on PrEP and will engage communities as needed in development and roll-out of key messages. PEPFAR will ensure Truvada commodity needs for the PrEP program are met and maintained. For COP21 the plan is to initiate 49,826 individuals on PrEP. PEPFAR/T is also supportive of exploring the feasibility of the vaginal ring (DVR) and eventually, long-acting cabotegravir (CAB-LA) for prevention.

Client Centered Supply Chains Responsive to Program Needs:
PEPFAR/T will enhance supply chain data availability for accurate and complete forecasts and orders by strengthening data management systems. This will include reinforcing granular-level reporting of commodity data, ensuring the data sources systems (E- Systems, eLMIS, CTC2, etc.) are functional, and triangulating clinical and stock level data. The goal is to continue strengthening demand and supply planning for ARVs and laboratory commodities. With regard to effective, cost-efficient viral load and EID testing, PEPFAR/T will ensure the viral load reagents are available and will support a transition to emphasis on high throughput platforms. Efforts will be made to pursue all options for improved laboratory services, including implementation of the Global RFP in collaboration with the GoT, careful monitoring of the transition of sample transportation systems to the Tanzania Postal Corporation, improved DBS sample quality for early infant diagnosis, and a joint assessment of the OU plan for diagnostic network optimization.

For ensuring alignment with the PEPFAR strategy, PEPFAR/T uses several approaches:

1) Partners have the opportunity to discuss the COP guidance and provide feedback on implementation strategy and target setting

2) Partner work plans are submitted annually and updated as needed when strategies change. This ensures that the partners' written work plans are aligned with the most recent strategy decisions.

3) PEPFAR/T holds weekly inter-agency PEPFAR COMPASS Team meetings. These are internal to USG and are utilized to review data and rapidly share best practices or challenges. When a best practice is identified, PEPFAR/T works to take it to scale across partners.

4) Review of monthly data which has been expanded to include pediatric indicators across the clinical cascade so staff and partners can track progress on identification and viral load suppression for timely course correction. In COP21 PEPFAR/T will continue utilizing the monthly data portal to monitor progress of sites key CQI indicators.

5) PEPFAR/T holds full partner management meetings quarterly, but also meets monthly and sometimes bi-weekly with clinical implementing partners. This allows for collaborative performance reviews and problem-solving discussions concerning programmatic shifts.

6) PEPFAR/T holds all-partner meetings at least quarterly. At these meetings, the team announces any changes that affect multiple partners to allow for immediate implementation. They also provide opportunities for stakeholder engagement.

7) PEPFAR/T has continued to engage with GoT regularly through monthly meetings chaired by the Chief Medical Officer. In COP21, these meetings will continue with a focus on updated COP21 activities and priorities. These meetings ensure that if GoT action is required to address challenges or enhance performance, it can be done rapidly. Most recently, PEPFAR/T and the GoT agreed to monthly meetings to supply chain plans and issues related to laboratory services, which are crucial to program implementation.

4.5 Commodities

The availability and accessibility of life-saving health commodities is a cornerstone of epidemic control and achieving the 95-95-95 goals. The demand for commodities has risen as programs have expanded to more patients and advanced toward epidemic control. This has increased both the financial need for commodity procurement and the management burden of large volumes of commodities. Global shortages of key commodities introduce a challenge in Tanzania's ability to secure the total volumes needed. For example, key pediatric ARVs such as Lopinavir/Ritonavir 100/25 mg tablets faced national stock outs in Tanzania in 2019 and suboptimal supply of TLD in 2021 continue to limit the scale-up of 6MMD as manufacturers and procurement agents were unable to respond quickly with the stock needed. In-country stakeholders identified quantities of drugs needed to meet the anticipated demand for these drugs in 2020 and planned for a nine-month lead time for drug delivery. In February 2020, continued global drug shortages for Lopinavir/Ritonavir 100/25mg now have extended the lead time for receipt of full supply to up to 13 months after the order date. Other products, such as Isoniazid and Emtricitabine/Tenofovir DF 200/300 mg tablets, have or may face a rise in demand that outstrips manufacturers ability to ensure full supply. Tanzania is particularly vulnerable to these global impacts due to the size of Tanzania's program and its central role in driving global demand.

Activities in Tanzania will focus on improving forecast accuracy in quantification and improving the alignment of demand estimates with program scale up. Monthly meetings with PEPFAR/T and the supply chain staff at the NACP have been instituted in COP19 to support this important activity. During the TLD transition, the program forecasted needs and created a distribution plan for pre-positioning stock in anticipation for increased demand at the facility level. Similar activities for the introduction of pediatric granules and pDTG are ongoing; and due to stalled TE program, plans for the utilization of the TE overstock for the PrEP program are underway.

As product types and volumes increase, so too does the complexity of the in-country supply chain. Long term investments in the Medical Stores Department, the Logistics Management Unit, and other supportive supply chain institutions have allowed Tanzania's public health supply chain system to support increased demands. Recommendations from a holistic supply chain review are being implemented in order to improve functionality and planning. The supply chain system redesign has been implemented in Mwanza and is currently being rolled out across the country. This design moves the supply chain system from a quarterly to a bi-monthly ordering and a monthly reporting system, allowing for more current facility-level data. The new, more efficient supply chain design makes the system more responsive to changes in consumption and provides increased visibility of stock availability at the service delivery level. Bottom-up quantification focuses on facilities identifying their own commodity needs. Improved access to and utilization of facility-level data ensures a more client-centered approach as it puts the needs of health facilities—where the patients are—at the forefront of national decision making.

As part of COP 21, PEPFAR Tanzania will continue to collaborate with NACP and the Global Fund to address any gap in ARV commodities. PEPFAR/T will also participate actively in the ongoing quantification exercise to ensure sufficient supplies are in place for 6MMD and a transition to DTG-10. This is in line with current plans to transition to optimal pediatric regimens whereby Lopinavir 100mg and 80mg tabs will be phased out and replaced by DTG 10mg. The recommended regimen DTG 10mg has been factored into the SPT 21 following the most recent quantification. DTG10mg is expected to be available in country from March 2022, considering supplier lead time and duration for registration in country.

The TE orders that are reflected in the SPT21 are for PLHIV, and not for PrEP. The available stocks and re-allocated orders of TE for PrEP are sufficient to accommodate the estimated COP21 target of 49,000 clients.

The current supply plan for TLD considers 6MMD requirement which will be dependent on adequate stock levels in accordance with the GOT min- max requirements. PEPFAR/TZ is working with the GF to ensure that there's adequate stock to support these GOT requirements for 6MMD.

4.6 Collaboration, Integration and Monitoring

4.6.1 Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH

The PEPFAR program in Tanzania is coordinated and managed through the interagency team consisting of PEPFAR Coordination Office, USAID, CDC, and DOD with each agency ensuring teamwork, results sharing, data-informed decision making, and strategic staffing. Accelerating progress toward HIV epidemic control requires coordination and innovation

across technical areas with intensified focus on measurable outcomes and impact. The guiding principles include interagency collaboration, data transparency, efficient programming and sustainability, and ownership. Technical teams within and across the agencies operate through specific Goal Teams and Cross Cutting Core Groups to foster constructive dialogues between agencies to stimulate innovation and enhance program standardization. To close the loop, interagency Action Pillars lead responsibility for strategic coordination and catalytic prioritization, while ensuring focus on and monitoring progress across elements critical for success, including ensuring effective policies are in place, ensuring effective tools and approaches are implemented, generating data to drive performance, and using data to monitor site-level progress. At the management level, the PEPFAR COMPASS team provides regular opportunities to inform each agency about activities and initiatives which optimizes efficiency across PEPFAR/T programs.

There continues to be regular engagement between PEPFAR/T and GOT. PEPFAR/T personnel are members of national technical working groups that convene regularly to address program implementation and propose policy adaptations. What started in FY18 as PEPFAR/T leadership monthly meetings with the Deputy Minister for Health and other senior MOH teams to track policy and performance, has transitioned to monthly meetings with GOT technical staff to monitor implementation progress of the COP19 agreed upon minimum policy commitments. On a quarterly basis, these meetings are chaired by the Minister for Health. PEPFAR/T is also engaging in monthly coordination meetings with UNAIDS, WHO, GFATM, UNICEF, and other UN organizations to ensure that shifts in priorities are shared and program barriers are urgently identified and addressed in a unified and collaborative manner.

PEPFAR/T continues to be engaged in GFATM grants planning and oversight in-country. Two PEPFAR staff sit on the Country Coordinating Mechanism (known as Tanzania National Coordinating Mechanism) as voting members through the Development Partners Group on HIV and AIDS (DPG-AIDS) and Bilateral Donors constituencies. In the spirit of planning together to ensure no duplication in funding while maximizing efficiencies with GFATM and PEPFAR support, the Global Fund Country Team (GFCT) is fully engaged in COP planning and PEPFAR/T is likewise fully engaged in GFATM Funding Request development.

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.

4.6.2 Strengthening Partner Management

In COP21 PEPFAR/T will build off important practices around partner management that were developed in COP18 and COP19. PEPFAR/T will continue to strengthen approaches and processes to ensure highly effective, timely, and standardized partner management is in place to achieve COP20 targets and to 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 FY20, PEPFAR/T put systems in place to ensure optimal sharing of best practices, challenges, and remediation steps across all partners. Practices that were implemented and scaled-up during COP18 and COP19 will continue across all partners, nationally.

For COP21, this includes practices that were developed in response to restrictions faced during the COVID-19 pandemic, which made site visits and in-person activities impossible. Virtual

platforms for data collection, review, and monitoring will continued to be leveraged as necessary to ensure safety of staff and beneficiaries.

1) **Implementation & Reporting**: In COP21, 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 - using the PEPFAR Monitoring, Evaluation, and Reporting (MER); Site Improvement Monitoring System (SIMS); and financials by reviewing outlays and budget analysis - all of which are currently available on a quarterly basis. Additionally, PEPFAR/T will continue using monthly data on key programmatic areas of interest to track progress of activities including index testing, multi-month dispensing, and the pediatric cascade. Indicators can be added as needed based on priorities. PEPFAR/T is committed to transitioning to the use of one data system with the MOH. As the GOT clinical care database reaches full implementation, most of these indicators will transition to being extracted directly from that system. Quality management and integrated analysis will be applied to identify facility and community sites that are under-performing, improve implementation fidelity and support the 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 COP20**: Immediately after the COP19 approval meeting in DC, USG "regional teams" were launched, whereby regions were divided amongst 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 three 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.
    b. **Continuing the Regional Teams**: Despite the limitations of the COVID-19 pandemic during COP20 implementation, PEPFAR/T still draws on the structure of regional teams to conduct virtual reviews of granular data. Partners also continue to dedicate a lead staff person 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 intensive site visits, which are currently being conducted virtually. This will include tracking of remediation across all performance measures (program achievements, quality,

and expenditure). Likewise, among the 241 sites, virtual 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:** Continuing in COP21, 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 the progress being made in 2020 to achieve targets overall and across sub-populations. The assessments will include analysis of performance against targets and investigate whether 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, CSOs, and IPs 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 – through quarterly PEPFAR partner meetings. Engagement will also continue through continued collaboration with and support for the KVP Forum, and through regular monitoring of CLM small grantees.

4.6.3 Improving Integration of Health Systems Interventions

In COP21, PEPFAR/T will continue to collaborate and coordinate with GOT and development partners 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 have been targeted to improve the allocation and performance of service HCWs using both community and clinical site-specific service delivery data to identify need and alignment PEPFAR HCWs support with GOT human resources processes for sustainability. Data and evidence-based approaches will be used to estimate the site level needs for HCWs and additional PEPFAR supported HCWs will be optimally prioritized to sites with unmet program needs using service delivery processes and COP21 targets. Health Care workers safety, client-centered approaches and performance management will be focused in COP21.

For Laboratory services, PEPFAR/T will maintain certification and accreditation standards of 19 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 continuously improved quality of HIVtesting 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 (VL) testing coverage to ensure that all eligible patients receive at least one VL test. In collaboration with health care providers and implementing partners, PEPFAR/T will scale-up VL demand creation activities, support integration of CTC3 within laboratory information systems to improve result turnaround time, and continue to support diagnostic network optimization and multiplexing strategies for VL, EID, and TB. PEPFAR/T will also support the transition to optimize utilization of high throughput platforms, and work with the MOH and in-country stakeholders to improve coordination and oversight of commodity availability, equipment functionality, and utilization of integrated sample referral systems for HIV, TB, and other diseases.

4.6.4 Improving Quality and Efficiency of Service Delivery

PEPFAR/T is focused on key principles that are foundational for program success and have been essential to the accelerated progress toward epidemic control that Tanzania has demonstrated over the past year. These key principles – utilizing people, data and systems to drive impact – are at the heart of the PEPFAR/T approach to improving the quality and efficiency of service delivery. These principles have proven even more crucial during the COVID-19 pandemic, during which PEPFAR/T relied on facility and community-based staff and GoT counterparts to work virtually with the PEPFAR/T team to closely monitor implementation and progress. Using a continuous quality improvement (CQI) approach, supported by the focused use of data down to the site level, the introduction of new tools, and monitoring at national, health facility and implementing partner levels, in close collaboration with Government of Tanzania, PEPFAR/T has been able to use the regular and detailed information necessary to make quick, incremental improvements in scale-up of key interventions and implementation of strategies to support improved models of care delivery across community and facility sites. Investments in important health systems have ensured the maintenance of effective service delivery and policy to support the scale-up of life-saving interventions. Innovative platforms such as Project ECHO Tanzania to catalyze sharing of knowledge, dissemination of best practices and creation of communities of practice that link together the expertise and lived experience across geography and time to enhance peer learning, provider capacity and translation of policy into practice.

In COP21, PEPFAR/T and GOT will continue working closely together to sustain the gains, build on successes by expanding the reach of proven strategies, and focus on client and family-centered approaches that measure progress not just by the number of people reached but also by the quality of the services delivered and the strength of the systems to put people at the center.

4.6.5 Supporting community-led monitoring of treatment services with minimum quarterly meetings to review reported observations and recommendations with representatives and follow up as needed

PEPFAR/T has been actively engaging with CSOs, UNAIDS, and GOT counterparts to prepare for the design and implementation of community-led monitoring in COP20. CSOs have developed a framework for community-led monitoring and have begun to identify priority indicators- including specific indicators for KVP services and stigma and discrimination - to measure. Recognizing that funding is insufficient to roll out a national program, PEPFAR/T

conducted an analysis to identify geographic areas of focus for these activities. Approximately 20 districts were prioritized based on low retention rates, followed by low viral load suppression rates. These areas will be the first to receive community-led monitoring activities, with possible scale-up planned based on lessons learned from these specific areas.

Community-led monitoring activities will be supported primarily by the PEPFAR Small Grants program, as well as through USAID's ongoing activities with the National Council for People Living with HIV/AIDS (NACOPHA). A CDC M&E partner will likely offer technical assistance for NACOPHA and selected CSOs to finalize the data collection tools, and in data collection itself. As per the requirements of the Small Grants program, formal reports will be generated quarterly and disseminated among local health teams and PEPFAR who will facilitate discussion of the findings with implementing partners and higher levels of government to ensure continuous quality improvement at the facility level. The PEPFAR Coordination Office will release a Notice of Funding Opportunity allowing community-based organizations to competitively bid to operationalize community led monitoring in their respective locations.

In COP21, CLM activities will continue to be implemented through the PEPFAR small grants program and NACOPHA. During COP20, NACOPHA developed and piloted draft CLM data collection tools. UNAIDS, who is helping to coordinate the CLM initiative, convened a meeting for CSOs (both those funded and those interested in working on CLM) to review and provide input into the tools. Final tools will be used as the foundation for CLM roll out, recognizing that some CSOs may want to add additional topic or population specific indicators, and that as rounds of data collection ensue, indicators may be added or refined to gather more information on a specific topic. Efforts will also be made to ensure client satisfaction with index testing services is assessed. UNAIDS will conduct a training for CSOs in data collection, and it's anticipated that roll out will begin by early June for 11 PEPFAR small grantees and NACOPHA.

A second round of CLM-specific PEPFAR small grants will be made available at the end of COP 20 to be awarded in time for the beginning of COP21. In response to requests made in the People's COP, PEPFAR will be more attuned to applications coming from KP and PLHIV-led organizations. However, it should be noted that the grants go through a competitive and objective review process that holds applicants to a high standard. In COP20, for example, nearly half of applicants were rejected due to incomplete applications. To address this, the PEPFAR Small Grants team will host a workshop prior to the next call for grant applicants to guide potential applicants to avoid common pitfalls in the hopes that more grantees will progress to the technical phase of the review process. PEPFAR will continue to prioritize focusing CLM initiatives in geographic areas/facilities with lower retention rates.

4.6.6 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 the sustainability of investments made. Critical above-site programmatic elements include data systems and real-time data utilization, HIV-related surveys and surveillance systems, supply chain, human resources for health (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, mapping, and the total market approach will also ensure the utilization of GOT resources for greater shared responsibility to sustain epidemic control. In this regard, PEPFAR/T COP19 activities

have integrated and aligned key functions of the HIV program for institutionalization into existing government systems.

In COP21, 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 the implementation of COP19, Table 6, Sustainability Index and Dashboard (SID) 2019 results, MER, SIMS and other contextual information. In addition, guidance from the Planning Level Letter (PLL) that highlighted the key programmatic challenges, partner performance issues, Minimum Program Requirements (categorized by Care & treatment, Case Finding, Prevention & OVC and Policy & Public Health Systems Support), were considered as part of the above site activities for COP21. This will ensure implementation in addressing the challenges faced, where some are policy-related, and others are capacity related. In COP21, PEPFAR/T will continue to address the sustainability barriers identified in the most recent SID that was completed in 2019, including service delivery efficiency and quality of service, gaps in domestic resource mobilization (GOT commitment to finance at least 30% of national HIV response), full integration of quality improvement concepts and laboratory capacity, 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.

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 the 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. PEPFAR/T is working on a multi-faceted NHIS that includes biometrics as one of the multiple identifiers and a national health client register for both deterministic and probabilistic matching. Tanzania has implemented system updates in HIV system software to deploy the unique identification strategy in HIV systems once a GOT ICT system audit has been completed. Client register development is underway. 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. Community-led monitoring may be an opportunity to ensure confidentiality is maintained and to minimize risks of loss of privacy in this context.

Finally, PEPFAR/T will continue to work collaboratively with MoHCDGEC and PO-RALG through the existing GOT platforms to ensure COP21 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 MMD, nurse-initiated management of ART, HIV case-based surveillance (CBS), enabling lay workers to perform HIV testing, 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. This is part of the Government to Government (G2G) engagement to ensure proper coordination and implementation of key HIV policies with fidelity.

In COP21, with a reduced above site budget, PEPFAR/T will focus on sustaining key system interventions that are at scale. Using the Table 6 format, PEPFAR/T will continue to monitor above site investments using the approaches outlined above. All above site activities will be mapped to ensure that they address key systems barriers, priority areas in the PLL, and program budget elements.

4.6.7 Use of Unique Identification across sites and programs in clinical settings

PEPFAR/T is committed and ready to support unique identification that supports the 1.4 PLHIV receiving care in Tanzania. Currently, each person receives a unique ID when initiating care and treatment (CTCID) that is used within the HIV clinics. While the facility-based database (CTC2) allows for patient-level monitoring at the facility level it does not allow for tracking of clients who move between facilities or be register with multiple IDs. Biometrics were successfully integrated into the CTC2 system under a PEPFAR supported pilot project in Zanzibar in 2017. PEPFAR subsequently supported the successful integration of biometric capabilities into the Mainland CTC2 system in 2019, but activation of biometrics has not been approved by GOT. MoHCDGEC has approved integration of biometrics in a newly planned health information system (Afya Care), but that system will only support 28 regional hospitals (among the 3,000+ facilities serving PLHIV). Activation of biometrics into CTC2/3 has not yet been approved by GOT. PEFPAR will continue to advocate for activation into CTC2/3 data system as CTC2/3 is currently supporting 3,000+ facilities and 1.4 PLHIV. While the GoT is working towards a comprehensive health identification strategy, progress has been slow with unclear approval, development and implementation timelines as to when scaled coverage will be achieved to reach the majority of PLHIV in country.

4.7 Targets for Scale Up Location and Populations

Standard Table 4.7.1

Table 4.7.1: Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY22) *HTS_TST*	Newly Identified Positive (APR FY22) *HTS_TST_POS*	Newly Initiated on ART (APR FY22) *TX_NEW*
Total Men	**748,386**	**58,249**	**55,333**
Total Women	**591,800**	**19,606**	**18,637**
Total Children (<15)	**516.090**	**21,666**	**20,652**
Total from Index Testing	**240,162**	**61,125**	**58,068**
Adults			
TB Patients	***25,347***	**2,572**	**2,518**
Pregnant Women	***444,468***	**1,561**	**1,529**
VMMC clients	***NA***	**NA**	**NA**
Key populations	***99,530***	**9,280**	**NA**
Priority Populations	***198,262***	**3,166**	**NA**
Other Testing	***690,378***	**34,034**	**32,332**
Previously diagnosed and/or in care	***NA***	**NA**	**NA**
Pediatrics (<15)			

HIV Exposed Infants	***17,836***	**228**	**226**
Other pediatric testing	**0**	**0**	**0**
Previously diagnosed and/or in care	***NA***	**NA**	**NA**

Standard Table 4.7.2

Table 4.7.2: VMMC Coverage and Targets by Age Bracket in Scale-up Councils					
SNU	**Size estimate (15-50yrs)**	**Target - VMMC_CIRC (15-50yrs, FY21)***	**Current coverage (end of FY21) using National average**	**Target - VMMC_CIRC (FY22); 15-50yrs**	**Expected Coverage (in FY22) using National average**
_Military Tanzania		3,299		4,583	25%
Arusha CC	186,952	-		-	
Arusha DC	120,841	-		-	
Biharamulo DC	110,214	5,246	66%	1,522	35%
Buchosa DC	121,162	14,562	68%	7,783	68%
Bukoba DC	106,664	517	59%	2,061	25%
Bukombe DC	81,819	2,778	78%	3,457	78%
Bunda DC	78,418	6,850	100%	4,191	100%
Busega DC	74,824	18,413	98%	6,881	100%
Chalinze DC	81,129	-		-	-
Chato DC	132,201	4,661	77%	4,599	67%
Gairo DC	62,427	-		478	-
Geita DC	225,254	15,420	88%	3,304	78%
Geita TC	79,343	3,027	82%	1,745	40%
Igunga DC	143,623	17,433	72%	5,878	90%
Ifakara TC				1,433	83%
Ilala MC	496,208	-		-	-
Ileje DC	47,129	20,191	36%	3,919	20%
Ikungi DC				3,836	
Iramba DC	85,614	4,551	90%	3,385	-
Iringa DC	93,703	3,473	77%	5,917	75%
Iringa MC	90874			2,590	100%
Itigi DC				3,967	
Itilima DC	98,525	9,542	80%	2,712	68%
Kalambo DC	70,712	30,851	54%	12,163	79%
Kaliua DC	140,180	20,386	90%	7,235	92%
Karagwe DC	127,455	2,222	57%	9,780	61%
Kibaha TC	57,721	-		-	-
Kigamboni MC	64,969	-		-	-
Kigoma Ujiji MC	89,679	1,173	100%	6,191	100%
Kilolo DC	80,443	3,125	88%	3,451	63%

Kilombero DC	121,925	8,379	89%	3,217	94%
Kilosa DC	170,177	-		478	-
Kinondoni MC	391,568	-		-	-
Kishapu DC	100,605	7,612	67%	4,235	68%
Kondoa DC	71,976	-		-	-
Kondoa TC	23,333	-		-	-
Kongwa DC	108,886	-		-	-
Korogwe DC	91,857	-		-	-
Kwimba DC	134,465	11,491	58%	8,320	65%
Kyela DC	82,349	4,740	81%	4,949	53%
Kyerwa DC	114,586	6,996	53%	1,731	15%
Ludewa DC	49,390	2,681	99%	5,310	87%
Lushoto DC	104,039	-		-	-
Mafinga TC	31,209	1,193	59%	2,367	81%
Magharibi B	77,266	-		-	-
Magu DC	103,509	12,783	88%	4,321	89%
Makambako TC	36,168	2,648	75%	1,643	72%
Makete DC	36,650	1,458	87%	3,854	71%
Malinyi DC				5,730	
Manjani DC				3,967	
Masasi DC	98,206	-	-		-
Maswa DC	129,928	19,994	78%	9,035	95%
Mbarali DC	110,120	6,923	70%	6,986	40%
Mbeya DC	107,504	1,432	100%	5,392	40%
Mbogwe DC	67,211	5,464	73%	2,202	71%
Mbozi DC	165,968	29,710	30%	6,848	10%
Meatu DC	106,078	11,154	79%	4,905	83%
Missenyi DC	79,226	2,209	58%	3,199	25%
Misungwi DC	120,546	8,288	63%	3,624	51%
Mjini	93,799	-		-	-
Mkalama DC				3,611	
Mkuranga DC	76,907	-		-	-
Momba DC	53,640	1,532	30%	4,264	15%
Morogoro DC	103,127	-	100%	2,865	-
Morogoro MC				716	21%
Moshi DC	184,620	-	100%	-	-
Mpanda DC	64,089	321	100%	3,295	43%

Mpanda MC	45,370	2,955	100%	2,961	100%
Msalala DC	84,694	8,762	100%	3,861	85%
Mufindi DC	88,287	3,150	99%	3,732	63%
Muheza DC	87,005	-		-	-
Muleba DC	204,846	3,143	71%	2,759	47%
Musoma DC	78,207	5,500	100%	2,280	100%
Musoma MC	54,613	6,122	100%	2,376	100%
Mvomero DC	117,034	4,522	98%	2,653	100%
Ngara DC	106,534	8,093	80%	8,580	92%
Njombe DC	30, 365	2,898	100%	3,870	94%
Njombe TC				1,742	
Nkasi DC	101,146	14,248	64%	2,294	45%
Nzega DC	153,870	11,812	74%	5,426	100%
Nzega TC				3,165	100%
Rorya DC	91,081	-		-	-
Rungwe DC	89,787	13,428	84%	8,862	78%
Sengerema DC	117,931	10,094	100%	4,942	94%
Serengeti DC	84,516	-		-	
Shinyanga DC	114,049	14,139	78%	5,058	73%
Shinyanga MC	70,805	1,488	82%	1,234	22%
Sikonge DC				6,330	
Singida DC				2,257	
Singida MC				1,354	100%
Songwe DC	49,411	2,772	60%	4,149	30%
Sumbawanga DC	105,794	7,021	73%	4,087	100%
Sumbawanga MC	84,193	10,292	64%	2,515	50%
Tabora MC				5,426	100%
Tanga CC	123,996	-		-	
Tarime TC	29,306	-		-	
Temeke MC	477,566	-		-	
Tunduma TC	50,299	8,416	30%	2,248	10%
Ubungo MC	347,638	-		-	
Ukerewe DC	127,187	2,134	100%	3,055	50%
Ulanga DC	58,006	-	100%	5,730	100%
Urambo DC	71,911	9,249	100%	5,426	100%
Ushetu DC	93,415	14,825	100%	4,499	88%
Uvinza DC	139,887	20,953	92%	2,485	93%
Uyui DC	136,449	18,555	90%	7,218	100%
Wanging'ombe DC	58,241	2,289	72%	2,626	55%
TOTAL	10,477,492	550,651		340,742	

Standard Table 4.7.3

Table 4.7.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY22)**	**FY22 Target**
PP_PREV	**374,095**	AGYW (15-19) 25% AGYW (20-24) 45%	**531,218**
KP_PREV	**191,033**	KP (FSW 95%; MSM 85%; PWID 90%)	**175,151**
KP_MAT	**9,974**	**90%**	**5,978**
TOTAL	**5,498,236**		**712,347**

Standard Table 4.7.4

Table 4.7.4: Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY22 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target)**
Military Tanzania	-	349	349
Arusha CC	19,437	6906	4919
Arusha DC	6,822	4304	2976
Buchosa DC	-	4235	3023
Bukoba DC	15,758	4393	3129
Bukombe DC	17,566	3716	2652
Bunda DC	19,117	1989	1420
Busega DC	13,077	1188	812
Chalinze DC	-	2555	1819
Chamwino DC	29,071	2465	1759
Chato DC	21,283	4704	3354
Chunya DC	11,264	4636	3307
Dodoma MC	62,558	10907	6101
Geita DC	34,471	7483	5329
Ifakara TC	81,094	2829	2018
Igunga DC	18,313	6129	4365
Ilala MC	6,671	18939	13486
Ilemela MC	-	3270	2337
Iramba DC	-	2530	1805
Iringa DC	-	5897	4202
Iringa MC	20,198	15517	10826
Kahama TC	26,202	23997	3097
Kaliua DC	19,902	4076	2804
Karagwe DC	34,221	2723	1944
Kibaha TC	18,259	3010	2147
Kigamboni MC	4,846	2382	1694
Kigoma Ujiji MC	-	2158	1532
Kilolo DC	16,715	9835	6043
Kilombero DC	17,032	4530	3227
Kilosa DC	13,671	4523	3223
Kinondoni MC	15,669	10468	7462
Kishapu DC	110,777	2820	2028
Kongwa DC	22,029	2660	1897
Kwimba DC	33,217	5236	3656
Kyela DC	15,529	23629	4121
Ludewa DC	14,999	4875	3477

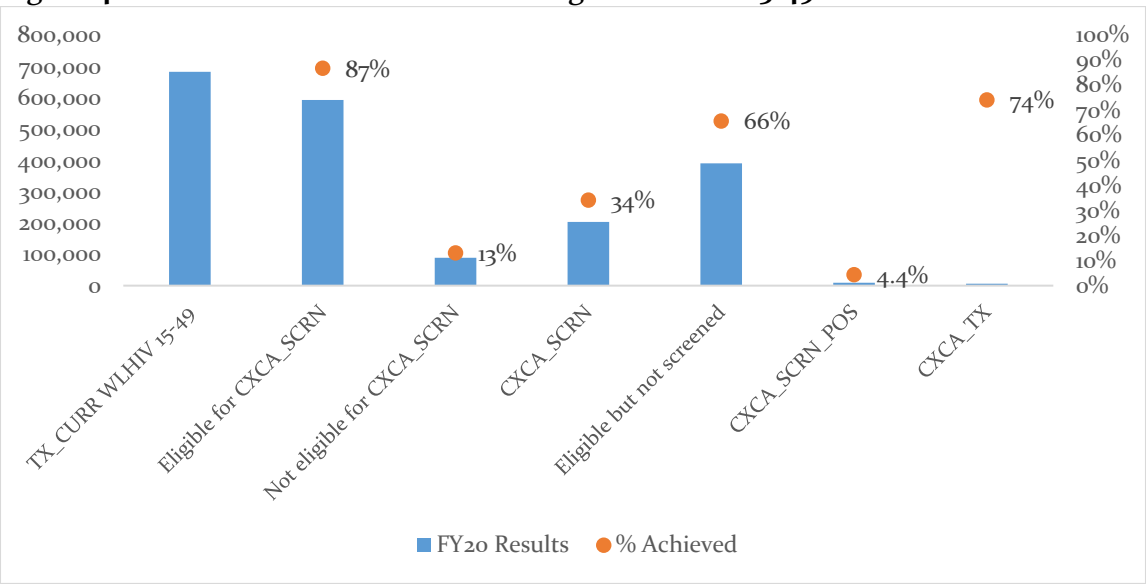
Mafinga TC	5,570	3759	2680
Magu DC	23,614	5771	4114
Makambako TC	11,397	3556	2535
Makete DC	9,821	7451	4770
Malinyi DC	3,494	1399	998
Manyoni DC	22,568	1987	1417
Masasi DC	22,189	2806	1998
Masasi TC	36,182	1378	982
Maswa DC	21,346	3649	2600
Mbarali DC	20,045	28197	4326
Mbeya CC	-	32862	6545
Mbeya DC	32,000	3668	2612
Mbinga DC	10,708	16597	10921
Mbinga TC	28,346	5036	3388
Mbozi DC	367	8248	5883
Meru DC	8,467	2529	1804
Missenyi DC	14,218	3707	2644
Misungwi DC	14,017	4420	3154
Mjini	17,826	1772	1369
Mkuranga DC	-	3202	2280
Momba DC	-	2081	1485
Morogoro DC	21,656	1497	1067
Morogoro MC	29,833	16758	11264
Moshi DC	10,232	15916	10304
Moshi MC	9,597	5176	3692
Mpanda MC	14,672	3224	2299
Msalala DC	11,267	21235	2336
Mtwara MC	19,148	1831	1305
Mufindi DC	42,487	29991	6105
Muleba DC	6,355	33135	2861
Mvomero DC	22,033	2629	1872
Njombe DC	-	6501	4235
Njombe TC	-	6037	4299
Nkasi DC	-	2898	2067
Nyamagana MC	52,550	39152	8080
Nyasa DC	27,269	2543	1813
Nzega DC	13,485	7525	5361
Rorya DC	9,503	5594	4068
Rungwe DC	19,871	4215	2998
Sengerema DC	-	5012	3570
Shinyanga DC	11,709	28104	2153
Shinyanga MC	8,311	15378	2238
Singida MC	20,449	1857	1324

Songea DC	18,991	4877	3181
Songea MC	93,214	9758	6246
Songwe DC	10,003	3459	2470
Sumbawanga DC	16,238	4105	2929
Sumbawanga MC	-	3903	2794
Tabora MC	-	3879	2767
Tanga CC	13,100	7242	4901
Temeke MC	34,589	16077	11476
Tunduma TC	17,512	2224	1585
Tunduru DC	-	3136	2232
Ubungo MC	-	6368	4548
Ulanga DC	-	1613	1151
Ushetu DC	-	25716	2598
Uvinza DC	-	1385	1012
Uyui DC	-	4529	3235
Wanging'ombe DC	-	4219	3007
Total		**724,636**	**338,288**

4.8 Cervical Cancer Program Plans

In FY20, 806 sites offered cervical cancer screening and treatment services. A total of 203, 277 eligible WLHIV aged 15-49 (34 %) were screened (See Figure 4.8). Despite not having a set aside budget, many regions performed well on cancer screening in FY20 compared to the previous year. This was due to the PEPFAR/T dedicated interagency commitment in collaboration with Ministry of Health, Community Development, Gender Elderly and Children (MOHCDGEC); Local Government authorities, implementing partners and trained health care workers to ensure all eligible WLHIV were reached with cervical cancer screening and treatment services. Implementing partners targeted high-volume sites which had integrated, in situ, the 'screen and treat' approach with visual inspection with 5% acetic acid -VIA, cryotherapy and skilled staff for precancerous lesions, within the CTCs and/or RCH sections.

Figure 4.8: FY20 Cervical Cancer Screening Results for 15-49



The data source for these indicators are the health facility cervical cancer screening registers, treatment forms and monthly aggregated registers. The screening register captures client's biodata, cervical cancer screening variables, and HIV status. PEPFAR/T will continue to address data quality issues in COP21 which will include capturing of cervical cancer screening and treatment cascade for women who are referred for Loop Electrosurgical Excision Procedure (LEEP) services to avoid double counting along the cascade.

Main challenges facing cervical cancer screening services in Tanzania include (1) low number of HCWs trained on cervical cancer screening and pre-invasive lesions management, (2) shortage of equipment e.g. carbon dioxide cylinders (3) data management issues (inadequate data accuracy), and (4) few numbers of mentors to improve the quality screening and pre-invasive lesions management. To address these challenges; PEPFAR/T interagency team will continue to provide virtual TA to IPs and the council health management teams (CHMTs), while the CHMTs will conduct outreach services to sites with no cervical cancer screening services and support facilities in data management, review, and use. Plans are underway for sites providing cryotherapy to have extra number of cylinders on site to avoid shortage of carbon dioxide. PEPFAR/T plans to support coordination of the National Cervical Cancer Screening Program (CECAP) TWG, to closely monitor the implementation progress among high volume sites in high-disease burden regions.

PEPFAR/Tanzania will continue to implement a "screen-and-treat" approach for the management of precancerous lesions to maximize opportunities for immediate cryotherapy treatment. All clinical implementing partners will integrate cervical cancer screening for HIV+ women into routine HIV treatment services. We will implement visual inspection with 5% acetic acid (VIA) as a single-visit 'point-of-care' clinical screening for early detection of cervical cancer and clients will be managed using cryotherapy treatment and excisional treatment approaches such as LEEP for cryotherapy ineligible lesions. Women with suspected invasive cervical cancer in places where LEEP services are not available on-site, will be referred for additional evaluation and treatment at established referral sites in the country. Before the referral, the health care worker will determine the women's level of understanding as to why she is being referred for LEEP before proceeding with counseling and referral. We will strengthen the capacity of health care workers in information capture, that is, the review of referral form and filling all required information either electronically or in writings. The referring sites will use the existing Tanzania's feedback mechanism to ensure all women referred for LEEP services access all required services.

By and large, the allocated funds will focus on capacity building among HCW in screening and treatment of cervical cancer. IPs will further continue to support 1) training and mentoring of health care workers to reach more sites with eligible clients; 2) implementation of CQI; 3) the availability of commodities, and 4) procurement, repair and maintenance of equipment /machines, for an effective 'screen and treat' in situ. Funds will also support sample transportation systems and will support information, education, and communication efforts to raise awareness to potential clients, in collaboration with the Ministry of Health, Community Development, Gender Elderly and Children. The Tanzanian National guideline advocates for screening all eligible women for cervical cancer regardless of their HIV status, PEFFAR/T on the other hand, will provide clear instructions to IPs to prioritize their efforts to women living with HIV.

Cervical cancer prevention services are continuing despite the COVID-19 situation in the country. All preventive measures for COVID 19 are being observed. In preparation for Cervical Cancer service prevention scaleup, the program continues to support the procurement of

supplies and equipment (cryotherapy and thermocoagulation machines) for the newly selected sites to support screening and treatment of precancerous lesion. Due to the COVID-19 situation, demand creation is limited at the facilities to ensure eligible women attending CTCs and RCHs services are captured and offered screening.

In COP21, the allocation of $3 million for cervical cancer services in Tanzania will go a long way to improve the cervical cancer screening services and the reach. In COP21, it is expected that 50% of the eligible clients will be screened in facilities that contribute to 80% of clients currently on treatment (see Figure 4.8). Women living with HIV aged 25-49 years are the primary beneficiaries of the cervical cancer program supported by PEPFAR/Tanzania. These women are mobilized and educated on the importance of cervical cancer screening and its close association with HIV.

4.8 Viral Load and Early Infant Diagnosis Optimization

PEPFAR/T has rapidly increased community VL suppression in the past year through progress in identification, linkage and retention. Currently, there are 22 VL/EID testing laboratories. Specimen collection and transportation are done through the integrated hub and spoke sample transport system. Transitioning of sample transportation role from private courier to Tanzania Postal Corporation (TPC) is on-going, and TPC is already working in some regions. PEPFAR/T is working closely with MOH, TPC, PEPFAR implementing partners, and other stakeholders to support this transition and to ensure services are not affected during this transition. All VL/EID testing laboratories are electronically reporting centrally in the Open Laboratory Data Repository through LIS, except the two military laboratories. Technical integration of CTC3 with Laboratory Information Systems and CTC3-LIS data flow is expected to go live by the end of FY2022. During COP21, PEPFAR/T support work collaboratively with the GoT to support a transition to better utilization of high through put VL test platforms (Roche & Abbott) within the existing Laboratory Diagnostic Network to ensure efficiencies and uninterrupted HVL testing. Strengthening sample referral and transportation systems to ensure timely results return and utilization will be an essential step in this plan. Furthermore, efforts will also focus on strengthening oversight & coordination for reliable supply chain systems to minimize stock-outs and systems maintenance. This will include working with the GoT to take advantage of the Global RFP. PEPFAR/T will continue to support multiplexing strategies for VL, EID and TB.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of point of care Testing (POCT) for VL, EID and TB testing in hard to reach councils and priority populations. Of the 264 GeneXpert platforms that were placed through the TB program, there are currently 63 GeneXpert platforms doing VL/ EID and TB testing. Of the 264 platforms, 88% of them have the GXAlert electronic system and data from these is reported centrally in a separate database, with on-going efforts to bring this data to the Open LDR. In COP21 PEPFAR/T will work with MOH and stakeholders to conduct needs assessment for optimizing POCT platforms within the lab network and strengthen the integrated sample referral system for TB, EID & VL.

PEPRAR/T will focus on client centered services and utilize high-quality treatment literacy approaches including U=U to achieve undetectable viral loads through treatment adherence. In COP21, PEPFAR/T will review available treatment literacy materials to understand and assess any gaps. Members of the target communities have been, and will continue to be involved in message development. PEPFAR/T will continue to ensure that clients with high VL results will receive adherence counseling, be offered a second VL test, and appropriate action

thereafter implemented as per the national VL testing algorithm. In COP21, PEPFAR will support NACP by procuring VL reagents and consumables for all conventional VL tests.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

5.0 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR/T COP20 systems investments build on previous years PEPFAR investments and FY20 program shifts and achievements. The main program shifts in COP19 were focused on ensuring rapid progress in finding PLHIV, effectively linking them to care and retaining them on life-saving anti-retroviral treatment, reducing HIV-related morbidity and mortality, and breaking the chain of HIV transmission (U=U) to achieve sustained epidemic control. To sustain the gains achieved so far requires consistent use of data to measure progress and to guide real-time adjustments to ensure that the right strategies are implemented through effective utilization of health workforce supported by training, mentorship, and provision of client centered services to improve the quality of HIV services and ensuring focused communities of practice are reaching the right people in the right places at the right time.

In COP20, PEPFAR/T systems investments will focus on addressing key systems barriers identified which include the following:

- Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and commodities,
- Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates,
- Insufficient public resource commitments and expenditures to meet national HIV program needs for epidemic control,
- 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,
- Inadequate capacity to manage diagnostic network optimization for VL, EID, and TB, supply chain modernization and laboratory quality management including the fidelity of the lab/clinic interface,
- Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites,
- Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites,
- Slow adoption and implementation of key evidence based policies, guidelines and procedures to facilitate rapid scale up and implementation with fidelity of ART optimization, Viral Load/Early Infant Diagnosis optimization, HIV self-testing, PrEP, TB Preventive Therapy (TPT), Differentiated Care Service Delivery Models, Multi Month Dispensing, use of lay workers, biometric unique identifier, and other key strategies across scale up councils and key populations
- Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at national and subnational levels and improve patient-level service delivery and monitoring, and
- Lack of strategic engagement of faith based and private sector for achieving epidemic control and shortage of market segmentation/total market approach.

PEPFAR/T COP20 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.

5.1 Information Systems and Data Use

Data and Systems are two of the three foundations for PEPFAR/T FY22 approach to support continuous quality improvement and ability to measure impact for Tanzania's COP21 implementation plans, and to achieve sustained epidemic control.

As background, the primary data system that supports PLHIV are called Care and Treatment (CTC). The various CTCs include:

- CTCID: Unique number provided to new clients at entry into treatment.
- CTC cards: Physical card retained by the client (CTC1), and a clinical file maintained at the facility (CTC2).
- CTC databases: Facility-based health information system that captures clinical, lab, and pharmacy information (CTC2), and a national, de-identified, aggregate database pulling from the CTC2 database (CTC3).
- CTC dashboard: A visualization platform utilizing CTC3 database.

For COP21, the specific key barrier identified as contributing toward the gap are highlighted in the Table 5.1.

Table 5.1: Key barriers related to HIS to meet the needs of more than 1.4m PLHIV in care

Epidemic Control Barrier or Systems Gap Identified: Gaps in surveillance and program data (i.e. data quality and completeness, HI systems) impedes ability to analyze and use timely data to inform HIV program decisions and policy actions at the national and subnational levels and improve patient-level service delivery and monitoring.	
Current status (value from investment to date) (2020 Results)	**Key selected activities and benchmarks (2021 Plans)**
CTC2/3 • CTC2 database covers more than 90% of static sites. • Integration of pharmacy, HTS, and lab modules has begun. • CTC2 ➔ CTC3 data transfer occurs on a weekly basis yet processing challenges remain preventing a de-identified replication of data for national-level, aggregate, and real-time monitoring.	**CTC2/3** • Increase CTC2 (+pharmacy, testing, and lab modules) database coverage and functionality to 95% of PEFPAR static facilities. • CTC2 ➔ CTC3 databases: Complete/accurate weekly file acceptance for 95% of static PEFPAR sites. • CTC3 databases: Standardized and automated weekly checks and reports generated during file processing for data quality, file acceptance/rejection and primary reasons.

	• CTC3: <1 day turnaround time for automated communication to the facilities regarding file acceptance/processing success and challenges with effective remediation guidance for 95% of static PEPFAR sites
Unique Identification • A unique CTC ID is provided to all new clients receiving clinical care and is used within the CTC2 system at HIV clinics. While the CTC2 system does facilitate patient level monitoring at the facility level, it does not allow for tracking clients who move between facilities or registered with multiple CTC IDs. • **Biometrics** were successfully integrated into the CTC2 system under a PEPFAR/T supported pilot project in Zanzibar in 2017. PEPFAR/T subsequently supported the successful integration of biometric capabilities into the Mainland CTC2 system in 2019, but activation of biometrics has not been approved by GOT. • MoHCDGEC has approved integration of biometrics in a newly planned health information system (Afya Care), but that system will only support 28 regional hospitals (among the 3,000+ facilities serving PLHIV).	**Unique Identification** • Activation of biometrics into CTC2/3 has not been approved by GOT. PEFPAR will continue to advocate for activation into CTC2/3 data system as CTC2/3 is currently supporting 3,000+ facilities and 1.4 PLHIV.
Lab Information Systems To improve functionality, leverage resources, and improve data quality and use for service delivery and quantification purposes, currently assessing the various LIS systems and interoperability to identify remaining gaps for specimen tracking/results and patient-level monitoring.	**Lab Information Systems (LIS)** Integrated and functional specimen tracking/results and patient-level monitoring for Tier 1 and Tier 2 sites (80% PLHIV)
Interoperability (CTC2/3, community systems, lab systems, DHIS2, etc.): Health Information Mediator was strengthened with initial ongoing integrations, development of SoPs and technical guidance.	**Interoperability (CTC2/3, community systems, lab systems, DHIS2, etc.):** Health Information Mediator will be further enhanced for aggregated data exchange across multiple platforms (DHIS2, CTC2/3, OVC, etc.)

5.1.1 Scaling HIS to meet the needs of than 1.4m PLHIV in care

Tanzania's Information Systems and Data Use investments have improved information systems capabilities to servile delivery as well as data quality and use facility and national levels. The focus of FY22 will be to scale functionality of key systems (i.e. CTC2/3, lab information systems, community systems) and interoperability to be able to support real-time, client-level monitoring for more than 3,000 facilities and 1.4 PLHIV in care. Improved

functionality and interoperability will drive improved data quality, continuous quality improvement, patient monitoring, and data use for programmatic and policy decision-making.

Systems interoperability to meet the needs of more than 1.4m PLHIV in care

In COP20, PEPFAR/T built upon and extended the Health Information Mediator (HIM) by adding relevant capabilities that support the GoT health programs while concurrently addressing the USG and other partner needs for accountability on programs such as PEPFAR/T. The HIM platform was enhanced to support open and global goods standards for sustainability. Over 13 integrations have been developed and successfully tested, awaiting deployment, and strategic documents to support proper functioning of the HIM were developed including: capacity strengthening plan for Tanzania HIM, Tanzania HIM SOPs and Tanzania HIM standard guidelines and security framework.

Under COP21 PEPFAR/T will continue to further enhance the HIM platform to support open standards such as FHIR, HL7, ADX, etc. to facilitate sustainable information exchange. The HIM will be extended to accommodate additional use such as NHCR integrated with additional all-health EMRs (AfyaCare, GoTHOMIS) as they are developed and scaled, and CTC2 to support unique client/patient identification; aggregate data exchange implemented from different systems to DHIS2; Community systems connected to CTC3, and OVC use cases explored, developed and integrated through the HIM.

PEPFAR-TZ will also invest to improve data and data governance; and to strengthen governance and capacity of the GoT to support and maintain the HIM. To facilitate data exchange between the MoHCDGEC and the PO-RALG, use cases that require interoperability between HIM and Muungano Gateway will be addressed. Furthermore, to improve accessibility of surveillance data, interfaces will be developed to support interoperability and data exchange between surveillance systems and the RITA system to routinely monitor deaths in community and facilities.

Along with ensuring interoperability of systems, PEPFAR/T will continue to support implementation of the Health Data Repository (HDR) meant to receive de-identified individual level data from all-health EMRs through the HIM and provide program managers, decision makers and other stakeholders with secure access to specialized, programmatic (HIV, TB, MCH, etc.), de-identified, patient level data with associated dashboards.

5.2 Human Resources for Health

In COP20, 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 telehealth services such as ECHO, e-learning models, etc.) 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).
5) 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 Human for Health Information System (HRHIS) to capture indictors that will support the design of an HRH cascade.

For COP20, the specific key barriers identified as contributing toward the gaps are highlighted in the Table 5.2.

Table 5.2: Key barriers related to human resources for health (HRH)

Epidemic Control Barrier or Systems Gap Identified	**Current status (value from investment to date) (2019 Results)**	**Key selected activities and benchmarks (2020 Plans)**
Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites	Draft National Health Sector e-Continuing Professional Development (e-CPD) coordination framework developed Development of Learning Management System (LMS) at CDE to host the in-service field epidemiology training intermediate course (cohort 5) http://tzcde.ghelearning.org/ Training modules for mid-level cadres to undertake task sharing roles developed Training of nurses on nurse initiation and management of antiretroviral therapy (NIMART) and training of other HCWs per the task sharing policy	**Activities** Strengthen, expand social welfare workforce and monitor performance including transitioning of workforce to Local Government Authorities (LGAs) in 84 councils Provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSMs, focused on adolescent and pediatric outcomes. Build on the previous HRH inventories of PEPFAR HRH support to address the chronic HRH shortages for HIV service delivery Continue to provide technical support to MOH in implementation of a retention plan to assist to reduce the vacancy rates Support for HRHIS Assessment Framework (HAF) implementation, as

		part of the business model for interoperability **Benchmarks** Proportion of HRH direct support aligned to priority HIV program and regional strategies developed for effective transitioning of HCW A reduction in vacancy rate to 45% (all cadres) 45 high-volume sites implementing an efficiency change and 60 HCWs self-reporting increased competence (from baseline) in key HIV areas No less than 20% of PEPFAR supported HCWs contracted and transitioned to GoT
Inefficient system for HCWs prioritization, recruitment, production, allocation, and retention across priority service delivery sites	Simplified Workload Indicators and Staff Needs (WISN) and Prioritization and Optimization Analysis (POA) used to distribute 6,180 HCWs. WAO tool handed over to MOH for validation and expected to use during next recruitment cycle. National Health Sector HRH requirement and recruitment plan 2018-2023 developed	**Activities** Improve HRH deployment at the central level- POSPSM- using WISN--POA-WAO (Workforce Optimization Allocation) To support the MOH in increasing recruitment, retention and allocation of health and social welfare workers at all levels Strengthen HRH performance management of health workforce and develop customized retention packages in 185 LGAs, to retain health workers **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 Integration with and utilization of WISN+POA+WOA in POPSM and HRHIS systems

5.2.1 Human Resources for Health Achievements to date

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 2020, the FELTP program has trained 450 health care workers in Field Epidemiology and Laboratory

management that are in multiple regions and districts within the country. These individuals are responding to public health emergencies and building and evaluating surveillance systems. For COP20, 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. Fostering the FELTP program is a collaborative effort between clinical implementing partners and CDC staff. More importantly, it is a part of the mentorship model to assist in building skills of residents and enable transfer of knowledge on current HIV related interventions.

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 COP18, WISN + POA will be institutionalized into GoT systems. In COP19, PEPFAR/T upgraded the IT platform for institutionalization of WISN + POA + WAO into interoperable GoT systems including HRHIS and 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 in COP20 will continue to build on the progress from the previous years to ensure institutionalization of the various tools with the goal of ensuring interoperability with the HRHIS, as part of the business model designed.

PEPFAR/T's strategy to address misdistribution and misallocation of existing health workers is implemented through a coordinated approach that engages POPSM, MOH, PO-RALG and Ministry of Finance and Planning (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.

5.2.2 Human Resources for Health Priorities and COP20 Activities

PEPFAR/T will continue to focus on host country institutional development for HRH leadership, governance, and management. PEPFAR/T will ensure that at least 75% of HCW are retained for one year using the information available in the HRHIS to monitor progress. This will be done through continued technical support to GoT (MoHCDGEC & PO-RALG). 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 and 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 COP20, PEPFAR/T will continue to 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 COP20, PEPFAR/T will strengthen performance management of health workforce and develop customized retention packages in 185 LGAs, to support test and start, acceleration of differentiated service delivery models, and acceleration of TPT services.

COP20 will continue to support mid and lower-level cadres through translation of the task sharing policy into operational practice, including supervision and mentorship and 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 linkage case management model scale-up, 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.

In COP20, PEPFAR/T will continue to work with NACP and other development partners to further identify and align with the HRH priority areas all the while 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. They will also concentrate on supporting data quality and surveillance-based activities, in addition to supporting the utilization of the emergency operation center for real-time data analysis for public health action. PEPFAR/T will support the scale-up of virtual communities of practice though 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 and test and start. It will ensure standardized training support to clinical mentors and expanded access to virtual learning support at the 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 the health systems that contribute to ensuring high quality HIV service delivery through on-the-job, competency-based tiered field epidemiology training.

In order to achieve efficiency gains in implementation of key polices and strategies, PEPFAR/T will continue to leverage efforts through partners during implementation of various strategic plans, such as the Human Resource for Health draft strategic plan 2020 – 2025 and Digital Health strategy 2019-2024. The strategic priorities within these documents and others are complementary, and they align with PEPFAR support areas.

In COP 21, PEPFAR/T will continue to build on the investments made, with an emphasis on ensuring the safety and wellbeing of the healthcare workforce, optimization of healthcare workers and advancing sustainability planning, as guided also by the PEPFAR/T HRH strategy. For instance, in FY21, as part of the healthcare workforce safety & wellbeing initiation, the training of HCWs/CHWs under the task sharing policy roll out was halted to allow time for conversions of the training modules to e-CPD ones. This will allow wider coverage of training to be done through virtual means in COP21. As of FY 20 Q4, about 1,252 (12%) out of the 10,000 targeted eligible NIMART nurses were trained through USG supported IPs and enrolled in the certification process. This work will continue in FY 22.

In FY22, PEPFAR/T will continue with the strategic direction to support the HMIS epidemiolocal surveillance sub-system by providing support to the residents and graduates of the Field Epidemiology and Laboratory Training Program. In COP 21, HRH data alignment and data utilization efforts to improve HRH requirements, allocation, equity, performance management, retention and productivity to support various priority HIV interventions will be enhanced. PEPFAR/T is committed to use various data sources such as the HRH inventory, the HODA (**H**uman Resource for Heath **O**perating Unit **D**ata **A**nalytics) dashboard, HRHIS data, HRH solutions by Data.Fi, ER, POA-WISN-WAO, and many others for sustained HRH investments.

5.3 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 - NHLQATC, four zonal referral laboratories, four specialized hospital laboratories, 29 regional level laboratories, 130 district level laboratories, and 583 laboratories in health centers). In all of these laboratories, PEPFAR/T supports scale-up of HIV viral load testing for routine monitoring and EID services that include access, uptake, documentation of final diagnosis, sample transport networks, and a results return system using a spoke and hub system to transport the samples from facilities to testing labs. PEPFAR/T supports EQA/PT program, certification program, and laboratory quality management to ensure accurate, timely, reliable test results through continuous quality improvement and accreditation of laboratories, as well as continuous quality improvement for HIV rapid testing, TB and recency testing. PEPFAR/T supports access to testing for HIV and tuberculosis through diagnostic network optimization and multiplex use of platforms to increase equipment utilization for better management of diseases.

5.3.1 Laboratory Systems priorities and COP20 activities

PEPFAR/T will focus on addressing the COP20 identified gaps to increase VL coverage and quality of testing. This will be done through (1) elimination of barriers that hinder scale-up of VL coverage and timely return of results for patient care, (2) accreditation of viral load testing laboratories to international standards ISO 15189, (3) progressive improvements to laboratory Information Systems, (4) optimization of dashboard for VL, EID, and TB, and (5) continuous scale-up and quality improvement of HIV Rapid Testing.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of Point of Care Testing (POCT) for viral load, EID, and TB testing in hard to reach councils and priorities population. The POCT equipment will be placed strategically to complement conventional platforms in order to ensure reduction in turnaround time for VL/EID and TB results leading to timely patient management.

PEPFAR/T will focus on client centered service and utilize high-quality treatment literacy training approaches to help achieve undetectable viral loads through treatment adherence. Also, PEPFAR/T will continue to ensure that clients with high VL results receive adherence counseling, offered a second VL test, and advised on the appropriate action thereafter per the national VL testing algorithm.

PEPFAR/T has rapidly increased community VL suppression in the past year through progress in identification, linkage and treatment continuity. Currently, there are 22 VL/EID testing

laboratories. Specimen collection and transportation are done through the integrated hub and spoke sample transport system. In COP21, PEPFAR/T will work with the GOT to transition sample transportation to Tanzania Postal Corporation (TPC) is on-going, and TPC is already working in some regions. PEPFAR/T is working closely with MOH, TPC, PEPFAR/T implementing partners and other stakeholders to support this transition and to ensure services are not affected during this transition.

All VL testing /EID testing laboratories are electronically reporting centrally in the Open Laboratory Data Repository through LIS, except the two Military laboratories. Technical Integration of CTC3 with LIS complete and CTC3-LIS data flow is expected to go live by the end of FY2022.

As part of COP21, PEPFAR/T support will focus on improved utilization of high throughput VL Testing platforms (Roche & Abbott) within the existing Laboratory Diagnostic Network to ensure efficiencies and uninterrupted HVL testing

PEPFAR/T will strengthen Sample Referral & Transportation Systems and timely results return and utilization. Emphasis will be made to increased oversight and coordination for reliable supply chain including utilization of the Global RFP, and continued support for joint strategies for VL, EID and TB.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of Point of Care Testing (POCT) for VL, EID and TB testing in hard-to-reach councils and priority populations. Of the 264 GeneXpert platforms placed through the TB program, 63 GeneXpert platforms currently conduct both VL/ EID and TB testing. In COP21 PEPFAR/T will work with MOH and stakeholders to conduct needs assessment for optimizing POCT platforms within the lab network and strengthen the integrated sample referral system for TB, EID & VL.

5.4 Policies and Governance

Policies that are critical to reaching the country's targets include those related to HIV self-testing, PrEP, differentiated care service delivery models, same day ART initiation, and multi-month dispensing. Same-day ART initiation has been scaled-up and circulars were released to change from 14 days to within seven days in May 2019. Among eligible clients enrolled on care, 97% are initiated on ART within seven days. On the contrary, multi-month dispensing has been scaled up with 77% of eligible clients receiving at least three months ART. Dar es Salaam region began implementation of 6MMD in February 2020. The recently amended HIV and AIDS Prevention and Control Act (HAPCA) allows self-testing in adults and lowers age of consent from 18 to 15 years. Optimized ARV regimens for both adults and pediatrics has been rolled out to all supported facilities.

5.4.1 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 is implemented in all care and treatment facilities with 97% of newly diagnosed positive initiated on ART within seven days. Index Testing is being scaled up with a focus on fidelity with monthly monitoring implemented to track progress, and implementation of 6MMD is underway in one region. The experience will guide further scale up in other regions. In addition, NIMART guidelines have been approved, trainings have been conducted, and tracking of impact on initiation has been

put in place. The GoT plans to conduct an assessment and mapping of unemployed medical trained personnel to support HIV testing activities. GoT and PEPFAR/T have agreed to use unique patient identification with biometric finger scanning as one of the components for the unique ID. HIV Data system draft documents and the requirements are being finalized. Throughout these policy processes, the GoT has demonstrated an increased political will to promote client centered care. After the HIV law revision, the GoT is in the process of developing regulations and framework to guide roll out of HIV self-testing countrywide. Phased implementation has started in three regions of Mwanza, Njombe and Ruvuma. PrEP has been integrated into the combination prevention intervention after the demonstration project. It is currently being implemented in nine regions, and plans to scale up are underway.

5.4.2 Policies and Governance priorities in reaching and Sustaining Epidemic Control

Since 2017, 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 of ART optimization, EID, self-testing, community ART, TPT, DSM, MMD, 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 COP20 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 COP20, PEPFAR/T will continue to 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 COP20 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 six-month dispensing in selected regions with three months dispensing countrywide. PEPFAR/T 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 for women of reproductive age and adolescents. PEPFAR/T will also scale up adolescent psychosocial support services and specialized services for pediatric and adolescent PLHIV. In addition, PEPFAR/T 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.

GoT policy around customs clearance and VAT application for the import of medical products remains a key concern. Publicly funded, privately financed, and donated products are all impacted by regulations on international import and goods clearance. PEPFAR/T continues to work with the GoT to identify challenges in this area and will provide some support to the pharmaceutical regulatory sector to ensure quality and identify areas where policies and processes can be streamlined. Clear, fast, and consistent import processes mean that life-saving health commodities, such as ARVs, can reach patients faster, consistently, and in the appropriate quality condition. These policies are important for long term sustainable epidemic control.

Updates for COP21

In COP 21 PEPFAR Tanzania will continue to provide technical support to GOT to implement PrEP scale up in country, and build on the achievement of the initial pilot implementation during previous COPs and the near final National PrEP implementation Strategic Framework. Moreover, PEPFAR Tanzania will continue to support capacity building for the healthcare workers to provide these services as well as developing real-time monitoring systems to PrEP services in country.

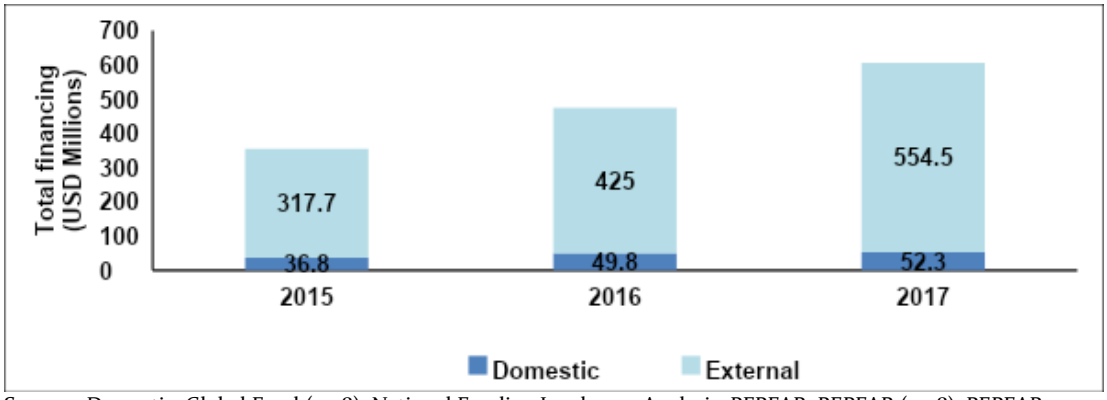
The other investments in COP 21 will be to continue strengthening the scale up of the advanced HIV disease services from the current 140 sites in COP20 to over 400 sites in COP21. Additional support will be focused on the gradual improvement in access to the commodities as well as the increased capacity building to health care providers in selected sites, as well as the monitoring and reporting systems for these services which the focus of integrating these services into routine HIV care, treatment and support services.

Finally, the strategy will be to maintain and monitor the performance/ progression of other policies implemented in COP 20 with the GOT on monthly and quarterly basis.

5.5 Financing

The goal of PEPFAR/T's systems investment in finance is for Tanzania to support sustainable financing for epidemic control. While there were some improvements in the PEPFAR/T SID 3.0 for this domain, the HIV program is largely donor dependent. A recent UNAIDS HIV investment case report indicated that PEPFAR and the Global Fund accounted for 88% of financing in 2015 and 2016 and 90% in 2017, respectively. Several other donors and partners beyond PEPFAR and the Global Fund have provided small amounts of financial support and technical assistance. The graph below depicts the trend in HIV financing over time using data from the TACAIDS and UNAIDS Tanzania HIV Investment Case Report- 2019 (unpublished data).

Figure 5.5: Domestic and external HIV expenditure 2015-2017



Sources: Domestic: Global Fund (2018). National Funding Landscape Analysis. PEPFAR: PEPFAR (2018). PEPFAR Expenditure Report 2017; Global Fund: Global Fund (2018). Global Fund Expenditure Report 2017. Tanzania HIV Expenditure; Other external funders: Global Fund (2018). National Funding Landscape Analysis.

PEPFAR continues to be the largest donor for Tanzania's HIV program, especially for the funding of national program priorities like care and treatment. According to the UNAIDS Investment case, "*PEPFAR contributed USD 290.4 M in 2015, rising by 17% in 2016 and 11% in 2017. PEPFAR accounted for more than 80% of total HIV expenditure in 2015 and 62% in 2016 as expenditure on the Global Fund grant accelerated. In 2016 Global Fund spending rose from USD 21.6 M to USD 80.4 M.*"

PEPFAR supports sustainable financing efforts to improve efficient use of existing resources and domestic revenue generation. As part of improving efficiencies, PEPFAR has supported national and local government systems for improved public financial management (PFM). The national budget of Tanzania does include some funding for HIV/AIDS, and increased avenues have been developed for public participation in budget advocacy and formulation. PEPFAR supports strengthened public financial management at the health facilities, and local government authorities improve budget allocation and budget execution. There are enduring systemic weaknesses related to fiscal space, particularly limited resource allocations for HIV from the Total Government Expenditure and inefficiencies in the use of existing resources (Tanzania National Health Accounts 2016/2017). Furthermore, the country's efforts on the Single National Health Insurance remain stalled through political processes and complicated proposals- like merging of the Workers Compensation Fund to function as a source of pooled resources for health insurance. In COP20, PEPFAR/T will target better PFM systems and interventions across the health financing continuum, with a focus on strategic purchasing. The health financing reforms instituted by the GoT and supported by PEPFAR, as part of the Direct Health Facility Financing (DHFF), have provided the impetus for better outputs-based financing and presents opportunities for providers at local levels to better match payments to priority services.

However as identified though the SID 3.0, sustainable financing remains one of the weakest scores on the sustainability framework, and several challenges exist that impact the country's efforts at domestic resource mobilization and improved efficiencies in the use of existing resources.
Table 5.5 describes systems barriers, results from the previous year's investments, and some of the key activities planned.

Table 5.5: Systems barriers related to financing

Epidemic Control Barrier or Systems Gap Identified	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 has continued to support the GoT commitment to Single National Health Insurance. While the operational details are still under political review, the technical work to inform policy, decisions continue through analytical studies and research. The Direct Health Financing Reforms have increased the transparency and flow of resources to the local levels. This has increased provider autonomy and potential for increased governance and accountability. PEPFAR, through the GHSA-TA activity, has completed studies to inform how direct funding at the facility level would improve product availability and reduce stock outs of essential medicines like Cot rim for management of OIs for people living with HIV/AIDS (PLWHA) 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.	**Activities:** Continue Support for implementation of key components of the national health insurance strategy, the iCHF program roll out, which is managed by the Local Government authorities and have potential for greater coverage for PLWHA. Support NHIF analytics and programming that emphasizes market segmentation and co-payments for paying clients to increase the potential of revenue generation and greater security of the Fund. Increase the support and TA to the NHIF for improved management structures and payment modalities This will also be linked with policy dialogue to inform the benefits package and different premium levels **Benchmarks** Proportion of regions that implement improved insurance schemes to generate additional revenue for priority HIV services Proportion of councils that are using updated PlanRep and FFAR tools to inform council level planning for inclusion of priority services including HIV

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	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. 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 MOFP. These practices are fundamental to PFM practices-which in turns increases efficiency in use of public resources.	**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 Improve efficient use of HIV resources by increasing budget execution levels of allocated HIV resources within the GoT national budget **Benchmarks** Percentage of approved budget transferred from national level to LGA Level

5.5.1 Financing Achievements to date

PEPFAR/T's investments and support for Direct Health Facility Financing (DHFF) Management and public financial management over time has resulted in more efficient GoT systems for budgeting, disbursement, management, and use of funds. The redesigned GoT planning system, PlanRep is now a web-based national platform that is linked to the annual council planning process. This is used together with the improved financial systems-Facility Financial Accounting and Reporting Systems (FFARS), which is a simple accounting system used by service providers to acknowledge receipt of revenue, process procurements, manage expenditures, and produce financial reports for all funds flows.

PEPFAR/T's support for the redesign and launch of PlanRep and the improved financial accounting and reporting systems (FFARS) have led to improvements across all PEPFAR/T's scale up councils to develop, review, and approve annual plans and monitor budgets using 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.

5.5.2 Financing priorities and COP20 finance activities

PEPFAR/T will continue to support and leverage the ongoing GoT financing reforms, including the Direct Health Facility Financing (DHFF) Management system to increase use of

public finance for the HIV/AIDS response and increase efficient use of the existing resources. PEPFAR/T support over the past three years has contributed to incremental gains towards improved allocative efficiencies, especially at the lower government levels, which is a key condition for the efficient use of public resources.

PEPFAR/T will continue to support the DHFF as a part of fiscal decentralization in the country. The goal is to create a unifying purchasing framework that refines the different fund flows and DFF payments to the facilities and improve provider capacities to efficiently use these resources to deliver priority health and HIV services. PEPFAR will continue to conduct analytics on financing and other critical system areas to inform efficiencies in use of public resources. As an example, through USAID's Global Health Supply Chain Activity, PEPFAR supported a report that documents the impact of DHFF on the availability of commodities at the facilities. The report indicates that there is an opportunity for greater leverage of these resources to support HIV services that are not funded through PEPFAR, such as increasing the availability of cotrimoxazole for treatment of OI's among PLWHA.

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 to receive on-time disbursements of allocated resources from MOFP to enable HIV service delivery is running smoothly through its second year of implementation.

As a result of these foundational PFM investment, PEPFAR/T will use these financial systems to inform the Activity Based Costing Management ABC/M activity, an OGAC priority which is featured for Tanzania, among three other East African Countries. The Activity based costing is designed to determine baselines of cost estimates for HIV program activities. This will contribute to inform PEPFAR goals for financial and program sustainability by supporting informed resource allocation decisions and maximizing PEPFAR investments. The ABC/M has been launched as a core funding activity, but PEPFAR/T's core IPs, including the Public Sector Systems Strengthening (PS3) and HP+, will support these activities on the ground.

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) will continue with extra support for TA to NHIF and support for implementation of the iCHF, which has potential for greater coverage, especially for low income, informal sector populations affected by HIV. In addition, PEPFAR/T will continue support to the regions and districts to ensure effective administration and management – and insurance coverage, especially for PLWHA through the improved community health fund (iCHF).

Updates for COP 21

As part of the PEPFAR mandate for financial sustainability, COP21 will continue support for improved PFM systems that enhance local government planning and budgeting. Increased efficiencies in use of public resources provides the foundation for greater domestic spending for HIV programs.

In addition, COP 21 funds will continue to a strengthen key financial management systems, including the new accounting system MUSE, which is replacing the EPICOR described above.

PEPFAR/T will also leverage the momentum presented by the new government to support discussions on Single National Health Insurance and support fiscal space analytics that have been requested by senior officials as part of these deliberations.

PEPFAR/Tanzania will continue collaboration with the HQ led Activity Based Costing (ABC/M) activity, conducted only in Uganda and Tanzania during Phase 1. However given the above-site cuts (28%) for COP21, Phase 2 of these activities will be supported solely with HOP resources.

5.6 Private Sector NEW for COP20

The general business environment is constrained by increasing and constantly changing regulations. This negatively impacts the ability of the private sector to contribute to the HIV/AIDS epidemic. However, there have been some changes in law and regulations pertaining to epidemic control that have created opportunities for leveraging private sector resources, expertise, and networks to achieve epidemic control.

5.6.1 Private Sector Achievements to date

Some of the key private sector achievements over the previous year include:

- *HIV Self-Testing*: In November 2019, Parliament passed legislation allowing HIV self-testing and lowered the minimum age for self-testing to 15 years of age. The law does not restrict private sector sale of HIV self-test kits. TMDA has registered OraQuick and INSTI- and BIOSURE are in the process of being registered
- *Condom Supply* and Total Market Approach *(TMA)*: (a) The TMA HIV commodities core group is using evidence from PEPFAR-funded assessments that shows consumer willingness to pay for condoms and illustrates how untargeted distribution of free condoms will destroy potentially sustainable markets. The TACAIDS subcommittee on condoms has inserted TMA narrative in revisions of the national condom strategy and has connected TACAIDS leadership with private sector suppliers as part of TMA advocacy.
- *HIV In-Service Training and Private Provider Coaching*: The GoT is now routinely empaneling health facilities to be certified sites in-service training for staff and pre-service students doing practicums at these facilities. This was piloted in the private sector and has now been adopted by the public sector. The success of this activity will now be applied to promoting client-centered task sharing at private facilities in hopes that success in the private sector will induce change in the public sector.

Table 5.6: System barriers related to the private sector

Epidemic Control Barrier or Systems Gap Identified	Status (value from investment to date) (2019 Results)	Key selected activities and benchmarks (2020 Plans)
Lack of strategic engagement of faith-based and private sector actors for achieving epidemic control and shortage of market segmentation/total market approach	Advocacy led to legislation permitting self-testing Advocacy for TMA has increased GoT and Global Fund awareness of the dangers of long-term sustainability by flooding the market with free condoms	**Activities**: Continued intervention at GoT national level to enshrine TMA principles in policies and strategies Engage stakeholders at selected subnational levels to implement TMA in condom and HIVSTK distribution **Benchmarks:** # HIVSTKs and condoms distributed through corporate testing model # HIVSTKs and condoms distributed through ADDOs # new male cases found # young people collecting ARVs at ART sites

		#/type lower cadre staff participating in task sharing at private facilities % share condom market by commercial providers % share condom market by social enterprise

5.6.2 Private Sector Priorities and COP20 Activities

SID 3.0 scoring does not represent the full picture of private sector investment and environment in Tanzania. Despite some improvements in the score, there remains weak private sector engagement in the response to HIV/AIDS caused in part by regulatory constraints imposed by the GoT. In addition, some epidemic control programs work at cross-purposes with the goal of building a sustainable HIV/AIDS response through the private sector. For example, the proposed massive distribution of free condoms threatens established commercial markets and modestly priced condom markets being nurtured by social enterprise. The fact that the Global Fund-supported program of free condoms in Tanzania has stalled for so long is due, in part, to the success of PEPFAR/T in resolutely championing TMA. TMA advocacy will continue at the national level but in COP20, it will be supplemented by interventions at carefully selected subnational levels where local GoT authorities, private sector capacity, and potential consumer demand present market creation opportunities.

Business unfriendly regulations have induced understandable caution in the private sector. PEPFAR/T interventions in COP20 are intended to spark innovation and informed risk-taking. A clinical coaching program among selected private providers will demonstrate the value of task sharing in providing HIV/AIDS services as specified in the NIMART policy. The intervention will include elements of business and HRH management so that private providers offer client-centered quality care, utilize more fully their lower cadre staff in providing HIV/AIDS care, and develop financially sustainable business strategies.

Based on evidence generated in prior PEPFAR-funded assessments, a private sector ART service model aimed at promoting self-testing and retaining youth on treatment will be piloted around dense and sexually active youth populations surrounding vocational training centers, colleges, and universities. Youth-friendly ART pick-up sites will include a network of private health facilities, pharmacies, and testing, care and treatment centers. Digital applications and youth-centered messaging that encourage self-referral will be part of the marketing strategy.

Legislation allowing HIV self-testing presents an opportunity to increase case finding among adolescent and young men through the more than 10,000 Accredited Drug Dispensing Outlets (ADDOs). Using E-vouchers at a subnational pilot site, targeted marketing will be used to attract customers who will purchase HIVSTKs and generate the evidence that GoT will require for scale-up.

Male case-finding will be the aim of interventions near and at businesses that are reliant on a male workforce. Given male reluctance to visit health facilities, various modalities will be

tested to motivating employed men to test. The intervention will involve creating informal and formal partnerships among HIVSTK providers, businesses, and PEPFAR implementing partners.

COP 21 UPDATES:
As part for the PEPFAR mandate for Private Sector engagement, in COP21, PEPFAR/T will build on the progress made in Total Market Approach (TMA) advocacy. TACAIDS and NACP have taken the lead for training 11 LGAs in national TMA policy, creating simpler training materials, and gathering feedback that informed the creation of an LGA TMA planning tool. The TMA planning tool will be distributed nationwide in COP21 to help LGAs identify potential private sector opportunities for complementing and strengthening the local response to the pandemic. The expectation is that as sale of HIVSTKs at community pharmacies improves, this will strengthen the advocacy case for authorization of the ubiquitous drug outlets network, which are often in unserved rural populations, to expand the dispensing of HIVSTKs within communities.

5.7 Supply Chain and Commodity Management

PEPFAR/T investments in supply chain capacity to date have resulted in improved efficiency and responsiveness. With support from PEPFAR, the Global Fund, and other stakeholders, Tanzania redesigned its supply chain system in FY18. The new system increases reporting frequency from quarterly to monthly, allowing for more current data for decision-making. Delivery schedules to facilities also increased in frequency, helping to ensure product availability to clients. The new design began national roll out in FY19, and in FY20 is now being implemented in the Mwanza and Tabora zones that cover Mwanza, Simiyu, Shinyanga, Geita, Tabora and Kigoma regions. National rollout will continue in FY21, in collaboration with Global Fund, MOH, and MSD.

The IMPACT team initiative capacitates Regional and District Supply Chain Managers to review and analyze logistics data at facilities with the goal of improving data quality. Improved quality of logistics data contributes to vital and informed decision making to address commodity stock imbalances. Bolstered by the new supply chain system design, PEPFAR will continue to support the IMPACT teams in FY21.

PEPFAR/T investments in supply chain data improvements include the roll out of the eLMIS. Data from the eLMIS were utilized during the TLD transition to identify a rapid distribution plan and stock availability. The data are also being utilized for the pediatric regimen transition. Integration of this system with other systems like Epicor 9 at the MSD has improved delivery times to health facilities.

In FY21, PEPFAR/T will continue to support these systems and data improvements in the supply chain, as well as support other vital areas to commodity security. Activities will include the implementation of the laboratory network optimization recommendations, equipment standardization, and equipment module in eLMIS in order to improve availability of viral load reagents; continued support to the supply chain system redesign roll out; data quality improvements and upgrades to eLMIS; supporting GoT in consistent and agile supply plan monitoring; and support strengthening the quantification of new or scaled up products as they are integrated into the system (i.e. PrEP and self-test kits).

Table 5.7: System barriers related to commodities and supply chain logistics

Epidemic Control Barrier	Current status (value from investment to date) (2019 Results)	Key selected activities and benchmarks (2020 Plans)
Inefficient systems and resources for import, product registration, clearance, and distribution of commodities under new policy mandates	Support provided to NACP and MSD to pre-position stock for TLD transition and plan for pediatric optimization. New program products, such as self-test kits, quantified at a national level and registered with regulatory authority.	**Activities** Support NACP and MSD to support new product demand as a result of pediatric transition and prevention programs. Build capacity of Tanzania Medicines and Medical Devices Authority on medicines evaluation and registration, formulation development, and stability testing. **Benchmarks** Proportion of eligible pediatric patients transitioned optimized regimens. Number of days for product registration and import
Inadequate linkage between patient-level facility data and logistics information system for effective management of ARVs and other commodities	eLMIS integrated with DHIS2, MSD ERP, and GoTHOMIS-EMR with minimal loading in Health Information Mediator (HIM)	**Activities** Conduct analysis utilizing supply chain data and clinical data to monitor key program transitions (pediatric transition, Prep, self-testing, etc.). Use data-driven approach for decision making Support continued roll out of supply chain system redesign. Incorporate new monthly data to ensure agile and responsive national supply chain **Benchmarks** Facility stock data captured at national level

Changes and Updates for COP 21

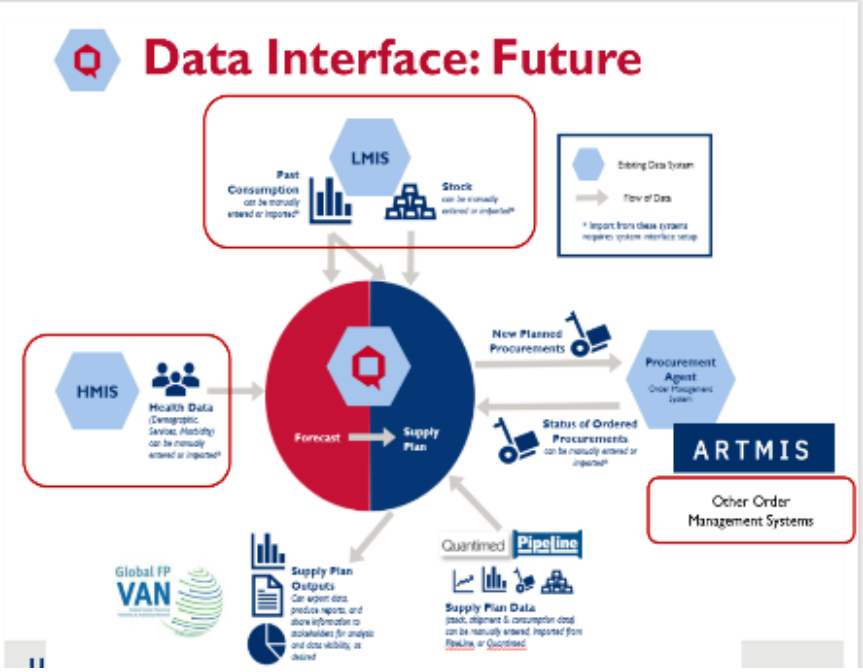
Under COP21, PEPFAR/T will continue to support integration of Tanzania Health Supply Chain Portal (THSCP) to receive data from different systems (eLMIS, MSD Epicor, DHIS2, FFARS, etc.) through the interoperability layers (Health Information Mediator-HIM) providing a one-stop center for HIV supply chain data and resources. This will support monitoring of commodity expiry rates, tracking health commodities procurement, and will provide high-level, end-to-end supply chain visibility.

In addition, PEPFAR/T will continue with the above-site systems investments that strengthen supply chain governance and support enhanced data availability and use. New and improved dynamic dashboards will promote data-driven decision making, facilitate analysis of supply chain performance, and provide enhanced visibility of VL commodities and TLD, all of which will positively impact product availability.

PEPFAR/T will support implementation of the Tanzania Health Product Registry (THPR) that enhances the capabilities to uniquely identify HIV and other health programs commodities using standardized codes and names across the Health System. The THPR facilitates standardized information sharing and use across different data systems (CTC2, eLMIS, EMRs, etc.) through the interoperability layer – the HIM – and support processes for product recalls through reverse logistics.

Other SC activities for COP21 include continuing to build the capacity of ICT developers at the MoHCDGEC – to facilitate the eLMIS upgrades (Tier 3) and transition plans to the GoT.

In response to NACP needs, and taking lessons from the GF, both upstream and downstream commodity visibility will further be enhanced through the introduction and use of a cloud based QAT (*quantification analysis tool- see below)* that interphases with other existing system to improve quantification outcomes, procurement, and stock status visibility at all levels.



5.8 Surveillance, Research, and Evaluation (SRE)

In COP21, PEPFAR/T proposed a total of five SREs - surveillance (3), research (1), and evaluation (1). DOD proposes implementing two SREs, one evaluation and one research and CDC proposes implementing three surveillance activities. USAID is not proposing any SRE activities. proposes none.

In COP21, DOD will continue to implement 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 COP20, sustaining the gains in treatment services is important as along with improving management of HIV advanced disease. This longitudinal assessment will help to understand the impact of long-term co-morbidities on HIV outcomes. 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 examine factors associated with incomplete viral suppression through HIV drug-resistance testing. Viral suppression in adolescents is an area that continues to pose challenges towards attaining HIV epidemic control in Tanzania, thus, understanding facilitators and inhibitors to suppression is a key component of reaching epidemic control. 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 important in attaining HIV epidemic control.

CDC proposes three surveillance activities for COP21. This includes completion of the *Bio-behavioral survey and size estimation among FSW, MSM, and PWID in mainland Tanzania (IBBS); Establishing Recent Infection Surveillance Using Point of Care Regency Testing among Persons Newly Diagnosed with HIV Infection in Tanzania (HIV recency surveillance); and* Tanzania *HIV Impact Survey (THIS) A Population-Based HIV Impact Assessment 2020-2021 (PHIA 2020-2021)*.

The *Bio-behavioral survey and size estimation among FSW, MSM, and PWID in mainland Tanzania (IBBS)* 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 the COP20 planning letter to prioritize expansion of Key Populations prevention activities. Data from this activity 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 enough programming per the number and HIV prevalence of KPs in the country. This activity will continue for COP21 and will be implemented in modular phases.

The *Establishing Recent Infection Surveillance Using Point of Care Regency Testing among Persons Newly Diagnosed with HIV Infection in Tanzania (HIV recency surveillance):* is being implemented among persons newly diagnosed with HIV infection by integrating a point of care testing for recent infection into routine HIV testing services with data collection, analysis, and use to

support targeted interventions as part of routing program monitoring. A point of care test for recent infection will be applied to blood samples from persons who are identified as newly diagnosed HIV-positive and are determined eligible for the rapid recent infection testing as part of the HIV testing services provided in facility and community settings. The test result will be used only for surveillance purposes to identify recent HIV infections and population groups with new HIV infections. Routine HIV recency surveillance will be established within existing HIV testing services in Tanzania, which includes index partner testing that is conducted to all newly identified PLHIVs. These data will be used at a regional and national level to inform allocation of HIV prevention resources overall and for age, sex, and risk group sub-populations at a regional and national level.

For COP21, PEPFAR/T is planning to invest and implement the *Tanzania HIV Impact Survey (THIS) A Population-Based HIV Impact Assessment 2020-2021 (PHIA 2020-2021)* which is critical to inform robust PLHIV estimates to further refine the programmatic strategy to reach 95-95-95. Since the PHIA 2016-2017 results, PEPFAR has implemented targeted programmatic activities focused on identification of PLHIV and geographic shifts to focus on regions with low identification of people living with HIV. Updated survey data, paired with improved performance in program data, will address variability in regional estimates that current inhibit accurate target setting and progress monitoring for the reduction of incidence in country as well as retention in care.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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

There are currently 22 vacancies across all agencies: DOD (0), USAID (8), CDC (13), and State (0). Most of these are amid the recruitment process, and it is expected that offers of employment will be extended during the 2021 calendar year.

DOD has no vacant positions, all four positions which were vacant during COP20 have been filled. These include an M&E Officer, Administrative Assistant, HIV Care and Support Officer, and the Health Management Communications Officer. These positions will help advance site-level monitoring activities and increase focus on client-centered services. Due to the skillset needed, lower costs, and faster turnaround time, DOD has hired an eligible family member (EFM) for the position of Health Management Communications Officer rather than hiring a Deputy Country Director. No new/additional positions will be added during COP21. DoD's staffing structure will remain the same placing DOD good position to achieve program goals and targets.

CDC is in the process of filling thirteen vacant positions. Three positions are pending on-boarding, one position is awaiting a work permit before on-boarding, the Public Health Advisor (PHA) (USDH) has been selected and will on-board in July, the Deputy Associate Director for Programs position (DADP) (USDH) is pending acceptance of an offer. Four positions, the Data Analyst, Project Assistant, IT Supervisor and the Health Policy Analyst, are at the Regional

Classification Center (RCC). Two positions are pending posting: Finance Specialist and Clinical Surveillance Officer (USDH). CDC is working with the Embassy on updating position descriptions for the remaining four positions. CDC has restructured to better align with our expected outcomes. One local lab position has been re-purposed to serve as the Deputy Associate Director for Data and Science. The Lab Advisor direct hire position is re-purposed to function as the Clinical Surveillance Officer (USDH).

USAID has also recently restructured its office to create a Program, Analysis, and Operations team. This team oversees monitoring, evaluation, and learning as well as budgeting in procurement to ensure these key elements of effective implementation are managed as a whole. The team has also adapted two local M&E positions so that there are two staff exclusively dedicated to SI for PEPFAR activities. The Health Office has created an Evaluation Learning Advisor (ELA) position that will focus on the continuous review and application of best practices to activity implementation. This restructure positions USAID to achieve program goals and 95-95-95 targets. USAID is in the process of filling eight vacant positions (ELA, HIV/TB Treatment Advisor, Pediatric HIV Specialist, TB Specialist, Supply Chain Advisor, Supply Chain Specialist, SI Specialist, and the Deputy PEPFAR Coordinator). For six of these vacancies, offers have been made and start dates are anticipated in Q3 2021. The two remaining positions – Pediatric HIV Specialist and ELA – are in the recruitment process.

State successfully recruited one additionally locally employed staff (position) of Grant Officer Representative and is anticipating the Deputy Coordinator (hired through USAID) to start in August 2021. State is currently considering incorporating an EPAP position back into the staffing structure. This position has been unfilled for over a year when a prior staff member departed post. Otherwise, no changes will be made to the existing structure, and there are currently no vacancies.

Peace Corps is currently analyzing its staffing profile for FY 22, which may lead to agency right sizing and restructuring. Although Peace Corps is still in the decision-making process, Peace Corps expects to reduce two positions. One position may end completely and one may be repurposed to better align with programmatic needs as Peace Corps prepares for re-entry by Q3 of FY 22. Peace Corps Tanzania's organizational changes will create efficiencies and optimize staff talent to (1) refine technical programs so volunteer activities address national strategic priorities, (2) develop stronger monitoring and oversight systems to ensure maximum impact of direct and indirect beneficiaries, and (3) strengthen GoT collaboration to eliminate volunteer visa issues that have impeded HIV implementation in the past.

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

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, CDC, DOD, and State have reduced their cost of doing business (CODB) by 10% in COP21, which is commensurate with overall budget reductions for the fiscal year. Peace Corps' CODB remains the same from the previous year.

PEPFAR/T revised the interagency team structure to be focused on changing priorities since the original structure was established in 2015. The structure has put in place working groups that are goal oriented with time-bound deliverables that respond to current priorities, rather than general technical area focused. For example, there is a group focused on ending mother to child transmission, a group focused on identifying, linking, and retaining patients, and a group focused on reducing mortality, to name a few. These Goal Teams will be focused on four action pillars: (1) generate data to drive performance, (2) ensure all sites are performing, (3) ensure implementation of effective policies, and (4) developing activities and tools to support effective implementation and CQI. The Goal Teams will develop 30-60-90 day plans to address these action pillars and will report on their progress at weekly PEPFAR Steering Committee meetings. Cross-cutting Core Groups will also be established focused on HIS/data systems, supply chain and commodities, HRH and health financing, and reporting. These Core Groups will provide support to the Goal Teams to ensure they achieve their objectives. This new structure is currently being Beta tested and will be refined based on experience.

7.0 American Rescue Plan Act Funding

The Government of Tanzania in collaboration with PEPFAR Tanzania is requesting funding to support COVID-19 mitigation with the goal to ensure people living with HIV (PLHIV) can maintain access to treatment and that the health care workers and laboratory workers supporting PEPFAR programs are protected and able to work in a safe environment. Activities will focus on infection prevention and control (IPC) measures to protect health facility staff at PEPFAR supported sites, laboratory support for genetic sequencing, support for vaccine rollout planning and dissemination to health care workers if decided, mitigation of losses in pediatrics due to the pandemic, COVID-19 case management, and the expansion of community ART distribution.

Category from list:

- Prevent, prepare for, and respond to coronavirus
- Infection Prevention and Control Programming (IPC)
- Clinical Management
- Risk Communication and Community Engagement during COVID-19
- Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of coronavirus
- Laboratory
- "Repair of Program Injury" i.e., support for programmatic acceleration and recovery from adverse impacts on program performance due to COVID-19.

Description of activities:

Infection Prevention and Control

Protecting healthcare workers (HCWs) is a priority for the Government of Tanzania (GOT), USG agencies, and PEPFAR implementing partners, and is documented in the national response plan. Use of personal protective equipment (PPE) as an IPC measure is necessary to protect frontline HCWs at PEPFAR supported care and treatment centers and associated community-based activities to ensure their safety during service delivery. With presumed community transmission of COVID-19 in Tanzania, HCWs and facility-based implementing partners continue to be at risk, and PPE supply in Tanzania is not meeting the current demand. PEPFAR Tanzania proposes to procure and distribute PPE and other infection prevention commodities, noting that the bulk of the commodities are anticipated to be supported through Tanzania's C19RM Global Fund

application. Through thoughtful PPE procurement and distribution PEPFAR Tanzania will enable that HCWs and implementing partner staff to safely implement PEPFAR activities, while minimizing disruptions to service delivery.

Funds will also be allocated to implement facility-level IPC improvements through triage management, enhancement of facility IPC systems, facility risk assessments, IPC quality improvement activities, training, and mentorship of HCWs. This comprehensive approach will build additional COVID-19 safety measures broadly into health facilities and provide further protection for CTC activities by preventing potential COVID-19 patients from mixing with other clients at the health facility, including PLHIV. Currently, capacity of HCWs to manage critical and severe COVID-19 cases is suboptimal. This will ensure that HCWs, including those at CTCs, easily identify, isolate, triage, basic emergency care and refer/treat COVID-19 cases is a key component of critical case management. USG investments have been made into training clinicians on IPC related to COVID over the last year, and Tanzania-specific curricula and virtual training programs have been developed. However, coverage from those programs has not been sufficient to protect all PEPFAR sites. PEPFAR clinical partners will be used to implement this expanded program.

Finally, the allocated funds will support implementation of risk communication and community engagement (RCCE) activities. RCCE activities are vital in stopping the outbreak and controlling its amplification. RCCE draws heavily on both formal and informal community structures which include volunteers, frontline personnel, and key community influencers. In many cases these groups do not have prior training on the COVID-19 outbreak. Various modalities of sending messages to communities will be used, including mass media campaigns and printed materials. Previous USG investments into developing RCCE messages for COVID will be expanded and updated.

Vaccine Access
The PEPFAR/Tanzania will use these resources to develop and implement vaccine rollout training, supporting materials, and vaccine distribution. These funds will enable Tanzania to rapidly develop and deploy a vaccination plan and will focus on vaccination of health care workers as an important step to assure the continuity of PEPFAR programs in country.

Clinical Management
PEPFAR/Tanzania will invest to support Tanzania's National Oxygen Scale-up Plan, which was developed by the GOT following an assessment of oxygen production, supply and use in mainland Tanzania. Optimal care provision to critical COVID-19 cases with oxygen supply is of paramount importance, however, Tanzania is in dire need of support for oxygen supply, oxygen delivery equipment/accessories, Point of Care Testing Kits and proper training on oxygen therapy especially at larger health facilities. In collaboration with GFATM C19RM funds, oxygen use knowledge gap and oxygen shortages will be quantified at all levels of health facilities including lower-level health centers, district hospitals, regional and zonal referral hospitals, and the national hospital. In addition, the development of a Critical Care Training Plan will be implemented to ensure a HCWs have been trained to reduce morbidity and mortality.

Laboratory
Enhancement of laboratory capabilities and services is an integral part of Tanzania's national COVID-19 response plan. Priorities include, but are not limited to, training of laboratory staff and procurement of laboratory supplies. Current sentinel surveillance sites have limited or no capacity

to conduct sequencing for COVID-19 or detect variants. Funding will be used support sentinel surveillance for COVID-19 sites at or near selected PEPFAR supported facilities. Funds will be used to procure laboratory reagents, supplies to conduct genetic sequencing for COVID19, and to train laboratory staff. Understanding the state of the epidemic in this fashion will inform decisions to scale up or down PEPFAR activities in the face of outbreaks or new strains.

Mitigation and Repair of program injury

Over the past year, COVID-19 has negatively impacted PEPFAR Tanzania programs, especially the PMTCT/EID and pediatric programs. Since the beginning of the pandemic in Tanzania, fewer children have been going to facilities, resulting in fewer HIV tests and early infant diagnoses. This population has also experienced interruptions in treatment (IIT) due to suboptimal MMD enrollment and reduced access to psychosocial support including peer-led support groups that were disrupted by COVID 19. The program has also suffered attrition across the clinical cascade because of restrictions on gatherings and families suffering financial hardship.

The activities listed below include support for programmatic acceleration and recovery from adverse impacts on PMTCT/EID, pediatrics, and OVC program performance due to COVID-19. The following will be implemented across the country:

- Recovering the losses in PMTCT/EID for mother-baby pairs and C/ALHIV: mitigate service access and uptake by supporting procurement of self-test kits for pregnant and breastfeeding mothers; scale up MMD for children and adolescents; recruit additional community volunteers to follow up index contacts and link them to treatment; community demand creation on HIV and COVID-19 services; implement aggressive tracking strategies on missed appointments, defaulters, and clients who are lost to follow up; and introduce a "virtual" mentor mother model.
- Expansion of community ART distribution: improve ART continuity and provide client-centered services through the expansion of community ART for recipients at high risk of treatment interruption as per Ministry of Health guidelines.
- Accelerate OVC programming: Drawing on existing volunteers, including Community Case Workers, PEPFAR will help recruit and train 25,000 CHWs to provide comprehensive OVC case management services as per Ministry of Health guidelines.

This plan has been developed based on priorities on national COVID-19 Response Plan submitted to PEPFAR/Tanzania by the Government of Tanzania through the Ministry of Health. PEPFAR/Tanzania shall submit the implementation arrangement and work plan for implementation of ARPA funds amounting $20.5 million. Alignment of these plans with Global Fund C19RM will be prioritized to ensure complementarity of activities and to minimize duplication of efforts.

APPENDIX A -- PRIORITIZATION

Table A.1: PSNU Prioritization and ART Coverage

Region	PSNU	Prioritization	All	All	All	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
			Total	<15	15+	<01	<01	01-04	01-04	05-09	05-09	10-14	10-14	15-19	15-19	20-24	20-24	25-29	25-29	30-34	30-34	35-39	35-39	40-44	40-44	45-49	45-49	50+	50+		

Military Tanzania	Military Tanzania	Scale-up: Saturation	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Arusha	Arusha CC	Scale-up: Saturation	100%	129%	99%	73%	67%	117%	151%	166%	114%	62%	62%	65%	85%	108%	145%	73%	70%	126%	200%	90%	76%	79%	84%	87%	106%	117%	139%
Arusha	Arusha DC	Scale-up: Saturation	65%	95%	63%	33%	94%	92%	98%	95%	69%	54%	60%	45%	64%	71%	84%	33%	88%	97%	102%	61%	64%	52%	64%	56%	60%	64%	67%
Manyara	Babati DC	Sustained	86%	119%	84%	50%	92%	114%	156%	114%	66%	53%	75%	59%	90%	98%	103%	50%	109%	133%	94%	92%	57%	77%	93%	54%	91%	77%	104%
Manyara	Babati TC	Sustained	96%	135%	95%	100%	156%	122%	159%	113%	98%	70%	108%	96%	95%	92%	95%	100%	78%	156%	124%	78%	83%	95%	103%	99%	109%	87%	89%
Pwani	Bagamoyo DC	Sustained	89%	91%	88%	0%	43%	88%	104%	89%	95%	101%	93%	78%	79%	75%	89%	0%	61%	106%	117%	69%	101%	99%	106%	82%	82%	81%	93%
Dodoma	Bahi DC	Sustained	82%	116%	80%	0%	93%	105%	105%	65%	49%	30%	83%	81%	88%	76%	99%	0%	200%	119%	129%	100%	109%	70%	68%	69%	71%	84%	89%
Simiyu	Bariadi DC	Sustained	49%	59%	48%	0%	78%	67%	40%	18%	34%	34%	50%	58%	51%	55%	68%	0%	69%	70%	60%	11%	36%	49%	55%	51%	46%	42%	45%
Simiyu	Bariadi TC	Sustained	116%	108%	116%	0%	137%	96%	93%	61%	53%	70%	119%	105%	133%	140%	141%	0%	121%	123%	119%	49%	91%	124%	136%	132%	118%	126%	112%
Kagera	Biharamulo DC	Scale-up: Saturation	92%	83%	93%	20%	121%	90%	60%	21%	71%	87%	123%	89%	94%	76%	96%	20%	125%	105%	70%	34%	115%	148%	136%	87%	83%	78%	70%
Mwanza	Buchosa DC	Scale-up: Saturation	80%	82%	80%	36%	116%	90%	63%	32%	57%	85%	96%	87%	86%	81%	80%	36%	98%	92%	77%	36%	111%	117%	101%	78%	69%	71%	57%
Kigoma	Buhigwe DC	Sustained	68%	84%	66%	0%	125%	100%	86%	41%	77%	68%	63%	56%	95%	73%	79%	0%	75%	75%	80%	25%	59%	61%	73%	56%	66%	67%	60%
Kagera	Bukoba DC	Scale-up: Saturation	95%	96%	95%	22%	102%	96%	81%	23%	61%	127%	147%	120%	97%	70%	67%	22%	109%	109%	102%	37%	150%	168%	132%	103%	91%	87%	63%
Kagera	Bukoba MC	Attained	88%	84%	88%	25%	66%	90%	81%	41%	57%	81%	92%	95%	87%	85%	87%	25%	98%	97%	79%	47%	100%	93%	88%	86%	96%	98%	89%
Geita	Bukombe DC	Scale-up: Saturation	107%	97%	107%	33%	154%	109%	68%	37%	40%	71%	103%	112%	119%	112%	128%	33%	139%	114%	84%	42%	95%	127%	134%	108%	111%	113%	102%
Tanga	Bumbuli DC	Sustained	127%	150%	126%	0%	200%	140%	147%	150%	124%	85%	128%	100%	111%	132%	126%	0%	167%	140%	173%	73%	103%	124%	166%	119%	133%	136%	131%
Mara	Bunda DC	Scale-up: Saturation	79%	82%	78%	0%	108%	87%	67%	51%	73%	76%	101%	88%	78%	83%	76%	0%	52%	93%	91%	48%	90%	92%	95%	70%	76%	72%	71%
Mara	Bunda TC	Sustained	93%	93%	93%	0%	108%	93%	71%	61%	32%	45%	66%	90%	105%	105%	122%	0%	72%	104%	116%	48%	68%	91%	101%	85%	102%	107%	111%
Simiyu	Busega DC	Scale-up: Saturation	92%	93%	92%	0%	92%	107%	83%	47%	30%	56%	90%	99%	113%	94%	107%	0%	76%	95%	99%	43%	82%	101%	115%	95%	105%	84%	85%
Mbeya	Busokelo DC	Sustained	102%	105%	102%	25%	96%	115%	114%	60%	51%	64%	90%	110%	98%	121%	106%	25%	83%	83%	121%	65%	89%	132%	137%	125%	101%	123%	80%
Mara	Butiama DC	Sustained	55%	64%	55%	0%	55%	82%	40%	37%	31%	52%	83%	64%	75%	58%	64%	0%	73%	93%	57%	41%	58%	67%	55%	49%	49%	44%	52%
Kusini Pemba	Chake	Sustained	102%	133%	100%	0%	200%	125%	250%	40%	67%	120%	75%	115%	38%	138%	113%	0%	200%	25%	100%	114%	107%	65%	150%	92%	117%	95%	91%
Pwani	Chalinze DC	Scale-up: Saturation	77%	87%	76%	0%	76%	87%	90%	48%	50%	84%	112%	74%	80%	66%	69%	0%	44%	100%	103%	52%	73%	90%	106%	78%	74%	67%	65%
Dodoma	Chamwino DC	Sustained	100%	120%	99%	33%	175%	152%	82%	95%	64%	55%	84%	80%	109%	97%	122%	33%	245%	111%	94%	84%	100%	91%	109%	82%	98%	88%	120%
Geita	Chato DC	Scale-up: Saturation	97%	82%	98%	25%	108%	91%	56%	16%	57%	112%	140%	121%	104%	83%	81%	27%	137%	98%	74%	35%	119%	149%	141%	110%	89%	78%	69%
Dodoma	Chemba DC	Sustained	80%	122%	78%	0%	180%	125%	80%	90%	25%	74%	90%	88%	89%	65%	87%	0%	225%	158%	100%	89%	89%	78%	90%	70%	74%	59%	80%
Mbeya	Chunya DC	Sustained	133%	129%	133%	50%	134%	102%	119%	80%	74%	98%	117%	136%	143%	120%	133%	50%	121%	141%	161%	94%	157%	150%	159%	155%	144%	109%	126%
Dodoma	Dodoma MC	Attained	86%	112%	85%	33%	103%	105%	120%	124%	86%	57%	58%	69%	86%	90%	110%	33%	90%	111%	135%	61%	65%	71%	84%	77%	94%	96%	100%
Morogoro	Gairo DC	Scale-up: Saturation	134%	126%	134%	100%	289%	137%	100%	42%	64%	134%	178%	149%	157%	117%	123%	100%	233%	104%	91%	76%	158%	204%	180%	142%	112%	106%	114%
Geita	Geita DC	Scale-up: Saturation	74%	75%	74%	20%	121%	84%	50%	22%	36%	71%	91%	84%	82%	72%	76%	21%	128%	91%	60%	30%	78%	99%	98%	78%	70%	67%	54%
Geita	Geita TC	Scale-up: Saturation	86%	87%	86%	25%	111%	90%	81%	43%	40%	61%	86%	77%	91%	87%	104%	29%	116%	95%	76%	36%	82%	97%	93%	90%	86%	97%	85%

Kilimanjaro	Hai DC	Sustained	69%	120%	67%	67%	88%	109%	118%	130%	89%	45%	46%	56%	63%	77%	77%	67%	141%	128%	139%	78%	63%	63%	63%	63%	70%	75%	63%
Manyara	Hanang DC	Sustained	90%	130%	87%	100%	160%	108%	100%	70%	73%	78%	85%	58%	67%	92%	100%	100%	180%	108%	180%	43%	92%	101%	107%	73%	69%	113%	95%
Tanga	Handeni DC	Sustained	66%	86%	65%	0%	84%	102%	90%	62%	38%	48%	63%	76%	76%	71%	81%	0%	74%	81%	85%	48%	52%	60%	64%	61%	61%	62%	69%
Tanga	Handeni TC	Sustained	101%	116%	100%	0%	188%	74%	112%	159%	50%	49%	72%	82%	94%	103%	128%	0%	175%	126%	113%	84%	93%	65%	99%	79%	98%	127%	127%
Morogoro	Ifakara TC	Sustained	114%	150%	113%	125%	145%	134%	157%	143%	64%	64%	72%	78%	116%	143%	180%	167%	143%	146%	166%	60%	84%	93%	92%	98%	132%	125%	128%
Tabora	Igunga DC	Scale-up: Saturation	99%	97%	99%	10%	98%	106%	89%	49%	40%	51%	91%	86%	107%	104%	133%	10%	131%	96%	98%	41%	67%	100%	112%	90%	106%	103%	126%
Singida	Ikungi DC	Sustained	75%	113%	73%	0%	254%	129%	84%	78%	33%	34%	69%	76%	81%	82%	92%	0%	100%	124%	98%	84%	102%	75%	81%	62%	67%	67%	68%
Dar es Salaam	Ilala MC	Scale-up: Saturation	115%	119%	115%	0%	57%	114%	163%	168%	139%	79%	65%	68%	96%	114%	157%	0%	53%	115%	180%	115%	99%	96%	99%	108%	136%	141%	137%
Songwe	Ileje DC	Scale-up: Saturation	81%	97%	80%	50%	100%	94%	89%	74%	39%	75%	96%	83%	68%	96%	94%	50%	130%	118%	89%	27%	54%	76%	74%	82%	81%	85%	81%
Mwanza	Ilemela MC	Attained	71%	72%	71%	42%	64%	75%	57%	42%	53%	71%	86%	78%	77%	66%	62%	42%	79%	85%	79%	42%	94%	99%	90%	67%	62%	54%	49%
Singida	Iramba DC	Scale-up: Saturation	90%	124%	89%	67%	90%	109%	115%	76%	55%	41%	69%	67%	81%	98%	139%	67%	145%	160%	125%	67%	75%	77%	68%	82%	88%	96%	106%
Iringa	Iringa DC	Scale-up: Saturation	70%	82%	70%	40%	49%	60%	93%	62%	37%	41%	64%	75%	86%	74%	74%	40%	66%	85%	102%	44%	55%	66%	82%	73%	76%	79%	62%
Iringa	Iringa MC	Attained	115%	131%	115%	170%	85%	98%	173%	116%	74%	74%	105%	122%	132%	130%	128%	189%	84%	131%	151%	73%	72%	91%	122%	125%	137%	146%	118%
Singida	Itigi DC	Sustained	119%	129%	118%	50%	160%	148%	90%	57%	71%	54%	96%	118%	136%	123%	147%	50%	160%	160%	124%	80%	115%	113%	133%	124%	125%	126%	117%
Simiyu	Itilima DC	Scale-up: Saturation	69%	77%	68%	0%	92%	83%	70%	21%	37%	68%	91%	75%	73%	75%	78%	0%	104%	74%	79%	25%	53%	66%	69%	68%	60%	85%	73%
Shinyanga	Kahama TC	Attained	102%	106%	102%	0%	92%	122%	107%	59%	50%	75%	100%	101%	107%	111%	127%	0%	103%	121%	97%	46%	89%	111%	117%	100%	109%	102%	97%
Kigoma	Kakonko DC	Sustained	83%	81%	83%	0%	111%	88%	86%	42%	86%	88%	105%	95%	83%	74%	82%	0%	78%	64%	82%	40%	116%	114%	99%	92%	78%	65%	66%
Rukwa	Kalambo DC	Scale-up: Saturation	76%	85%	76%	50%	109%	126%	60%	33%	26%	58%	91%	74%	93%	94%	98%	50%	100%	115%	56%	35%	38%	62%	83%	81%	65%	80%	86%
Tabora	Kaliua DC	Scale-up: Saturation	105%	102%	106%	50%	170%	110%	76%	39%	68%	89%	118%	100%	113%	104%	119%	57%	173%	107%	91%	41%	113%	121%	144%	102%	96%	98%	103%
Kagera	Karagwe DC	Scale-up: Saturation	78%	81%	78%	33%	92%	89%	68%	32%	51%	88%	101%	86%	79%	67%	83%	33%	100%	94%	74%	41%	79%	101%	98%	76%	77%	69%	70%
Arusha	Karatu DC	Sustained	85%	110%	84%	50%	90%	129%	104%	103%	41%	69%	84%	86%	95%	69%	98%	50%	110%	110%	117%	84%	110%	104%	95%	80%	79%	61%	80%
Kaskazini Unguja	Kaskazini A	Sustained	184%	190%	184%	0%	200%	0%	350%	100%	133%	100%	100%	133%	170%	244%	141%	0%	100%	300%	150%	225%	238%	123%	281%	258%	305%	194%	106%
Kaskazini Unguja	Kaskazini B	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Kigoma	Kasulu DC	Sustained	83%	90%	82%	0%	78%	97%	52%	29%	57%	88%	116%	89%	93%	72%	91%	0%	178%	94%	110%	49%	86%	98%	107%	79%	75%	61%	70%
Kigoma	Kasulu TC	Sustained	96%	105%	95%	0%	71%	84%	91%	96%	68%	75%	67%	65%	86%	89%	132%	0%	171%	94%	143%	83%	79%	95%	97%	96%	119%	92%	95%
Kusini Unguja	Kati	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Pwani	Kibaha DC	Sustained	86%	104%	85%	0%	56%	103%	100%	107%	38%	60%	84%	78%	91%	94%	95%	0%	87%	129%	134%	59%	71%	78%	96%	91%	91%	84%	81%
Pwani	Kibaha TC	Scale-up: Saturation	133%	152%	132%	0%	68%	162%	176%	179%	117%	86%	105%	93%	123%	125%	168%	0%	82%	158%	228%	121%	107%	124%	132%	125%	153%	149%	141%
Pwani	Kibiti DC	Sustained	114%	118%	114%	0%	100%	128%	115%	81%	61%	73%	118%	99%	122%	109%	123%	0%	123%	115%	127%	80%	69%	108%	135%	118%	123%	124%	120%
Kigoma	Kibondo DC	Sustained	94%	88%	95%	0%	127%	75%	59%	53%	92%	88%	96%	95%	82%	92%	116%	0%	109%	98%	114%	47%	80%	99%	112%	114%	102%	85%	84%
Dar es Salaam	Kigamboni MC	Scale-up: Saturation	91%	102%	90%	0%	29%	110%	117%	100%	123%	87%	85%	68%	86%	80%	90%	0%	60%	136%	118%	89%	110%	107%	97%	88%	90%	92%	88%

Kigoma	Kigoma DC	Sustained	73%	82%	73%	0%	25%	100%	88%	32%	36%	69%	123%	157%	123%	84%	70%	0%	100%	108%	60%	47%	36%	79%	97%	84%	57%	69%	38%
Kigoma	Kigoma Ujiji MC	Scale-up: Saturation	92%	109%	91%	0%	37%	118%	128%	102%	61%	51%	67%	66%	91%	87%	131%	0%	100%	97%	135%	64%	63%	76%	99%	97%	101%	102%	94%
Tanga	Kilindi DC	Sustained	80%	119%	78%	0%	111%	114%	133%	47%	62%	61%	73%	78%	87%	94%	94%	0%	156%	100%	124%	49%	75%	87%	86%	64%	74%	72%	81%
Iringa	Kilolo DC	Scale-up: Saturation	81%	87%	80%	38%	78%	81%	93%	62%	40%	52%	84%	87%	90%	79%	79%	43%	76%	91%	91%	41%	66%	86%	97%	94%	83%	89%	72%
Morogoro	Kilombero DC	Scale-up: Saturation	99%	101%	99%	29%	112%	96%	95%	78%	107%	79%	104%	89%	95%	95%	103%	29%	90%	117%	105%	78%	123%	130%	107%	90%	91%	103%	94%
Morogoro	Kilosa DC	Scale-up: Saturation	92%	91%	92%	22%	75%	87%	92%	77%	70%	65%	96%	91%	107%	83%	95%	22%	77%	99%	105%	55%	88%	95%	113%	94%	96%	84%	87%
Lindi	Kilwa DC	Sustained	98%	119%	97%	100%	107%	100%	122%	88%	64%	64%	70%	99%	89%	104%	118%	100%	93%	129%	138%	60%	77%	83%	125%	94%	104%	99%	95%
Dar es Salaam	Kinondoni MC	Scale-up: Saturation	78%	87%	78%	0%	43%	84%	128%	122%	93%	51%	50%	52%	73%	83%	100%	0%	38%	94%	127%	68%	65%	69%	69%	75%	90%	95%	87%
Pwani	Kisarawe DC	Sustained	113%	131%	112%	0%	71%	121%	150%	106%	77%	56%	65%	83%	102%	98%	134%	0%	121%	139%	153%	107%	90%	81%	96%	104%	132%	150%	133%
Shinyanga	Kishapu DC	Scale-up: Saturation	67%	77%	66%	0%	72%	92%	65%	43%	29%	37%	62%	63%	72%	71%	89%	0%	67%	86%	79%	31%	48%	60%	77%	65%	63%	63%	78%
Manyara	Kiteto DC	Sustained	93%	106%	93%	67%	141%	107%	88%	95%	61%	68%	94%	81%	107%	89%	101%	67%	138%	112%	100%	73%	107%	94%	82%	94%	93%	87%	102%
Dodoma	Kondoa DC	Scale-up: Saturation	76%	93%	75%	0%	17%	105%	111%	97%	68%	51%	69%	63%	79%	79%	96%	0%	50%	110%	85%	74%	68%	74%	69%	54%	61%	73%	87%
Dodoma	Kondoa TC	Scale-up: Saturation	113%	190%	110%	0%	117%	162%	144%	142%	88%	83%	66%	69%	133%	85%	127%	0%	167%	250%	280%	108%	88%	80%	95%	101%	129%	105%	139%
Dodoma	Kongwa DC	Scale-up: Saturation	80%	104%	79%	20%	141%	97%	89%	63%	51%	71%	88%	68%	91%	91%	92%	20%	146%	103%	108%	68%	117%	74%	74%	66%	76%	77%	79%
Tanga	Korogwe DC	Scale-up: Saturation	70%	100%	69%	0%	53%	110%	93%	92%	52%	68%	77%	63%	69%	73%	75%	0%	56%	102%	142%	49%	65%	70%	69%	62%	70%	75%	67%
Tanga	Korogwe TC	Sustained	123%	194%	120%	0%	185%	146%	223%	130%	58%	39%	76%	85%	126%	116%	165%	0%	146%	182%	266%	68%	72%	59%	92%	119%	148%	168%	154%
Kusini Unguja	Kusini	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mwanza	Kwimba DC	Scale-up: Saturation	92%	86%	93%	8%	118%	86%	75%	22%	49%	96%	121%	118%	102%	88%	88%	8%	122%	90%	87%	31%	88%	116%	126%	105%	87%	85%	80%
Mbeya	Kyela DC	Scale-up: Saturation	101%	101%	101%	29%	57%	107%	102%	91%	51%	47%	73%	90%	104%	133%	123%	31%	75%	110%	113%	64%	66%	88%	98%	117%	118%	141%	90%
Kagera	Kyerwa DC	Scale-up: Saturation	96%	84%	97%	17%	89%	98%	69%	18%	59%	91%	110%	110%	99%	83%	96%	17%	144%	98%	67%	34%	126%	147%	121%	103%	92%	73%	88%
Lindi	Lindi DC	Sustained	78%	126%	77%	67%	95%	144%	117%	91%	60%	57%	66%	71%	77%	71%	89%	67%	100%	123%	158%	59%	82%	78%	91%	82%	87%	88%	60%
Lindi	Lindi MC	Sustained	108%	112%	108%	50%	42%	116%	110%	164%	53%	55%	68%	86%	93%	105%	126%	50%	92%	125%	145%	93%	62%	93%	112%	122%	131%	132%	108%
Lindi	Liwale DC	Sustained	71%	83%	71%	100%	38%	100%	40%	79%	35%	43%	27%	67%	104%	93%	79%	100%	75%	100%	120%	64%	66%	49%	76%	78%	87%	67%	63%
Arusha	Longido DC	Sustained	77%	121%	75%	0%	133%	131%	119%	153%	52%	53%	80%	59%	75%	69%	89%	0%	240%	100%	107%	111%	76%	80%	77%	54%	65%	73%	89%
Njombe	Ludewa DC	Scale-up: Saturation	85%	94%	85%	57%	78%	93%	104%	65%	38%	60%	100%	95%	98%	89%	74%	57%	85%	92%	97%	58%	70%	96%	106%	93%	95%	91%	73%
Tanga	Lushoto DC	Scale-up: Saturation	94%	99%	93%	0%	93%	116%	122%	119%	71%	38%	88%	67%	90%	82%	124%	0%	57%	117%	69%	76%	66%	60%	80%	71%	110%	102%	117%
Ruvuma	Madaba DC	Sustained	102%	94%	102%	0%	58%	105%	104%	68%	65%	96%	122%	100%	116%	112%	92%	0%	100%	92%	92%	49%	75%	140%	145%	118%	107%	90%	84%
Pwani	Mafia DC	Sustained	85%	102%	85%	0%	50%	100%	133%	146%	58%	88%	47%	83%	89%	83%	94%	0%	50%	63%	178%	75%	76%	58%	98%	88%	85%	107%	80%
Iringa	Mafinga TC	Scale-up: Saturation	100%	102%	100%	50%	76%	90%	111%	97%	58%	61%	93%	106%	123%	111%	105%	50%	70%	100%	131%	68%	87%	119%	122%	113%	108%	93%	73%
Mjini Magharibi	Magharibi A	Sustained	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Mjini Magharibi	Magharibi B	Scale-up: Saturation	15%	21%	15%	0%	20%	27%	0%	7%	37%	53%	42%	15%	23%	14%	6%	0%	40%	27%	25%	13%	34%	28%	14%	13%	7%	3%	3%

Mwanza	Magu DC	Scale-up: Saturation	81%	83%	81%	17%	72%	91%	66%	46%	43%	78%	96%	84%	95%	74%	80%	17%	95%	100%	82%	41%	91%	102%	105%	88%	78%	73%	68%
Njombe	Makambako TC	Scale-up: Saturation	62%	78%	62%	75%	55%	76%	81%	51%	38%	50%	60%	64%	60%	66%	57%	75%	74%	69%	90%	44%	71%	78%	82%	62%	58%	59%	46%
Njombe	Makete DC	Scale-up: Saturation	103%	100%	104%	33%	50%	95%	112%	68%	38%	50%	88%	105%	116%	114%	109%	40%	42%	96%	127%	51%	56%	102%	104%	118%	131%	135%	102%
Morogoro	Malinyi DC	Sustained	112%	115%	112%	50%	136%	124%	103%	91%	47%	98%	112%	105%	108%	117%	136%	50%	110%	110%	126%	82%	122%	119%	124%	96%	107%	127%	114%
Singida	Manyoni DC	Sustained	80%	105%	78%	100%	116%	96%	93%	104%	35%	60%	64%	81%	80%	88%	95%	100%	200%	102%	97%	60%	54%	78%	79%	74%	77%	79%	87%
Mtwara	Masasi DC	Scale-up: Saturation	88%	115%	87%	80%	88%	119%	91%	108%	41%	34%	55%	74%	89%	100%	109%	80%	71%	139%	150%	61%	56%	70%	80%	80%	91%	113%	92%
Mtwara	Masasi TC	Sustained	95%	98%	95%	100%	95%	97%	93%	108%	59%	56%	69%	74%	91%	122%	118%	100%	84%	89%	122%	54%	52%	77%	103%	93%	103%	117%	100%
Simiyu	Maswa DC	Scale-up: Saturation	74%	85%	73%	0%	120%	89%	79%	41%	26%	35%	73%	70%	77%	81%	110%	0%	114%	90%	72%	28%	42%	58%	77%	69%	70%	86%	94%
Mbeya	Mbarali DC	Scale-up: Saturation	83%	87%	83%	42%	58%	83%	97%	58%	52%	54%	78%	84%	91%	91%	90%	44%	65%	90%	99%	47%	77%	88%	95%	90%	86%	84%	75%
Mbeya	Mbeya CC	Attained	84%	105%	83%	44%	74%	99%	109%	134%	60%	53%	63%	74%	87%	90%	101%	46%	71%	119%	129%	94%	66%	81%	89%	85%	98%	97%	73%
Mbeya	Mbeya DC	Scale-up: Saturation	54%	65%	53%	15%	45%	61%	65%	25%	38%	37%	54%	58%	64%	52%	59%	15%	49%	73%	75%	26%	48%	57%	58%	58%	58%	60%	42%
Ruvuma	Mbinga DC	Scale-up: Saturation	90%	95%	89%	50%	93%	113%	89%	45%	38%	65%	81%	92%	110%	98%	99%	50%	108%	111%	76%	47%	59%	84%	89%	99%	95%	89%	99%
Ruvuma	Mbinga TC	Scale-up: Saturation	88%	88%	88%	20%	68%	97%	83%	70%	61%	60%	84%	89%	88%	90%	100%	20%	70%	107%	89%	61%	79%	87%	103%	85%	94%	81%	93%
Geita	Mbogwe DC	Scale-up: Saturation	96%	89%	97%	17%	113%	104%	74%	23%	50%	101%	119%	118%	104%	96%	93%	17%	105%	94%	84%	28%	86%	129%	127%	106%	94%	94%	82%
Songwe	Mbozi DC	Scale-up: Saturation	88%	95%	88%	23%	58%	89%	101%	61%	44%	44%	68%	84%	84%	103%	116%	23%	76%	108%	106%	46%	75%	86%	92%	90%	95%	106%	88%
Manyara	Mbulu DC	Sustained	114%	121%	113%	0%	160%	100%	132%	104%	46%	80%	111%	103%	97%	84%	150%	0%	200%	100%	122%	100%	107%	153%	97%	98%	145%	103%	120%
Manyara	Mbulu TC	Sustained	79%	89%	78%	0%	167%	111%	83%	79%	89%	114%	119%	93%	74%	38%	68%	0%	100%	75%	64%	80%	120%	102%	129%	69%	51%	66%	54%
Simiyu	Meatu DC	Scale-up: Saturation	77%	85%	76%	0%	134%	89%	70%	40%	17%	56%	72%	71%	81%	76%	112%	0%	142%	96%	68%	24%	46%	61%	83%	79%	79%	89%	92%
Arusha	Meru DC	Sustained	75%	101%	74%	50%	70%	89%	114%	168%	96%	49%	41%	59%	63%	82%	91%	50%	113%	105%	111%	96%	56%	63%	62%	71%	82%	78%	76%
Kaskazini Pemba	Micheweni	Sustained	77%	150%	73%	0%	0%	100%	200%	200%	0%	0%	133%	100%	100%	75%	67%	0%	0%	0%	200%	50%	50%	117%	83%	43%	57%	133%	38%
Kagera	Missenyi DC	Scale-up: Saturation	88%	96%	88%	29%	125%	106%	74%	31%	50%	98%	117%	95%	94%	79%	70%	29%	116%	112%	91%	38%	111%	148%	119%	98%	91%	83%	58%
Mwanza	Misungwi DC	Scale-up: Saturation	78%	80%	78%	18%	106%	77%	70%	29%	49%	83%	94%	76%	87%	74%	81%	18%	116%	85%	79%	29%	92%	101%	101%	86%	72%	65%	64%
Mjini Magharibi	Mjini	Scale-up: Saturation	226%	293%	224%	0%	144%	244%	433%	375%	257%	161%	156%	177%	221%	264%	214%	0%	238%	313%	311%	250%	209%	248%	259%	252%	270%	220%	184%
Singida	Mkalama DC	Sustained	90%	139%	88%	100%	129%	150%	88%	65%	51%	36%	42%	52%	87%	78%	155%	100%	271%	176%	126%	77%	116%	42%	65%	73%	71%	88%	125%
Tanga	Mkinga DC	Sustained	88%	132%	86%	0%	150%	138%	134%	93%	72%	34%	64%	71%	90%	84%	102%	0%	160%	122%	133%	83%	41%	65%	95%	84%	99%	94%	93%
Kusini Pemba	Mkoani	Sustained	98%	140%	96%	0%	0%	200%	0%	0%	150%	67%	75%	125%	180%	80%	145%	0%	0%	200%	300%	100%	80%	50%	86%	75%	163%	100%	47%
Pwani	Mkuranga DC	Scale-up: Saturation	111%	119%	110%	0%	78%	122%	126%	102%	50%	76%	95%	93%	120%	115%	136%	0%	123%	116%	141%	84%	61%	88%	107%	116%	129%	122%	111%
Katavi	Mlele DC	Sustained	133%	129%	134%	100%	125%	136%	106%	53%	74%	93%	122%	138%	154%	142%	147%	100%	200%	130%	130%	31%	126%	157%	171%	145%	129%	115%	131%
Songwe	Momba DC	Scale-up: Saturation	108%	110%	108%	33%	200%	123%	82%	40%	49%	60%	111%	95%	115%	123%	125%	33%	181%	113%	96%	44%	110%	96%	116%	144%	117%	115%	98%
Arusha	Monduli DC	Sustained	77%	77%	77%	50%	90%	71%	82%	95%	70%	36%	42%	78%	61%	89%	111%	50%	133%	63%	70%	64%	66%	54%	65%	61%	93%	65%	109%
Morogoro	Morogoro DC	Scale-up: Saturation	66%	81%	65%	33%	67%	104%	49%	69%	48%	51%	76%	65%	68%	75%	59%	33%	71%	100%	92%	37%	75%	66%	84%	70%	60%	66%	59%

Morogoro	Morogoro MC	Attained	76%	96%	76%	36%	53%	117%	121%	101%	74%	42%	53%	61%	76%	78%	101%	36%	49%	90%	120%	49%	52%	61%	71%	74%	91%	89%	85%
Kilimanjaro	Moshi DC	Scale-up: Saturation	58%	83%	58%	33%	57%	69%	84%	104%	69%	45%	59%	57%	56%	61%	65%	33%	53%	72%	131%	59%	48%	48%	56%	54%	57%	65%	54%
Kilimanjaro	Moshi MC	Sustained	139%	203%	137%	40%	97%	153%	317%	276%	119%	71%	74%	87%	130%	152%	203%	40%	103%	174%	348%	143%	76%	69%	101%	107%	165%	182%	233%
Katavi	Mpanda DC	Scale-up: Saturation	70%	76%	70%	33%	114%	88%	59%	28%	34%	61%	82%	77%	79%	77%	79%	33%	120%	89%	54%	27%	70%	79%	85%	64%	63%	61%	68%
Katavi	Mpanda MC	Scale-up: Saturation	128%	131%	128%	100%	92%	113%	135%	60%	59%	82%	120%	114%	148%	124%	176%	100%	125%	159%	138%	90%	120%	118%	148%	117%	133%	142%	126%
Katavi	Mpimbwe DC	Sustained	85%	84%	86%	50%	113%	85%	77%	19%	47%	71%	93%	109%	93%	85%	95%	50%	152%	97%	62%	27%	80%	97%	107%	81%	78%	82%	91%
Dodoma	Mpwapwa DC	Sustained	87%	96%	86%	33%	100%	89%	76%	52%	66%	60%	81%	73%	86%	98%	111%	33%	114%	120%	100%	73%	163%	95%	74%	68%	66%	76%	101%
Shinyanga	Msalala DC	Scale-up: Saturation	88%	86%	88%	0%	104%	105%	79%	30%	38%	85%	103%	91%	89%	88%	95%	0%	85%	104%	67%	47%	82%	109%	111%	92%	85%	86%	81%
Mtwara	Mtwara DC	Sustained	62%	83%	61%	50%	38%	75%	103%	89%	55%	21%	66%	59%	64%	67%	65%	50%	133%	75%	79%	46%	50%	65%	65%	60%	69%	75%	48%
Mtwara	Mtwara MC	Sustained	103%	127%	102%	75%	55%	169%	145%	102%	54%	43%	71%	78%	120%	121%	117%	100%	71%	143%	133%	65%	55%	70%	98%	108%	130%	140%	110%
Iringa	Mufindi DC	Scale-up: Saturation	82%	88%	81%	29%	57%	79%	98%	63%	38%	47%	80%	95%	93%	92%	78%	29%	58%	88%	105%	52%	62%	82%	91%	103%	90%	89%	69%
Tanga	Muheza DC	Scale-up: Saturation	81%	91%	81%	0%	71%	86%	98%	103%	73%	89%	102%	72%	78%	77%	81%	0%	38%	96%	116%	64%	79%	75%	85%	68%	85%	87%	81%
Kagera	Muleba DC	Scale-up: Saturation	82%	85%	81%	20%	99%	88%	82%	25%	53%	90%	107%	92%	85%	71%	71%	20%	98%	95%	74%	37%	93%	117%	104%	86%	75%	76%	70%
Mara	Musoma DC	Scale-up: Saturation	78%	79%	78%	0%	44%	91%	61%	27%	66%	86%	94%	86%	92%	85%	67%	0%	82%	84%	98%	57%	115%	107%	93%	88%	74%	60%	54%
Mara	Musoma MC	Scale-up: Saturation	86%	87%	86%	0%	47%	93%	95%	63%	42%	43%	72%	83%	91%	93%	106%	0%	79%	76%	110%	44%	71%	80%	76%	82%	99%	114%	99%
Morogoro	Mvomero DC	Scale-up: Saturation	75%	94%	74%	125%	85%	100%	105%	81%	48%	50%	59%	68%	78%	76%	86%	125%	115%	80%	82%	58%	53%	68%	75%	69%	82%	83%	81%
Kilimanjaro	Mwanga DC	Sustained	83%	130%	81%	0%	56%	100%	183%	138%	77%	47%	47%	58%	76%	79%	108%	0%	63%	132%	165%	73%	53%	43%	64%	71%	94%	104%	93%
Lindi	Nachingwea DC	Sustained	82%	119%	81%	50%	88%	100%	116%	84%	52%	52%	76%	58%	95%	81%	97%	50%	65%	153%	158%	61%	71%	91%	84%	77%	88%	92%	71%
Ruvuma	Namtumbo DC	Scale-up: Saturation	70%	78%	70%	33%	95%	88%	82%	25%	57%	61%	86%	66%	62%	72%	80%	33%	95%	80%	61%	35%	90%	86%	77%	60%	64%	73%	70%
Mtwara	Nanyamba TC	Sustained	74%	121%	72%	0%	100%	129%	122%	82%	38%	95%	122%	92%	72%	94%	58%	0%	0%	171%	138%	50%	48%	25%	110%	63%	81%	65%	70%
Mtwara	Nanyumbu DC	Sustained	82%	110%	81%	100%	79%	104%	123%	36%	35%	39%	71%	92%	81%	96%	88%	100%	77%	144%	107%	42%	78%	85%	120%	70%	85%	73%	79%
Mtwara	Newala DC	Sustained	72%	94%	71%	0%	83%	100%	94%	79%	32%	60%	80%	81%	73%	75%	80%	0%	33%	136%	88%	32%	38%	83%	70%	67%	70%	73%	73%
Mtwara	Newala TC	Sustained	90%	112%	89%	50%	92%	92%	145%	120%	87%	54%	62%	67%	80%	102%	105%	50%	67%	121%	120%	58%	60%	83%	82%	97%	105%	106%	84%
Kagera	Ngara DC	Scale-up: Saturation	88%	89%	88%	25%	96%	90%	102%	42%	56%	118%	115%	93%	91%	78%	81%	25%	100%	98%	67%	44%	102%	135%	112%	76%	81%	73%	73%
Arusha	Ngorongoro DC	Sustained	79%	98%	78%	0%	333%	120%	58%	77%	21%	82%	110%	111%	71%	53%	97%	0%	333%	60%	50%	56%	114%	85%	76%	56%	55%	60%	100%
Njombe	Njombe DC	Scale-up: Saturation	94%	108%	93%	25%	54%	104%	121%	73%	53%	84%	116%	107%	101%	99%	78%	25%	108%	99%	126%	67%	124%	115%	113%	104%	94%	89%	69%
Njombe	Njombe TC	Attained	93%	94%	93%	60%	60%	101%	74%	65%	49%	72%	97%	121%	100%	98%	94%	60%	82%	119%	109%	50%	106%	105%	105%	109%	98%	100%	66%
Rukwa	Nkasi DC	Scale-up: Saturation	79%	97%	78%	40%	87%	110%	73%	36%	35%	47%	67%	78%	81%	84%	109%	40%	141%	123%	90%	34%	55%	63%	82%	67%	81%	83%	103%
Katavi	Nsimbo DC	Sustained	57%	64%	56%	25%	88%	81%	47%	16%	20%	49%	66%	70%	66%	64%	58%	25%	76%	85%	41%	27%	57%	63%	73%	52%	49%	53%	52%
Mwanza	Nyamagana MC	Attained	96%	108%	95%	10%	92%	108%	116%	113%	80%	71%	72%	77%	92%	101%	125%	10%	94%	114%	121%	65%	95%	94%	88%	86%	104%	114%	107%
Geita	Nyang'hwale DC	Sustained	80%	85%	80%	33%	106%	83%	77%	23%	30%	82%	93%	89%	87%	77%	82%	33%	76%	91%	90%	29%	87%	109%	87%	91%	74%	80%	75%

Ruvuma	Nyasa DC	Sustained	110%	109%	110%	33%	105%	127%	100%	63%	120%	123%	152%	126%	97%	107%	105%	33%	158%	108%	97%	69%	153%	138%	139%	105%	100%	98%	88%
Tabora	Nzega DC	Scale-up: Saturation	84%	88%	84%	21%	79%	94%	77%	47%	52%	56%	84%	81%	83%	95%	99%	21%	110%	97%	90%	34%	66%	81%	99%	84%	83%	96%	90%
Tabora	Nzega TC	Sustained	43%	36%	44%	25%	81%	46%	26%	12%	21%	47%	49%	38%	34%	41%	40%	25%	60%	39%	23%	17%	46%	57%	64%	49%	47%	49%	41%
Tanga	Pangani DC	Sustained	107%	106%	107%	0%	78%	118%	107%	66%	47%	106%	86%	121%	139%	134%	109%	0%	100%	119%	104%	53%	46%	101%	97%	82%	128%	115%	121%
Kilimanjaro	Rombo DC	Sustained	92%	133%	90%	100%	133%	83%	189%	132%	97%	49%	67%	79%	93%	96%	98%	100%	133%	100%	147%	119%	79%	94%	82%	78%	111%	93%	84%
Mara	Rorya DC	Scale-up: Saturation	115%	98%	116%	0%	121%	98%	90%	40%	64%	87%	116%	122%	117%	105%	109%	0%	150%	109%	86%	65%	151%	157%	148%	132%	129%	112%	94%
Lindi	Ruangwa DC	Sustained	90%	114%	89%	33%	89%	130%	115%	93%	40%	62%	74%	80%	105%	85%	102%	33%	59%	142%	123%	58%	78%	105%	104%	94%	124%	90%	63%
Pwani	Rufiji DC	Sustained	89%	114%	88%	0%	100%	78%	129%	128%	69%	49%	58%	62%	96%	98%	109%	0%	100%	120%	144%	58%	75%	72%	99%	91%	90%	94%	90%
Mbeya	Rungwe DC	Scale-up: Saturation	97%	98%	97%	25%	59%	90%	107%	63%	60%	52%	77%	88%	105%	111%	112%	29%	89%	96%	117%	65%	91%	105%	107%	104%	110%	117%	83%
Kilimanjaro	Same DC	Sustained	104%	142%	102%	50%	113%	121%	144%	153%	64%	50%	66%	66%	82%	107%	129%	50%	143%	152%	169%	111%	70%	85%	95%	99%	116%	111%	120%
Mwanza	Sengerema DC	Scale-up: Saturation	120%	104%	122%	14%	91%	111%	91%	52%	68%	107%	135%	125%	123%	128%	121%	14%	112%	119%	108%	75%	144%	172%	157%	129%	118%	113%	93%
Mara	Serengeti DC	Scale-up: Saturation	85%	99%	84%	0%	86%	97%	101%	65%	51%	62%	83%	70%	84%	95%	115%	0%	145%	98%	97%	58%	65%	72%	79%	70%	75%	86%	120%
Shinyanga	Shinyanga DC	Scale-up: Saturation	112%	102%	112%	0%	115%	101%	102%	43%	51%	90%	111%	124%	115%	113%	123%	0%	138%	122%	83%	38%	106%	130%	150%	120%	107%	107%	115%
Shinyanga	Shinyanga MC	Scale-up: Saturation	113%	133%	112%	0%	85%	145%	147%	109%	66%	60%	86%	101%	122%	126%	149%	0%	85%	131%	162%	70%	84%	96%	114%	113%	118%	121%	123%
Kilimanjaro	Siha DC	Sustained	88%	107%	87%	50%	78%	162%	107%	105%	83%	61%	58%	61%	73%	90%	114%	100%	44%	104%	93%	73%	58%	58%	79%	80%	107%	103%	105%
Tabora	Sikonge DC	Sustained	141%	134%	141%	33%	161%	147%	135%	69%	68%	65%	117%	131%	163%	155%	200%	33%	183%	115%	129%	61%	90%	115%	154%	135%	131%	180%	176%
Manyara	Simanjiro DC	Sustained	77%	111%	75%	67%	200%	100%	70%	115%	92%	65%	78%	64%	85%	73%	92%	67%	172%	136%	92%	86%	99%	69%	82%	54%	69%	61%	76%
Singida	Singida DC	Sustained	84%	164%	80%	0%	200%	150%	163%	90%	79%	61%	98%	107%	90%	59%	90%	0%	350%	183%	125%	69%	77%	94%	85%	53%	82%	76%	79%
Singida	Singida MC	Sustained	83%	118%	81%	100%	137%	107%	104%	103%	53%	42%	58%	68%	91%	88%	109%	100%	111%	128%	129%	37%	60%	72%	89%	81%	95%	98%	82%
Ruvuma	Songea DC	Scale-up: Saturation	81%	84%	80%	33%	50%	104%	78%	80%	53%	62%	91%	69%	88%	87%	88%	33%	26%	90%	102%	59%	86%	91%	89%	80%	78%	85%	71%
Ruvuma	Songea MC	Attained	81%	87%	81%	18%	55%	92%	89%	75%	56%	46%	75%	71%	90%	86%	93%	20%	60%	101%	103%	51%	68%	80%	91%	80%	93%	89%	76%
Songwe	Songwe DC	Scale-up: Saturation	83%	91%	82%	50%	79%	76%	98%	43%	47%	54%	71%	77%	87%	92%	93%	50%	68%	92%	105%	57%	78%	78%	90%	92%	97%	91%	76%
Rukwa	Sumbawanga DC	Scale-up: Saturation	95%	95%	95%	86%	107%	117%	75%	33%	37%	59%	89%	105%	107%	109%	109%	86%	119%	122%	73%	34%	78%	89%	104%	99%	107%	115%	99%
Rukwa	Sumbawanga MC	Scale-up: Saturation	87%	98%	86%	143%	98%	110%	71%	59%	42%	47%	74%	79%	102%	94%	112%	143%	107%	126%	91%	47%	66%	76%	94%	83%	103%	98%	94%
Tabora	Tabora MC	Attained	77%	102%	76%	14%	88%	122%	117%	87%	42%	38%	52%	60%	76%	83%	99%	17%	77%	116%	85%	60%	63%	66%	80%	75%	85%	85%	87%
Mtwara	Tandahimba DC	Sustained	89%	107%	89%	50%	64%	113%	128%	75%	69%	77%	66%	87%	86%	110%	96%	50%	71%	119%	105%	55%	68%	76%	100%	102%	95%	114%	73%
Tanga	Tanga CC	Scale-up: Saturation	99%	124%	98%	0%	67%	102%	192%	159%	81%	46%	62%	70%	81%	117%	140%	0%	44%	120%	181%	94%	55%	61%	77%	84%	115%	125%	127%
Mara	Tarime DC	Sustained	67%	80%	66%	0%	62%	86%	75%	55%	37%	61%	88%	77%	84%	73%	80%	0%	70%	92%	89%	54%	68%	81%	65%	53%	53%	63%	65%
Mara	Tarime TC	Scale-up: Saturation	1025%	794%	1038%	0%	1300%	700%	975%	420%	414%	427%	577%	786%	913%	1031%	1146%	0%	700%	700%	650%	588%	763%	1114%	1163%	1023%	1152%	1365%	1570%
Dar es Salaam	Temeke MC	Scale-up: Saturation	68%	79%	68%	0%	25%	83%	110%	114%	88%	53%	48%	49%	64%	71%	91%	0%	41%	82%	117%	73%	59%	56%	60%	62%	75%	79%	76%
Songwe	Tunduma TC	Scale-up: Saturation	82%	84%	82%	33%	69%	94%	84%	60%	57%	60%	80%	82%	88%	87%	96%	33%	80%	96%	78%	49%	74%	101%	101%	81%	79%	71%	65%

Ruvuma	Tunduru DC	Scale-up: Saturation	100%	136%	98%	125%	163%	153%	113%	79%	53%	60%	73%	85%	103%	122%	111%	125%	165%	182%	94%	67%	105%	106%	111%	107%	108%	106%	81%
Dar es Salaam	Ubungo MC	Scale-up: Saturation	74%	78%	74%	0%	31%	75%	104%	117%	95%	77%	69%	60%	73%	69%	81%	0%	57%	94%	99%	71%	88%	84%	77%	68%	76%	75%	64%
Mwanza	Ukerewe DC	Scale-up: Saturation	96%	81%	97%	25%	100%	89%	66%	21%	74%	105%	120%	104%	107%	94%	87%	25%	83%	88%	80%	34%	108%	139%	122%	105%	95%	87%	77%
Morogoro	Ulanga DC	Scale-up: Saturation	79%	83%	79%	67%	68%	88%	53%	56%	69%	90%	90%	94%	85%	72%	72%	67%	50%	110%	105%	55%	157%	125%	90%	71%	67%	60%	60%
Tabora	Urambo DC	Scale-up: Saturation	83%	89%	83%	25%	92%	101%	61%	44%	24%	75%	94%	85%	90%	99%	101%	25%	80%	101%	105%	38%	61%	84%	95%	76%	83%	86%	85%
Shinyanga	Ushetu DC	Scale-up: Saturation	84%	77%	85%	0%	59%	97%	54%	36%	29%	56%	87%	98%	89%	89%	93%	0%	92%	102%	69%	25%	84%	104%	104%	93%	88%	84%	81%
Kigoma	Uvinza DC	Scale-up: Saturation	81%	69%	82%	0%	91%	91%	52%	20%	41%	73%	110%	94%	99%	82%	66%	0%	131%	82%	46%	25%	65%	114%	121%	91%	86%	73%	61%
Tabora	Uyui DC	Scale-up: Saturation	76%	80%	76%	22%	96%	92%	50%	29%	30%	46%	90%	75%	85%	82%	94%	22%	127%	95%	75%	30%	86%	82%	96%	73%	69%	64%	81%
Njombe	Wanging'ombe DC	Scale-up: Saturation	93%	104%	92%	43%	38%	96%	113%	60%	52%	65%	101%	104%	101%	96%	88%	50%	69%	107%	133%	56%	100%	103%	106%	101%	94%	103%	77%
Kaskazini Pemba	Wete	Sustained	100%	171%	95%	0%	0%	167%	233%	175%	120%	63%	90%	100%	100%	164%	70%	0%	400%	167%	100%	100%	50%	108%	100%	120%	88%	113%	76%

APPENDIX B – Budget Profile and Resource Projections

B1. COP21 Planned Spending in alignment with planning level letter guidance

Table B.1.1: COP21 Budget by Program Area 1

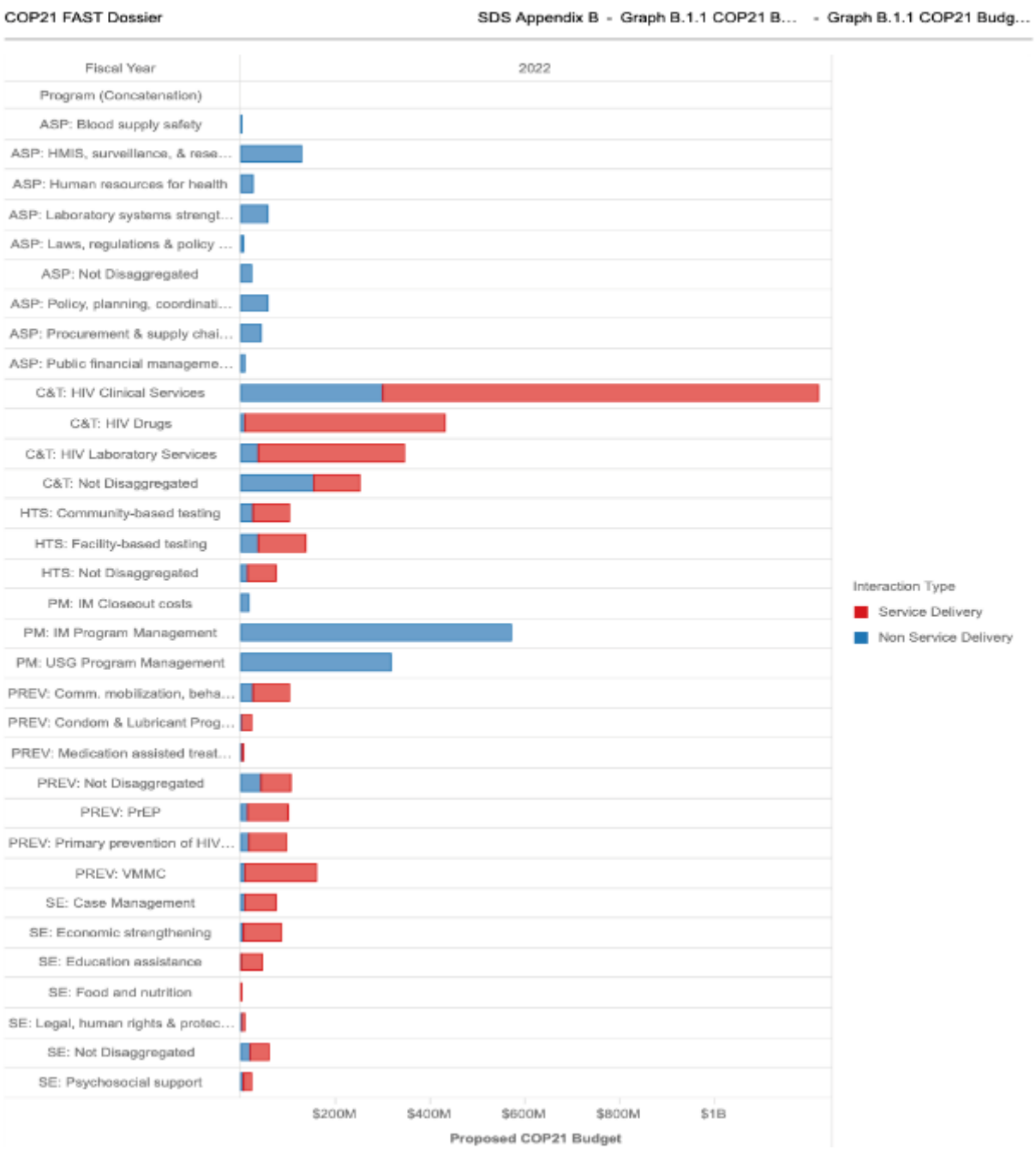


Table B.1.2: COP21 Budget by Program Area 2

Table B.1.2 COP21 Budget by Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		$168,249,572	$282,250,428	$450,500,000	37.35%	62.65%	100.00%
C&T	Total	$49,784,079	$187,973,233	$237,657,312	17.90%	82.10%	100.00%
	HIV Clinical Services	$35,423,971	$71,201,712	$110,915,683	28.86%	71.14%	100.00%
	HIV Drugs		$38,664,115	$38,664,115		100.00%	100.00%
	HIV Laboratory Services	$4,848,312	$45,317,955	$49,207,909	12.11%	87.89%	100.00%
	Not Disaggregated	$1,543,598	$9,804,365	$11,848,869	15.87%	85.79%	100.00%
HTS	Total	$15,209,741	$20,740,316	$35,841,057	42.45%	57.55%	100.00%
	Community-based testing	$3,100,153	$8,150,858	$11,258,011	27.55%	72.45%	100.00%
	Facility-based testing	$11,859,588	$12,380,058	$24,240,346	48.89%	51.11%	100.00%
	Not Disaggregated	$350,000	$200,000	$550,000	63.64%	36.36%	100.00%
PREV	Total	$16,649,358	$50,580,837	$67,159,395	24.79%	75.21%	100.00%
	Comm. mobilization, behavior & norms change	$11,534,128	$12,940,801	$24,472,929	48.67%	51.30%	100.00%
	Condom & Lubricant Programming	$840,000	$900,000	$1,800,000	52.83%	47.17%	100.00%
	Medication assisted treatment	$500,000	$2,204,261	$2,704,261	18.49%	81.51%	100.00%
	Not Disaggregated	$400,000	$5,879,180	$6,279,180	6.58%	93.42%	100.00%
	PrEP	$2,822,125	$7,282,814	$9,904,939	28.44%	73.53%	100.00%
	VMMC	$562,115	$22,155,891	$22,717,006	2.56%	97.44%	100.00%
SE	Total	$450,000	$25,327,962	$24,217,552	1.85%	98.15%	100.00%
	Case Management		$11,838,372	$11,838,372		100.00%	100.00%
	Economic strengthening		$6,804,765	$6,804,765		100.00%	100.00%
	Education assistance		$3,300,862	$3,306,862		100.00%	100.00%
	Not Disaggregated	$450,000	$2,119,833	$2,569,833	17.51%	82.49%	100.00%
ASP	Total	$26,158,801		$26,158,801	100.00%		100.00%
	HMIS, surveillance, & research	$6,758,898		$6,758,898	100.00%		100.00%
	Human resources for health	$3,895,654		$3,895,654	100.00%		100.00%
	Laboratory systems strengthening	$5,819,551		$5,819,551	100.00%		100.00%
	Laws, regulations & policy environment	$358,353		$358,353	100.00%		100.00%
	Not Disaggregated	$1,813,000		$1,813,000	100.00%		100.00%
	Policy, planning, coordination & management of disease control programs	$4,835,015		$4,835,015	100.00%		100.00%
	Procurement & supply chain management	$3,445,500		$3,445,500	100.00%		100.00%
	Public financial management strengthening	$1,050,000		$1,050,000	100.00%		100.00%
PM	Total	$68,514,433		$68,514,433	100.00%		100.00%
	IM Closeout costs	$1,630,688		$1,630,688	100.00%		100.00%
	IM Program Management	$38,664,633		$38,664,633	100.00%		100.00%
	USG Program Management	$27,219,112		$27,219,112	100.00%		100.00%

Table B.1.3 COP 21 Total Planning Level

Table B.1.2: COP21 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$46,215,345	**$404,284,655**	**$450,500,000**

Table B.1.4 COP 21 Resource Allocation by Program and Beneficiary

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary

Fiscal Year	2022													
Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	Percent to Total
Total	**$227,857,312**	**100%**	**$36,041,057**	**100%**	**$67,158,295**	**100%**	**$24,377,952**	**100%**	**$26,150,951**	**100%**	**$68,914,433**	**100%**	**$450,500,000**	**100%**
Females	$2,030,526	1%			$17,862,337	27%	$675,564	3%	$233,333	1%			**$20,801,760**	**5%**
Key Pops			$2,700,000	7%	$11,815,100	18%	$359,242	1%	$170,000	1%			**$15,044,342**	**3%**
Males	$1,524,710	1%	$1,656,213	5%	$23,277,006	35%							**$26,457,929**	**6%**
Non-Targeted Pop	$210,810,153	93%	$31,684,844	88%	$12,872,451	19%	$3,524,255	14%	$25,422,618	97%	$68,914,433	100%	**$353,228,754**	**78%**
OVC					$637,505	1%	$15,551,749	64%					**$16,189,254**	**4%**
Pregnant & Breastfeeding Women	$12,216,923	5%			$616,160	1%			$100,000	0%			**$12,933,083**	**3%**
Priority Pops	$1,275,000	1%			$77,736	0%	$4,267,142	18%	$225,000	1%			**$5,844,878**	**1%**

B.2 Resource Projections

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

In addition, agencies and program officers consulted with expenditure analysis data, work plans, performance reports and S/APR data. Additional consideration was given to earmarks and expected cross-cutting attributions based on the Planning Level 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 C – Tables and Systems Investments for Section 6.0

No longer required for COP21 submission.

APPENDIX D– Minimum Program Requirements

MPR	Status	Next Steps
Adoption and implementation of test and start with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups	Tanzania has adopted and implemented a test and start policy, which is aligned with WHO guidance.	N/A
Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3kg, and removal of all NVP and EFV based ART regimens	The DTG transition has moved quickly to **overall overage of 92% of all eligible clients (including 92% of all eligible women of child-bearing age)** as of December 2020. GF approved collection and destruction of legacy stock. Awaiting GOT plan for DTG10 transition.	Continued follow-up to ensure all legacy stocks are removed from facilities and disposed. Include DTG10 in supply plan with clear implementation timeline.
Adoption and implementation of differentiated service delivery models for all clients with HIV including 6 MMD, decentralized drug distribution, and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	3MMD continues (90% of eligible clients receiving). **6MMD started in Dar es Salaam in March 2020 and 73% of eligible clients receiving by December 2020.** Based on stock analysis, 6MMD expansion is slowed pending stock arrival in Q3 2021. Awaiting GOT plan for 6MMD scale-up outside of Dar. Decentralized drug distribution scaled-up in the context of COVID-19.	Continue monitoring stock levels. Work to further scale-up community ART distribution. Include 6MMD in supply plan with clear implementation timeline.
All eligible PLHIV, including children and adolescents, should complete TB preventive treatment by end of COP 21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	**On track to complete TPT by end of COP 20**. By FY21 Q1, 69% of eligible clients were either receiving or had completed IPT. Gaps remain in specific geographic areas and among children.	Continue scale-up. Targeted interventions for children and underperforming geographic areas.
Completion of diagnostic network optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups including 100%	Frequent stock-outs of lab reagents (HLV and EID) and overreliance on low throughput platforms have contributed to persistently suboptimal viral load and EID coverage. **COP 21**	Work with GOT on diagnostic network optimization transition plan COP 20-22. Closely monitor and troubleshoot TPC sample

access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	**support is prioritizing improved utilization of high through-put platforms within the existing laboratory diagnostic network with a focus on supporting lab optimization and supply chain strategies to ensure efficiencies and uninterrupted HVL testing. Plan for TPC to take on sample transport, though this hasn't been rolled out nationally.**	transport during scale-up. Explore virtual Lab TDY to support optimization plans.

MPR	Status	Next Steps
Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of IPV is established. All children under age 19 with an HIV-positive biological parent should be offered testing for HIV.	National index AE tool in use, national CTC2 chart incorporates elicitation form to track IPV, monthly portal updated to include pediatrics and community index testing monitoring as well as IPV tracking. HAPCA amendment published in GOT gazette and regulations have been approved and incorporated into the HIV self-testing framework. **Current self-test kit stock shortages.**	Self-test kit stock replenishment expected in August 2021.
Direct and immediate assessment for and offer of prevention services including PrEP to HIV negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high-HIV burden areas, high-risk HIV negative partners of index cases, KP, and high-risk adult men)	**PrEP program scale-up repeatedly delayed despite availability of Truvada since August 2020, pending revision of new PrEP implementation framework.**	GOT to sign/finalize framework (May 2021) Circular to facilities to start PrEP (May 2021)
Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17 with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year old	OVC packages have been aligned	Focus on increasing enrollment of CLHIV and providing prevention services to children aged 9-14.

girls and boys in regard to primary prevention of sexual violence and HIV		
Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting HIV testing, treatment, and prevention	The GOT prohibits user fees for HIV, TB, and MCH services in public and private settings. There is no evidence of user fees.	N/A
OUs assure program and site standards are met by integrating effective quality assurance and CQI practices into site and program management. CQI is supported by IP work plans, agency agreements, and national policy.	CQI integrated into all facilities and in line with national policies. CQI incorporated into work plans. Currently most quality assurance assessments and subsequent mentoring and supportive supervision being managed virtually.	N/A

MPR	Status	Next Steps
Evidence of treatment and viral load literacy activities supported by MOH and NACs and other host country leadership offices with the general population, and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Treatment and VL literacy integrated into facility and community-level counseling and communication activities. Stigma reduction messaging also ongoing.	UNAIDS stigma index.
Clear evidence of agency progress towards local, indigenous partner direct funding	Tanzania is **on track** towards its contribution to local, indigenous prime partner funding.	N/A
Evidence of host government assuming greater responsibility for the HIV response including demonstrable evidence of year after year increased resources expended	GOT has established an AIDS Trust fund and is exploring an HIV levy and partnerships with private sector entities to channel funds. ABC, NASA, and test case costing studies conducted to inform longer term plans. GOT is ready to have further discussions on sustainability.	Share ABC results once final. Look for opportunities to increase dialogue.
Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious mortality	PEPFAR utilizes the CTC2 system from HIV clinics to track outcomes among clients in	Explore options to add cause of death to CTC2 system.

	care, in morbidity (e.g., TB) and death.	
Scale-up of case surveillance and unique identifiers for patients across all sites.	Unique ID provided to all new clients for use within CTC2 system at HIV clinics, which facilitates patient level monitoring, but does not allow for tracking clients who move between facilities or are registered with multiple CTC IDs. Biometrics integrated into CTC2 during Zanzibar pilot in 2017**. Biometric capabilities integrated into Mainland CTC2 system in 2019, but system activation not yet approved by GOT. MOH approved integration in new Afya Care HIS system, but this will only cover 28 facilities.**	Awaiting GOT approval for biometrics implementation at HIV clinics.