Tanzania

Country Operational Plan

COP 2022

Strategic Direction Summary

April 29, 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

Abbreviations

3HP	3-months of Isoniazid-Rifapentine
3HR	3-months of Isoniazid-Rifampin
3MMD	Three to five months of multi-month dispensing
6MMD	Six months of multi-month dispensing
ABC/M	Activity based costing and management
AE	Adverse event
AFRICOS	African Cohort Study
AGYW	Adolescent girls and young women
ANC	Antenatal care
ANC-1	First antenatal care visit
AP3	Pediatric and PMTCT surge strategy
ART	Antiretroviral therapy
ARV	Antiretroviral
ATF	AIDS Trust Fund
AYA	Adolescent and young adults steering committee
AYFS	Adolescent and youth friendly services
BBS	Bio-behavioral survey
BCPE	Bukoba Combination Prevention Evaluation
CLHIV	Children living with HIV
C/ALHIV	Children and adolescents living with HIV
CBIM	Changing Boys into Men
CBO	Community based organization
CBS	Case-based surveillance
CCW	Community case worker
CDC	The United States Centers for Disease Control and Prevention
CDE	Continuing developmental education
CHAMPS	Comprehensive HRH Analytics and Monitoring Platforms
CLM	Community-led monitoring
CODB	Cost of doing business
COP	Country operational plan
CPD	Continuous professional development
CQI	Continuous quality improvement
CrAG	Serum cryptococcal antigen
CSO	Civil Society Organization
CTC	Care and treatment center
CTCID	Care and treatment center unique identification
DAMES	DREAMS Auxiliary M&E system
DBS	Dry blood spot
DCEA	Drug control enforcement authority
DHFF	Direct health facility financing
DHIS	District Health Information System
DHS	Demographic and health survey
DNO	Diagnostic network optimization
DPVr	Dapivirine vaginal ring
DQA	Data quality audit
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
DSM	Differentiated service delivery models
DTG	Dolutegravir
EAC	Enhanced adherence counseling
EC	Expert clients
EID	Early infant diagnosis

EMTCT	Ending mother to child transmission
EMR	Electronic medical record
EQA	External quality assessment
FAST	Funding allocation to strategy tool
FBO	Faith based organization
FCI	Faith and community initiative
FELTP	Field Epidemiology and Laboratory Training Program
FFARS	Facility Financial Accounting and Reporting Systems
FP	Family planning
FSW	Female sex worker
FTE	Full time equivalent
FY	Fiscal year
GBV	Gender based violence
GDP	Gross National Product
GHSC-PSM	Global Health Supply Chain Procurement and Supply Management
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GNI	Gross National Income
GOT	Government of Tanzania
HAPCA	HIV/AIDS Prevention and Control Act
HCW	Healthcare worker
HDR	HIV drug resistance
HEI	HIV-exposed infant
HIM	Health information mediator
HIVST	HIV self-testing
HMIS	Health management information systems
HPV	Human papilloma virus
HRH	Human resources for health
HRHIS	Human resource health information systems
HTS	HIV testing services
iCHF	Improved community health fund
IIT	Interruption in Treatment
IP	Implementing partner
IPC	Infection prevention and control
IPT	Isoniazid preventative therapy
IPV	Intimate partner violence
KP	Key populations
KVP	Key and Vulnerable Populations
LA-CAB	Long acting Cabotegravir
LCM	Linkage case management
LF-LAM	Lateral flow urine lipoarabinomannan assay
LGA	Local government authority
LIVES	Listen, Inquire, Validate, Enhance safety, and Support
LIS	Laboratory information system
M&E	Monitoring and evaluation
MAT	Medical assisted therapy
MC	Male circumcision
MCH	Maternal and child health
MER	Monitoring, evaluation, and reporting
MMD	Multi-month dispensing
MOFP	Ministry of Finance and Planning
MOH	Ministry of Health
MOU	Memorandum of understanding
MSD	Medical Stores Department

MSM	Men who have sex with men
NACOPHA	National Council of People Living with HIV/AIDS
NACP	National AIDS Control Program
NASA	National AIDS Spending Assessment
NBS	National Bureau of Statistics
NHCR	National Health Client Registry
NHIF	National Health Insurance Fund
NIDA	National Identification Agency
NIMART	Nurse initiated and managed anti-retroviral therapy
NMSF	National Multi-sectoral Strategic Framework
NNT	Number of clients tested to identify one HIV-positive client
NPHL	National Public Health Laboratory
NSA	Non-state Actors
NTLP	National TB and Leprosy Program
OGAC	Office of the Global AIDS Coordinator
OPD	Outpatient Department
OVC	Orphans and vulnerable children
PFM	Public financial management
PLHIV	People living with HIV
PLL	Planning level letter
PEPFAR	United States President's Emergency Plan for AIDS Relief
PEPFAR/T	PEPFAR Tanzania
PBFW	Pregnant and breastfeeding women
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother to child transmission
POA	Prioritization and optimization allocation
POART	Program oversight and accountability response team
POCT	Point-of-care testing
PO-RALG	President’s Office of Regional and Local Government
PrEP	Pre-exposure prophylaxis
PSM	Procurement and supply management
PSNU	Priority sub-national unit
PT	Proficiency testing
PWID	People who inject drugs
R/CHMT	Regional and Community Health Management Teams
RITA	Recent infection testing algorithm
RFP	Request for proposals
RTRI	Rapid test for recent infection
SBC	Social and behavior change
SDG	Sustainability development goals
SID	Sustainability index dashboard
SIMS	Site improvement through monitoring systems
SMS	Short message service
SNS	Social network services
SNU	Sub-national unit
SR	Shang Ring
SRE	Surveillance, research, and evaluation
STI	Sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TLD	Tenofovir, Lamivudine, Dolutegravir
TPC	Tanzania Postal Corporation

TPT	Tuberculosis preventative therapy
THIS 2016-2017	Tanzania HIV Impact Survey 2016-2017
THIS 2022-2023	Tanzania HIV Impact Survey 2022-2023
THPR	Tanzania Product Health Registry
THSCP	Tanzania Health Supply Chain Portal
TMA	Total Market Approach
TMDA	Tanzania medicines and medical devices authority
TWG	Technical working group
TX_CURR	Current clients on Treatment
TX_NET NEW	Net new clients on treatment
TX_NEW	New clients on treatment
U=U	Undetectable=Untransmissible
UHI	Universal health insurance
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	The Joint United Nations International Children Emergency Fund
USAID	The United States Agency for International Development
USG	United States Government
VAC	Violence against children
vAGYW	Vulnerable adolescent girls and young women
VAT	Value added tax
VIA	Visual inspection with 5% acetic acid
VL	Viral load
VLC	Viral load coverage
VLS	Viral load suppression
VMMC	Voluntary medical male circumcision
WAO	Workforce allocation optimization
WHO	World Health Organization
WINGS	Women's Income Generating Support
WISN	Workload indicators of staffing needs
WLHIV	Women living with HIV
WRAIR/DOD	Walter Reed Army Institute of Research/Department of Defense

1.0 Vision and Goal Statement

The findings from the Tanzania HIV Impact Survey 2016-2017 (THIS 2016-2017) transformed PEPFAR/Tanzania's (PEPFAR/T) understanding of the HIV epidemic in Tanzania and the programmatic challenges preventing the country from reaching epidemic control. Data from the survey triggered a programmatic overhaul. PEPFAR/T shifted activities and resources to scale up index testing with fidelity, link and retain clients on treatment. In addition, PEPFAR/T took concerted actions that shifted national policies for multi-month dispensing (MMD), community antiretroviral therapy (ART), self-testing, and pre-exposure prophylaxis (PrEP) scale-up. These changes led to historic performance during fiscal year (FY)19, FY20, FY21 and continue to shape PEPFAR/T's current interventions, approaches, and strategies moving into FY23 / Country Operational Plan 2022 (COP22).

It is important to note that while the THIS 2016-2017 transformed Tanzania's HIV response, the results are now outdated and a more up-to-date understanding of the HIV epidemic in Tanzania is urgently needed to help recalibrate epidemic control efforts. A follow-up Tanzania HIV Impact Survey 2022-2023 (THIS 2022-2023) is underway with data collection expected to start in October 2022 and preliminary results anticipated available to inform COP23 planning. The THIS 2022-2023 data will inform targeted investment of resources to ensure that PEPFAR/T continues to employee targeted programmatic strategies and client-centered services at the sub-national level and among sub-populations. Tanzania, like many countries around the world, faced unique challenges in program delivery due to the COVID-19 pandemic. While the COVID-19 pandemic did slow progress in identification and retention of people living with HIV (PLHIV), PEPFAR/T took an array of actions – including expansion of MMD and community-based ART refills - to mitigate its effects. The program continued to transition clients to optimal antiretroviral (ARV) regimens for better continuity of treatment and clinical stability among clients. Additionally, innovative use of technological platforms, including virtual site visits and short-message-service (SMS) reminders to clients, contributed to maintaining progress during the pandemic. PEPFAR/T has largely regained the ground lost during the pandemic in areas such as voluntary medical male circumcision (VMMC) service provision, Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) initiative, and community-based testing. We have also successfully sustained nationwide improvements in retention through the end of FY21.

Despite COVID-19-related setbacks, PEPFAR/T has seen increased treatment growth and population viral load suppression (VLS). The DREAMS program exceeded its FY21 target, reaching nearly 200,000 vulnerable adolescent girls and young women (AGYW) with a comprehensive package of interventions. Through partnership with the Government of Tanzania (GOT), PEPFAR/T is currently scaling up six months of multi-month dispensing (6MMD) with over 600,000 PLHIV enrolled in 6MMD as of December 2021 (FY22 Q1). Similarly, PEPFAR/T began national scale-up of PrEP and enrolled more than 34,000 new clients as of September 2021 when the national PrEP framework was approved by the GOT Achievements in 6MMD and PrEP scale-up enabled PEPFAR/T to meet two critical minimum program requirements on the pathway to epidemic control.

The use of the right data to identify and respond to programmatic gaps has been at the core of PEPFAR/T's success. This approach is coupled with working closely with diverse stakeholders, including the GOT, civil society, development partners, and implementing partners (IPs) to tailor effective strategies, strengthen systems, and advocate for evidence-based policies to close program gaps. Our vision for COP22 will continue to rely on our three core foundational principles – data, systems, and people – to ensure our activities take us on the right path to epidemic control. Despite the outdated THIS 2016-2017 findings, PEPFAR/T is using and triangulating various programmatic data, United Nations Joint Program on HIV/AIDS (UNAIDS') Spectrum estimates, and other modeling to inform strategies to improve and expand case finding, ensure linkage and retention on treatment, and continue to scale-up prevention services. In COP22, PEPFAR/T will prioritize targeted outreach efforts to ensure that services are delivered equitably to marginalized groups including key and vulnerable populations (KVP). A critical aspect of our vision in COP22 is to strengthen the systems, communities, and partners with whom we work to lay the foundation for sustainable epidemic control.

PEPFAR/T will continue to implement effective interventions to move us closer to meeting the UNAIDS 95-95-95 goals of ensuring that 95% of PLHIV know their status, 95% of those aware are on ART, and that 95% of those on ART are virally suppressed. In the context of the first 95, in COP22, PEPFAR/T will continue to give targeted HIV case finding a top priority with an emphasis on strengthening and expanding safe and ethical index testing (including intimate partner violence monitoring) and social network testing to identify people living with HIV among hard to reach populations. PEPFAR/T will hone our provider-initiated testing and counseling (PITC) screening to ensure we are not missing identification opportunities. Additionally, PEPFAR/T will continue to expand self-testing given that commodities are now available in country. Moreover, expansion of HIV recency surveillance will identify patterns in recent infections across geographic locations and sub-population groups. In the context of COVID-19, PEPFAR/T is continuing with ongoing efforts to ensure sufficient infection prevention and control measures are in place at PEPFAR/T-supported facilities and is expanding access to and provision of COVID-19 vaccinations with a focus on PLHIV. In COP22, PEPFAR/T will continue to support these efforts and will continue to leverage PEPFAR/T health systems as a platform for COVID-mitigation, preparedness, and response.

To reach the second and third 95 goals, PEPFAR/T will continue to rapidly accelerate ART uptake, prevent interruptions in treatment (IIT), optimize ARV regimens for both pediatric and adult clients, and expand the use of differentiated service delivery (DSD) models, including three months of multi-month dispensing (3MMD) and 6MMD for eligible clients. PEPFAR/T will redouble efforts towards the GOT goal of eliminating mother to child transmission (EMTCT) and will bolster performance across the pediatric cascade through an intensified surge strategy known as AP3. The persistent pattern of inequity in prevention of mother to child transmission (PMTCT) and early infant diagnosis (EID) outcomes between non-PEPFAR and PEPFAR sites is a major barrier to EMTCT goals in Tanzania. The AP3 efforts will expand the reach of focused technical assistance for PMTCT services in a selected subset of non-PEPFAR sites while closing gaps in poor performing PEPFAR-supported sites with a focus on ART linkage and retention for pregnant and breastfeeding women (PBFW), and coverage of EID at 2 and 12

months. A PMTCT cascade evaluation will be conducted in a random sample of PMTCT sites (including non-PEPFAR supported sites) to identify and quantify gaps in the cascade starting with antenatal care (ANC) testing and retesting down to 2-month EID and 12-month EID.

In the context of continually measuring progress towards the third 95 goal for VLS, in COP22 PEPFAR/T will strengthen viral load testing coverage (VLC) by continuing to prioritize high throughput platforms and work with GOT and Medical Stores Department (MSD) to increase transparency in the context of supply forecasting, quantification, and commodity distribution to health facilities to help minimize supply chain disruptions. PEPFAR/T is also currently working with GOT on an updated diagnostic network optimization (DNO) exercise to improve VLC, sample transportation systems, sample result turnaround time, and other systems essential for viral load service delivery. Viral load testing data will continue to inform client-centered services for clients on ART who are unsuppressed including better targeting of enhanced adherence counseling (EAC). PEPFAR/T will continue to strengthen index-testing and other prevention services for the sexual partners of unsuppressed clients on ART to reduce the risk of HIV transmission by unsuppressed clients.

In the context of prevention, PEPFAR/T will continue to rollout and strengthen PrEP services with an emphasis on reaching vulnerable adolescent girls and young women (vAGYW) including in DREAMS districts, key populations (KP), PBFW, and other persons engaging in HIV risk behaviors. PEPFAR/T will scale up promotion of HIV Undetectable=Untransmissible (U=U) messaging in both facility and community-based settings to foster an enabling environment for stigma reduction while also reinforcing the dual benefits of staying virally suppressed both for oneself and one's sexual partners. PEPFAR/T will support comprehensive condom programming and will work towards geographic saturation for VMMC services, which will include limited introduction of the Shang Ring device in COP22. In addition, DREAMS activities will expand coverage into three new councils (in addition to the existing 11 councils) to reduce the disproportionate burden of new infections more effectively among vAGYW.

Throughout these efforts, PEPFAR/T will employ an equity lens to ensure that marginalized populations are receiving quality services that meet their needs by addressing structural barriers, enhancing bio-behavioral surveillance and size estimation, and improving KP-friendly services. This will be complemented by efforts to address widespread stigma and discrimination as described in our efforts to address the new minimum program requirement. PEPFAR/T will prioritize people living with HIV/AIDS and other beneficiaries directly in anti-stigma and discrimination efforts and expand the focus of our ongoing community-led monitoring (CLM) activities to assess stigma and discrimination more comprehensively and to KP services at health facilities to ensure services meet the needs of these communities.

In COP22, PEPFAR/T will continue to prioritize strengthening laboratory systems, health information systems, supply chain systems, surveillance systems, and explore the best strategies to support human resources for health. The GOT has committed to establishing a technical working group focused on sustainability which will provide a forum to discuss these issues and opportunities for programmatic transitions through domestic resource mobilization.

From a systems perspective, one of the continued barriers to epidemic control in Tanzania is the supply chain system, which requires improved transparency during quantification and forecasting processes as well as for real-time consumption monitoring including distribution from MSD to health facilities. These issues as well as sample transport, and an optimized laboratory system will be addressed in the ongoing DNO. PEPFAR/T will also work to address supply chain challenges through implementation of the Global request for proposals (RFP), and continued advocacy for updated GOT shelf-life requirements in line with World Health Organization (WHO) guidelines.

PEPFAR/T's programmatic strategies must be built on a solid foundation of political will and an enabling policy environment. PEPFAR/T will continue strong stakeholder engagement in COP22. Close collaboration with GOT, UNAIDS, WHO, GFATM, and civil society organizations (CSOs) are also key to success and PEPFAR/T will provide opportunities for regular engagement throughout the implementation year. Continuing to work closely with civil society on CLM efforts to improve pediatric, KP, and other sub-population specific services, for example, will play a key role to achieve this goal. Continued engagement of the KVP Forum will ensure that KVP activities are being implemented effectively at the community level. In addition to the supply chain and laboratory policies and systems already highlighted, PEPFAR/T will also work with partners to advocate for MMD for children under five years and differentiated service delivery for tuberculosis preventative therapy (TPT). Finally, regular, and robust partner management meetings and monthly data reviews will continue to help ensure that we identify programmatic gaps in a timely fashion and address the root causes.

The successes of prior years have well-positioned Tanzania to achieve and sustain epidemic control. Although results from the pending THIS 2022-2023 are essential to allow us to refocus our evidence-based approach, PEPFAR/T will use COP22 to strengthen ongoing interventions and innovations to address programmatic gaps and intensify efforts to ensure equitable outcomes. PEPFAR/T will maximally use routine program data to inform site-level actions and monitor overall program performance in near real-time. Data quality assessments (DQAs) will be conducted regularly across all regions using a standardized approach to improve data quality. Through the strategies elaborated in this document, and with the continued collaboration of the GOT, civil society, donor partners, stakeholders, and the people we serve, PEPFAR/T's COP22 implementation will accelerate our success and pave the way towards an HIV-free generation.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The National Bureau of Statistics (NBS) projected that in 2022 Tanzania has an estimated population of 61,280,743.[1] However, results from a new census in August/September 2022 will provide more up-to-date estimates. The THIS 2022-2023 is underway, and preliminary

[1] Tanzania National Bureau of Statistics. National Population Projection, 2018.

estimates are expected to be available in February 2023. According to THIS 2016-2017,[2] the prevalence of HIV among adults (aged 15 years and above) in Tanzania was estimated to be 4.9% (6.3% among females and 3.4% among males). HIV prevalence among children ages 0-14 years was very low (0.4%), but higher among children born to HIV-positive mothers (6.3%). At the time of the THIS 2016-2017, there were approximately 1.4 million PLHIV in Tanzania. UNAIDS Spectrum 2022 now estimates a total of 1.7 million PLHIV in Tanzania[3], with large regional variations ranging from 8,251 in Zanzibar to 219,428 in Dar es Salaam.[4] The THIS 2016-2017 revealed an annual HIV incidence of 0.2% among adults (0.3% among females and 0.2% among males). For females, incidence of HIV infection was highest among the 25–34-year age band (0.7) and for males it was highest among the 35–49-year age band (0.2%)

Tanzania has made substantial progress towards epidemic control. The THIS 2016-17 showed that 61% of PLHIV in Tanzania knew their HIV status. Nationally, 94% of those who knew their HIV status were on ART, and 87% of those on ART were virally suppressed (89% among females and 83% among males). More recently according to 2020 UNAIDS estimates, 84% of PHLIV in Tanzania knew their status,[5] which marks a substantial improvement in identification since the THIS 2016-2017 findings. Moreover, in 2020, UNAIDS estimated that population VLS was 82% in Tanzania. 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 in 2015 to 45,239 in 2021. Additionally, the total deaths among PLHIV have also been steadily declining: from an estimated 40,785 in 2015 to 16,371 in 2021.[6]

KPs also play a critical role in HIV transmission dynamics in Tanzania. Studies in Dar es Salaam estimate that HIV prevalence is 36% among people who inject drugs (PWID), 26% among female sex workers (FSWs), and 25% for men who have sex with men (MSM).[7] More up to date bio-behavioral data and population size estimates for FSW and PWID will be available by September 2022 via an ongoing bio-behavioral survey (BBS) on the mainland of Tanzania. In addition, in FY23, an expanded BBS assessment will be conducted to include MSM, FSW, PWID and other KP groups on the mainland of Tanzania and in Zanzibar.

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% among males aged 40-44 years. According to the 2021 UNAIDS Spectrum Estimates, prevalence among adults aged 15-24 years is 1.3% (1.7% among females and 0.9% 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. Though not accounting for viral load

[2] Tanzania HIV/AIDS Indicator Survey (THIS) 2016-2017
[3] 2021 Spectrum estimates, 2020-point estimate
[4] 2021 Spectrum estimates
[5] UNAIDS. 2020 estimates, Tanzania. Available from: https://www.unaids.org/en/regionscountries/countries/unitedrepublicoftanzania
[6] 2021 Spectrum estimates
[7] Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

adjustments for potential misclassifications, trends in recent HIV infection surveillance in Dar es Salaam between December 2019 and April 2020 demonstrated that recent infections were highest (in descending order) among females aged 15-19 and 20-29 years and males 20-29, 30-39, and 15-19 respectively. National scale-up of HIV recency surveillance is now ongoing and will provide a fuller picture of risk factors associated with new HIV infections to inform targeted response efforts.

The burden of HIV infection also varies geographically across Tanzania, ranging from 11% in Njombe to less than one percent (<1%) in Lindi and Zanzibar. HIV prevalence also varies between urban (6%) and rural (4%) areas. Spectrum 2021 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 COP22 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 geographic areas of residence, Spectrum 2022 results show a shift of HIV burden among fewer regions compared to COP21 Spectrum files. Mara, Kilimanjaro, Dar es Salaam, Dodoma and Mtwara showed the highest net increase of estimated number of PLHIV compared to COP21 Spectrum outputs. Conversely, Mbeya, Njombe, Geita, Iringa, and Morogoro showed the largest decrease in estimated number of PLHIV compared to COP21 Spectrum outputs. Throughout the latter half of FY21, 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 COP22, targeted programming will continue to focus on the alignment of resources with the latest epidemiologic information.

The Spectrum 2021 national file was used to determine regional PLHIV estimates in COP22, to which the UNAIDS Spectrum 2022 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, VLS, national ART prevalence data among 15–49-year-old population from COP21 implementation, as well as granular program data to produce council-level age disaggregated estimates for the number of PLHIV. The 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 methods denominators between COP21 and COP20 were slightly impacted, particularly for regions outside of the top 10 highest burden regions for which THIS 2016-2017 was powered. As in COP21, PEPFAR/T used the Spectrum 2021 estimates in the COP22 Data Pack, but adjusted "current on treatment" (TX_CURR) targets by region accordingly to align with triangulated THIS survey data and programmatic

[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.

insights. This approach guides the geographic breadth and scope of activities to sustain the progress made in COP21.

In 2021, the GOT adapted and advanced key policies to move Tanzania closer to epidemic control). This included implementing 6MMD, and PrEP. During FY21 and into COP22, GOT will revise and update the National Guidelines for the Management of HIV and AIDS to incorporate the many policy and program updates as well as new emerging developments. By FY21 Q4, proxy linkage of newly diagnosed PLHIV is at Tanzania is on track to introducing dolutegravir (DTG) 10mg to enhance optimal ARV regimens for all eligible children. Interruptions in supplies for HIV self-test kits caused nearly 6 months of disrupted services, however, a recent GFATM-supported shipment of HIV self-test (HIVST) kits has been received and distributed. Finally, the GOT is supportive of ongoing efforts to scale-up TPT to more than 85 % of eligible clients on isoniazid preventative therapy (IPT) and will introduce new TPT regimens in COP22. PEPFAR/T aims to achieve 100% IPT coverage of all eligible clients during COP22 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.

According to the preliminary 2021 UNAIDS estimates, only 60% of children living with HIV (CLHIV) were diagnosed in Tanzania; but all of those diagnosed were on ART and approximately 91% of those on ART were virally suppressed. In FY22 Q1, 258,734 (99.6%) of the documented 259,771 pregnant women had a known HIV status at first antenatal care visit (ANC1), including those who knew their HIV status prior to ANC1. In that period, a total of 9,976 (99.9%) of the 9,990 pregnant women living with HIV received ART. Based on program data, 98% of pregnant women had HIV testing in at least one antenatal care visit. Though much work remains to be done, Tanzania has been making steady progress in improving its pediatric index testing cascade. Moreover, the two-month proxy EID coverage has continued to improve from 72% in FY20 Q1 to 84% in FY22 Q1. CLHIV without any IIT remains above 90% across all age bands, but interruptions tend to be more common among infants <1 year old. At the end of FY21 Q4 there was an estimated treatment gap of 33,280 among CLHIV.

The national coverage of male circumcision in Tanzania has risen from a national overall average of 72%[9] to 80% in males aged 15 to 29 years.[10] PEPFART/T continues to successfully implement VMMC in Tanzania. However, most of the circumcisions are performed in the younger age bands. For instance, in FY22 Q1, 114,014 circumcisions were performed among 15-29 years old adolescent boys and men versus 16,078 among men 30 years and older. In COP22 / FY23, a total of 401,505 circumcisions are expected to be performed with increased demand promotion focusing on use of mobile platform, interpersonal communication, public announcements, mass media, and pre-booking and more convenient client-centered scheduling.

[9] THMIS, 2012.
[10] THIS, 2016-2017.

PrEP scale-up in Tanzania is ongoing, following the GOT's approval of the national PrEP framework in 2021. However, there is a large unmet need for PrEP in Tanzania, which will be addressed in COP22 through continued scale up including advocating for introductions of alternative PrEP options such as the dapivirine vaginal ring (DPVr) and long acting cabotegravir (LA-CAB). A global comparison study estimated 3.7 PrEP users per 10,000 people in Tanzania compared to 150 PrEP use per 10,000 people in Lesotho.[11] In Tanzania, new PrEP users increased from 7,147 in FY20 to 33,828 in only the first quarter in FY22 Q1. In addition, 7,201 existing PrEP clients returned for their PrEP refills. Major challenges encountered in the PrEP implementation included: not all facilities starting service provision on time, limited demand promotion activities focusing on print materials, and no tracking of additional priority groups such as long-distance truck drivers and fisher folks. In COP22, PEPFAR/T will intensify PrEP demand creation, especially through targeted outreach via KP networks and integration with AGYW programming. PrEP services will also be expanded to private facilities including pharmacies. PEPFAR/T will strengthen the monitoring of PrEP use and enhance the joint supportive supervision to ensure high quality client-centered implementation of PrEP in an equitable fashion.

To address gaps in human resources for health (HRH) and supply chain, PEPFAR/T will continue to support the implementation of the task sharing policy, in conjunction with the HIV DSD roll out. PEPFAR/T has been focused on implementation of the task sharing policy including in-service training through distance and blended learning approaches. In COP22, PEPFAR/T will continue working 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 implementing 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. PEPFAR/T will continue to rely on 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 per capita in 2020 was $1,080[12], which indicates limited income to accommodate health expenditures. Tanzania's total health expenditure was 4% of gross domestic product (GDP) in 2019,[13] less than the Abuja declaration target of 15%. These indicators show the need for more Government spending on health as a percent of GDP per capita to provide essential health services in Tanzania.

[11] Bavinton RB and Grulich AE. HIV pre-exposure prophylaxis: scaling up for impact now and in the future. Lancet Public Health. 2021.
[12] World Bank. GNI per capita - Tanzania, 2020.
[13] World Bank. Tanzania health expenditure (%GDP) – Tanzania, 2019.

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, 2018
HIV Prevalence (%)		4.7		0.5		0.3		2.1		0.6		Not available		Not available	THIS, 2016-2017
AIDS Deaths (per year)	16,189		1,651		1,721		921		1024						SPECTRUM, 2022
# PLHIV	1,742,506		54,800		56246		110,948		55,536		912,702		552,273		SPECTRUM, 2022
Incidence Rate (2021)		0.27													SPECTRUM, 2022
New Infections (2021)	45,239														SPECTRUM, 2022
Annual births	2,101,519	NA													National Population Projections, 2018
% of Pregnant Women with at least one ANC visit	Not available	98	NA	NA			NA	99			NA	98			THIS, 2016-2017
Pregnant women needing ARVs	65,559														SPECTRUM, 2022
Orphans (maternal, paternal, double)	2,303,582		NA		NA		NA		NA		NA		NA		THIS, 2016-2017
Notified TB cases (Yr)	65,505		5,313		5,200		3,819		3,184		18,929		32,764		NTLP Annual Report, 2016
% of TB cases that are HIV infected	21,627	100	806	4	884	4	837	4	678	3	8,298	38	10,124	47	NTLP Annual Report, 2016
% of Males Circumcised	Males 15-29yrs	80%			NA	NA			NA	NA			NA	NA	THIS, 2016-2017
Estimated Population Size of MSM*	49,700														Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence		25%													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated Population Size of FSW	155,450														Consensus estimates on Key Populations

															Size HIV Prevalence in Tanzania, July 2014
FSW HIV Prevalence		26%													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated Population Size of PWID	30000														Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
PWID HIV Prevalence		36%													Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated Size of Priority Populations (specify)	61632														
Estimated Size of Priority Populations Prevalence (AGYW) (COP22 Datapack)	6,211,713														
PLHIV AGYW (COP22 Datapack)	236,045														
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

Standard Table 2.1.2

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#) (Source: UNFPA Population Projections)	**HIV Prevalence (%) (THIS 2016-2017)**	**Estimated Total PLHIV (#) (SPECTRUM 2022)**	**PLHIV diagnosed (FY22 Q1) (#) (FY22 Planned Cascade Datapack)**	**On ART FY22 Q1 (#)(FY22 Planned Cascade Datapack)**	**ART Coverage FY22 Q1 (%)(FY22 Planned Cascade Datapack)**	**Viral Suppression FY22 Q1 (%)(FY22 Planned Cascade Datapack)**	**Tested for HIV FY21(#) (PEPFAR MER FY21 Program Data)**	**Diagnosed HIV Positive FY21(#)(PEPFAR MER FY21 Program Data)**	**Initiated on ART FY21(#)(PEPFAR MER FY21 Program Data)**
Total population	62,307,001	4.7%	1,738,429	1,581,755	1,565,859	96%	97%	3,285,188	211,915	202,994
Population <15 years	26,798,198	0.4%	85,357	59,254	58,118	98%	91%	290,711	7,445	7089
Men 15-24 years	6,287,054	1.24%	58,228	45,119	44,085	98%	93%	158,449	4,894	4324
Men 25+ years	8,976,222	5.9%	555,487	498,090	460,022	92%	95%	688,674	73,497	68,203
Women 15-24 years	6,198,523	2.28%	107,850	95,277	95,272	100%	95%	858,926	24,390	24,166
Women 25+ years	9,338,059	7.6%	931,507	884,015	880,965	100%	98%	1,256,591	100,970	98,835
MSM (IBBSS 2011-12)	49,700	25%	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
FSW (IBBSS 2011-12)	155,450	26%	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
PWID (IBBSS 2011-12)	30,000	36%	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable
Priority Pop (AGYW)	6,211,713	PLHIV AGYW 236,054	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable	Unavailable

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals Currently On Treatment

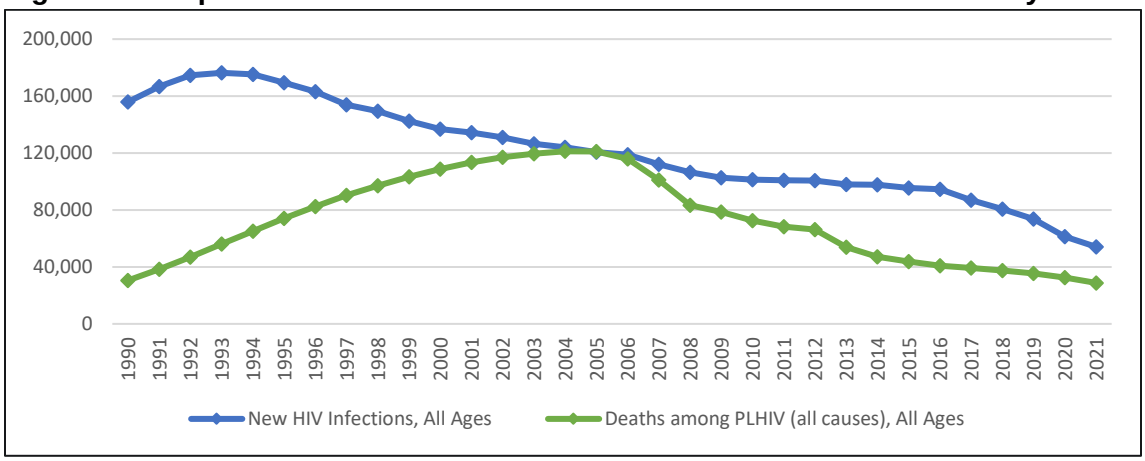


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

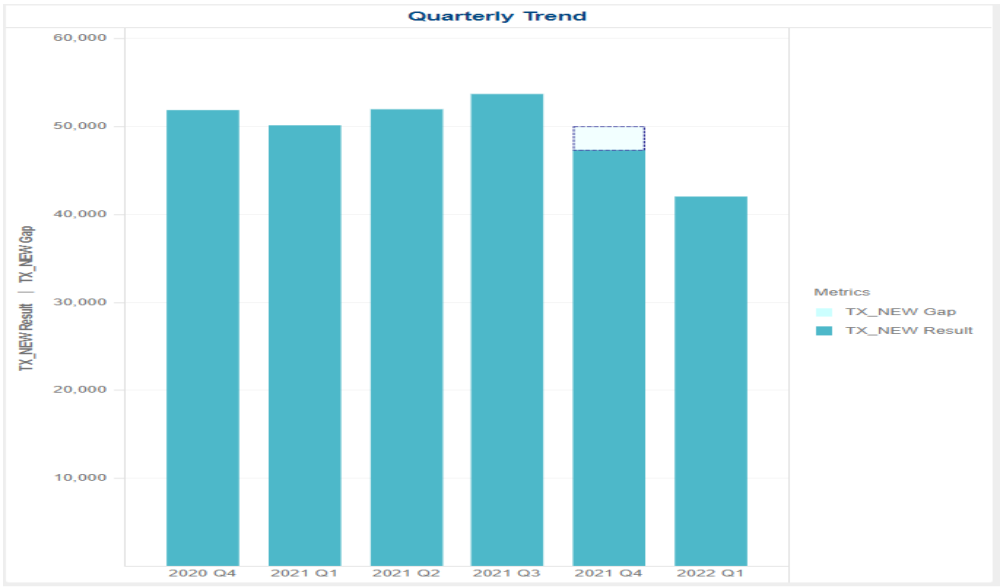


Figure 2.1.5 Assessment of ART Program Growth in FY21

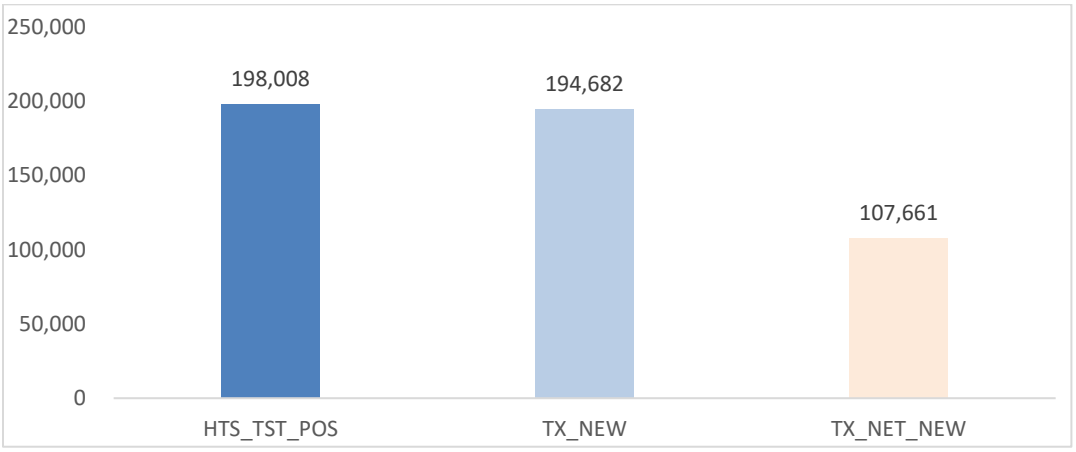


Figure 2.1.6 Clients Gained/Lost from ART by Age/Sex, FY21 Q4

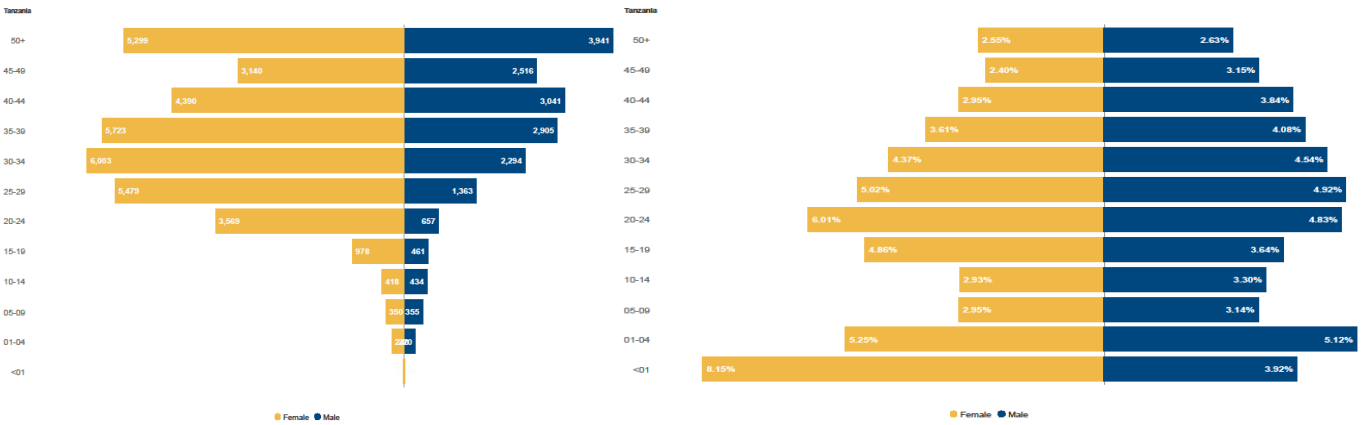


Figure 2.1.7 Epidemiologic Trends and Program Response for Tanzania

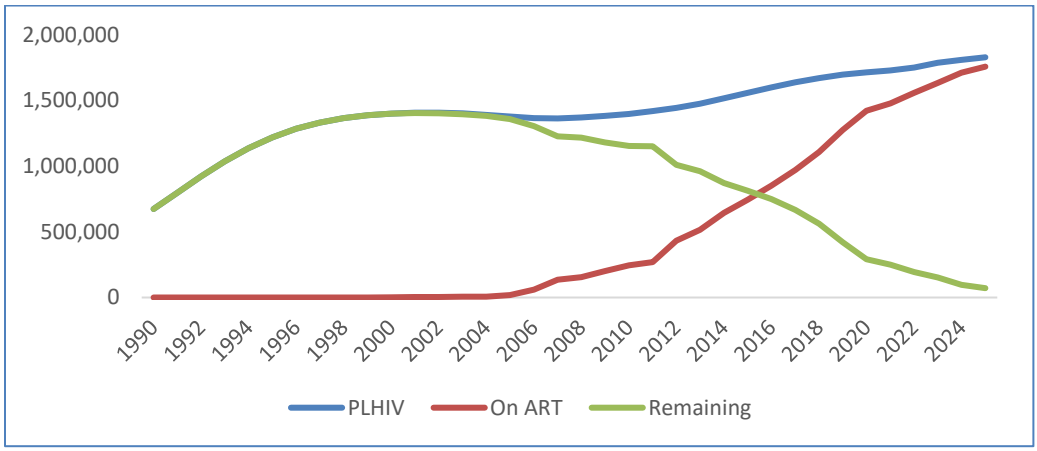
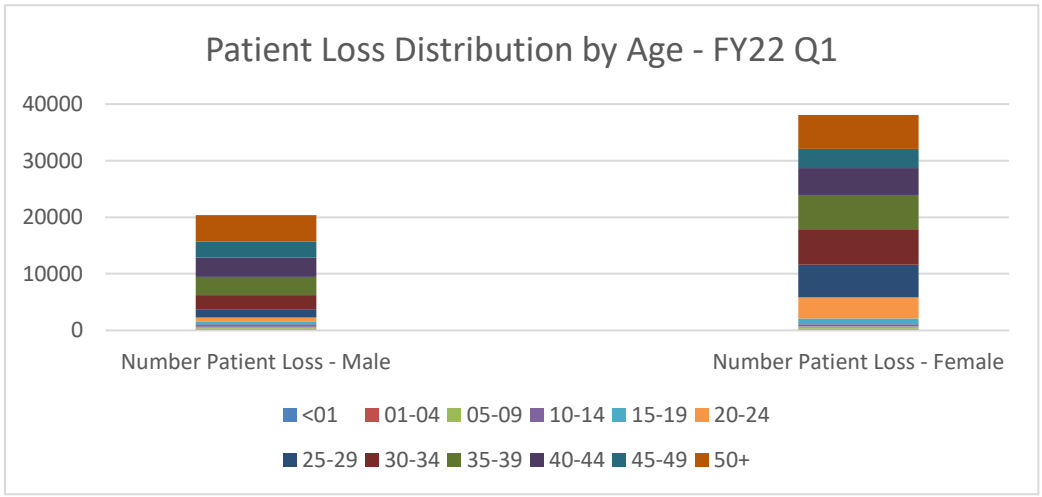


Figure 2.1.8 HIV Treatment Growth by Age/Sex



2.2 New activities and areas of focus for COP22, including focus on client ART continuity

COP22 priorities include several activities to focus on treatment program growth and ART continuity. As PEPFAR/T approaches treatment saturation, during COP22, PEPFAR/T will implement a strategic mix of testing modalities that considers yield, cost, and epidemiologic impact to ensure program equity. Safe, ethical index testing will be offered to all who are eligible, including newly diagnosed PLHIV, and will be implemented in a safe and confidential manner to minimize risk to clients and their contacts and will include close monitoring and support for intimate partner violence (IPV). Social network testing will be enhanced among key populations and other high-risk subpopulations who are otherwise hard to reach and HIV self-testing will be taken to scale now that self-test kits are available in country. PEPFAR/T will continue to use the national HIV testing screening tool to conduct targeted testing within in-patient, outpatient, and other clinical settings. As per the national guidelines, clients who do not meet eligibility criteria but insist on getting tested for HIV will not be denied testing services. Case finding for undiagnosed CLHIV continues to be a high priority, especially children of KP, vulnerable adolescents, and infants. To close the gap in PMTCT and pediatrics cascade, including improvements in EID, in COP22, PEPFAR/T will intensify maternal retesting during the third trimester and breastfeeding period. At-risk PBFW will be identified and enrolled in PrEP and linked to other combination preventive services. Furthermore, PEPFAR/T will scale up distribution of HIVST at maternal and child health (MCH) settings as a strategy to reach PBFW within PMTCT services. The full AP3 surge plan is detailed in Section 4.3: PMTCT.

IIT is more common among new clients compared to established clients as indicted by programmatic data that show greatest client loss within the first six months of care. PEPFAR/T therefore, will continue to focus on the linkage-case-management (LCM) model, using an evidence-based approach established through the Bukoba Combination Prevention Evaluation (BCPE) in Tanzania.[14] Using the BCPE model, PEPFAR/T will continue to link new clients and re-engaged clients with expert clients who provide peer support for treatment continuity. In COP22, to improve retention of key and vulnerable populations, including orphans and vulnerable children (OVC), youth and men, PEPFAR/T will implement an extended BCPE to provide support beyond 60 days post-diagnosis for all newly diagnosed HIV. Extended BCPE will enhance adherence to care and treatment services as already demonstrated in many geographic areas in Tanzania. Additional plans to address IIT will be grounded in ongoing program monitoring and analysis to understand reasons behind disengagement to ensure interventions are tailored based on geographic and sub-population needs. In addition, PEPFAR/T will continue to scale-up MMD, escorted linkage, and navigations (using gender and age-appropriate peers), and improved friendliness of services). Pediatric DSD models as well as youth engagement in interventions towards children and adolescents living with HIV (C/ALHIV) shall be implemented and emphasized. PEPFAR/T will also strengthen its client treatment literacy package by adding language on the importance of rapid initiation of ART, discussion of drug-drug interactions with contraceptive agents, and the importance of CD4 rapid testing for

[14] Steiner C, MacKellar D, Cham HJ, Rwabiyago OE, Maruyama H, Msumi O, et al. Community-wide HIV testing, linkage case management, and defaulter tracing in Bukoba, Tanzania: pre-intervention and post-intervention, population-based survey evaluation. Lancet HIV. 2020 Oct;7(10):e699-e710.

clients with advanced HIV disease. PEPFAR/T will begin to support point-of-care CD4 in COP 22 and will work with GOT to ensure clear quantification and monitoring of cryptococcal meningitis. Current cryptococcal meningitis monitoring tracks those eligible, number screened, number screened-positive, number receiving preemptive fluconazole, and number receiving treatment. The GOT has developed a matrix for advanced HIV disease with additional indicators that will be incorporated into the CTC3 database.

PEPFAR/T will also leverage COVID-19 vaccination platforms to expand tuberculosis (TB) case finding and will work with GOT to explore revision of TB screening guidelines to include Chest X-ray especially for inpatients, addition of C-reactive proteins and TB lateral flow urine lipoarabinomannan assay (LF-LAM). Moreover, innovative approaches will be encouraged to improve TB screening for clients on 3 and 6MMD. PEPFAR/T is also advocating to introduce and scale up of TPT MMD in the context of ARV MMD for PLHIV.

Gaps in the clinic-laboratory interface also interfere in the delivery of timely and quality laboratory services, including early infant diagnosis and viral load testing. Incongruency between viral load test and 6-MMD results in missed opportunities for person-centered services. To address the challenges, PEPFAR/T and GOT will continue to build capacity at facility level, implement monthly indicators tracking of key components of the clinical cascade and strengthen the health information systems tracking specimens and test results. PEPFAR/T will also participate in a newly revived National Lab technical working group (TWG), which coupled with monthly supply chain meetings, will ensure minimal interruptions in the lab commodity supply chain.

Comprehensive prevention is also a priority. PEPFAR/T will be expanding into three new DREAMS councils in COP22 to ensure DREAMS activities continue to expand to reach the most vulnerable adolescent girls and young women. DREAMS program plans, including expansion priorities can be found in the DREAMS section of this document. PrEP expansion is also a key area of focus, and more details can be found in the PrEP section later in this document. Priority and new activities, including structural interventions for hard-to-reach populations, including KP, is also expanded on later in this document.

2.3 Investment profile

The G0T's commitment to end the HIV/AIDS epidemic by 2030 remains strong as we jointly work towards achieving UNAIDS Fast-Track Targets and the Sustainable Development Goals (SDGs). Both the Tanzania Commission for AIDS (TACAIDS) and the National AIDS Control Program (NACP) have developed ambitious strategic plans with targets to expand ART coverage to 95% for all PLHIV by 2025 and reduce new infections to only 15,000 annually by 2023[15]. However, domestic financing is a small fraction of the total needed amount for HIV funding, and disbursement does not meet budget levels. The Tanzania HIV/AIDS response is almost entirely donor funded. The major donors include the U.S. Government and GFATM. External funding accounts for 94% of the total HIV funding in 2022 as shown in Table 2.3.1.

[15] TACAIDS (2018). Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23

Although the GOT's contribution appears quite low, it should be noted that this assessment does not capture GOT investments in infrastructure or salaries paid by GOT to all health care workers and other staff supporting HIV/AIDS service delivery and other activities.[16]

Total HIV financing has been fluctuating, but almost flatlined from $681M in 2018 to $687M in 2022. This is expected to decrease to $657M in 2023. PEPFAR and the GFATM accounted for 88% of financing in 2018, 2019, and 2022, 86% in 2020 and 90% in 2021. Several other donors and partners beyond PEPFAR and the GFATM have provided small amounts of financial support and technical assistance.[17]

Table 2.3.1

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$350,634,768	7%	26%	67%	0%	
HIV Care and Clinical Services	$262,116,015	0%	34%	66%	0%	
Laboratory Services incl. Treatment Monitoring	$49,481,056	0%	0%	100%	0%	
Care and Treatment (Not Disaggregated)	$39,037,697	63%	7%	30%	0%	
HIV Testing Services	$56,490,289	4%	32%	64%	0%	
Facility-Based Testing	$36,258,851	0%	33%	67%	0%	
Community-Based Testing	$12,568,748	0%	10%	90%	0%	
HIV Testing Services (Not Disaggregated)	$7,662,690	32%	61%	7%	0%	
Prevention	$97,602,061	11%	11%	78%	0%	
Community mobilization, behavior and norms change	$27,918,605	0%	10%	89%	0%	
Voluntary Medical Male Circumcision	$32,942,254	30%	0%	69%	0%	
Pre-Exposure Prophylaxis	$9,904,939	0%	0%	100%	0%	
Condom and Lubricant Programming	$5,865,000	9%	73%	18%	0%	
Opioid Substitution Therapy	$4,144,285	0%	35%	65%	0%	
Primary Prevention of HIV & Sexual Violence	$184,793	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$16,642,185	0%	12%	87%	0%	
Socio-economic (incl. OVC)	$34,319,991	0%	23%	77%	0%	
Case Management	$13,650,372	0%	0%	100%	0%	
Economic Strengthening	$6,890,785	0%	0%	100%	0%	
Education Assistance	$3,266,962	0%	0%	100%	0%	
Psychosocial Support	$0					
Legal, Human Rights, and Protection	$487,318	0%	100%	0%	0%	
Socio-economic (Not Disaggregated)	$10,024,554	0%	74%	26%	0%	
Above Site Programs	$73,897,095	58%	5%	37%	0%	
HRH Systems	$3,098,554	0%	0%	100%	0%	
Institutional Prevention	$1,313,421	100%	0%	0%	0%	
Procurement and Supply Chain Management	$4,237,720	0%	19%	81%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$9,485,419	0%	28%	72%	0%	
Laboratory Systems Strengthening	$6,516,955	0%	0%	100%	0%	
Public Financial Management Strengthening	$1,573,355	0%	1%	99%	0%	
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$5,079,523	0%	4%	96%	0%	
Laws, Regulations and Policy Environment	$358,333	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$42,233,815	98%	0%	2%	0%	
Program Management	$43,398,789	0%	13%	87%	0%	
Implementation Level	$43,398,789	0%	13%	87%	0%	
Total (incl. Commodities)	**$656,342,993**	**12%**	**21%**	**67%**	**0%**	
Commodities Only	**$204,435,201**	**0%**	**54%**	**46%**	**0%**	
% of Total Budget	*31%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

16 Report of National Aids Spending Assessment (NASA) Study for Financial Years 2015/16,2016/17,2017/18 And 2019/2020 In Tanzania Mainland

17 (2019). Tanzania HIV Investment case 2.0

Table 2.3.2

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$109,051,620	0%	55%	45%	0%	
Laboratory Supplies and Reagents	$42,426,395	0%	30%	70%	0%	
CD4	$0					
Viral Load	$26,938,711	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$15,487,685	0%	83%	17%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$341,550	0%	37%	63%	0%	
Essential Medicines	$136,987	0%	8%	92%	0%	
Tuberculosis Medicines	$204,563	0%	56%	44%	0%	
Other Medicines	$0					
Consumables	$21,796,959	0%	92%	8%	0%	
Condoms and Lubricants	$4,507,451	0%	100%	0%	0%	
Rapid Test Kits	$15,807,241	0%	99%	1%	0%	
VMMC Kits and Supplies	$1,482,267	0%	0%	100%	0%	
Other Consumables	$0					
Health Equipment	$447,826	0%	100%	0%	0%	
Health Equipment	$447,826	0%	100%	0%	0%	
Service and Maintenance	$0					
PSM Costs	$30,370,850	0%	58%	42%	0%	
Total Commodities Only	**$204,435,201**	**0%**	**54%**	**46%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Low levels of domestic financing present several challenges, including sustainability of domestic resource mobilization. Currently, the domestic funding is contributing to human resources, infrastructure, and program management. Support for commodities, which is the largest program expenditure, is nearly entirely donor funded. Critical prevention services are also mainly financed by donors. PEPFAR/T will continue to collaborate and coordinate with GOT and the GFATM to address key human resource gaps that stand as key barriers to fully implementing activities required for epidemic control. PEPFAR/T will support the establishment of and be part of a new TACAIDS-led technical working group focused on sustainability. The group will develop a road map that incorporates all necessary components of sustainable HIV epidemic control. A foundational aspect of this group is to help establish indicators/metrics to measure progress towards sustainability through enhanced local ownership and increased domestic financing of the HIV response.

The split of commodities between PEPFAR/T and the GFATM continues to be an area of strong collaboration across the two largest donors of the HIV response in Tanzania. The GFATM prioritizes commodities for ARVs, GeneXpert, TPT, rapid test kits (RTKs), chemistry/hematology, and laboratory commodities including CD4 and biochemistry. On the other hand, PEPFAR/T will support ARVs and commodities for HIV drug resistance, cryptococcal meningitis, PrEP, HPV DNA testing, TPT, viral load (VL), early infant diagnosis, VMMC, MAT, and HIV-1 recency test kits.

PEPFAR/T was able to allocate funding sufficient to cover all commodities as outlined in the COP22 supply plan tool. The next national quantification is scheduled in April 2022. The results will inform some minor commodity revisions and final orders.

The GFATM maintains the same level of funding as in previous funding cycle, dedicating 84% of its grant budget to commodities. On the other hand, PEPFAR/T dedicates approximately 20% of its COP22 budget for commodities.

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	$11,419,271.00	12	$42,314,809.00	USAID's maternal and child health programs work to ensure that all women and children have the same chance of a healthy life, regardless of where they are born (Njombe, Morogoro, Iringa, Ruvuma, Lindi & Mtwara).
USAID TB	$7,000,000	$2,250,000.00	7	$47,421,371.00	USAID's TB program targets to reach every person with the disease, curing those in need of treatment, and preventing the spread of new infections and the progression to active TB disease (Arusha, Kilimanjaro, Manyara, Singida & Dodoma),
USAID Malaria	$42,000,000	$14,471,600	6	$106,535,580	USAID has supported efforts under the U.S. President's Malaria Initiative (PMI) to improve prevention through insecticide-treated bed nets (ITNs), indoor residual insecticide spraying, and prevention of malaria in pregnancy. Additionally, PMI activities control the spread of malaria by assisting prompt diagnosis and treatment, disease surveillance, human resources capacity, malaria awareness, and healthy behaviors. In partnership with Tanzania's National Malaria Control Program and the Zanzibar Malaria Elimination Program (Arusha, Kilimanjaro, Manyara, Singida & Dodoma),
Family Planning	$25,000,000	$13,850,000.00	12	$46,526,314.00	USAID supports voluntary family planning programs in Tanzania that improve contraceptive access in public health facilities,

					ensure consistent availability of family planning commodities, and raise awareness of available services through social marketing, mass media, and community outreach (Arusha, Kilimanjaro, Manyara, Singida & Dodoma),.
CDC (Global Health Security)	$950,000	$ 600,000	1		Co-funding is for NIMR GHSA
Peace Corps - appropriated	$ 2,160,000	0	0	$ 2,823,746	Volunteers and their community counterparts engage with students to transfer Knowledge, Skills, and attitudes through: • Employing General teaching skills in Math and Science using STEM approach. • Improving school functions of facilities that support teaching and learning of Math and Science. • Improving safe schools trainings that focuses on addressing Gender based violence in school settings. • Volunteers and Counterparts receive training to build their capacity in teaching communities Behavior Change and Communication (BCC) messages.
Peace Corps - SPA	$ 240,975	0	0	0	• Printing malaria materials on BCC that are approved by National Malaria Control Program for use by counterparts and Volunteers • Volunteers and their counterparts are trained on improved agricultural practices who later transfer the knowledge to farmers and assist them to adopt these practices.
Total	$87,950,000	$42,590,871	$38	$242,798,074	

2.4 National sustainability profile update

In collaboration with UNAIDS and the GOT, PEPFAR/T completed the latest Sustainability Index Dashboard (SID) in 2021 to assess the country's sustainability landscape and to assist all HIV/AIDS stakeholders in making informed HIV/AIDS investment decisions. The SID 2021

findings have been shared with key stakeholders and have been used to guide COP22 above-site level budgeting priorities.

Tanzania's performance on the 2021 SID demonstrates the presence of strong systems to support a sustainable HIV control response. Since the inception of the SID in 2015, we have seen gradual improvement across all elements and domains, although the changes since 2019 have plateaued (Figure 2.4.1). While donor investments seek to continue to build and promote systems that are sustainable, Tanzania still receives substantial external financing for its national response to HIV/AIDS, as noted above. The GOT investment is mainly directed to supporting above site interventions. COP22 priorities in these areas will support resource tracking and advocate for domestic resources for HIV/AIDS services through the AIDS Trust Fund (ATF), strengthen the implementation of efficient and adoptive activity-based costing and management and well as development of clear roles and responsibilities in sustaining the response as we get close epidemic control. In addition, in COP22 PEPFAR/T will explore options for private sector contributions to further address the resource gap for HIV prevention activities at the community level; like a private public partnership existing in the education sector in Tanzania. The new sustainability technical working group led by TACAIDS will provide a forum for these conversations.

Cross-cutting investments from HIV funding sources have strengthened the health system. However, insufficient host country investments in both HIV and the health sector more broadly, is preventing Tanzania from reaching its full potential for sustaining the HIV national response and building a resilient health system.

Figure 2.4.1: Tanzania Sustainability Index and Dashboard (SID) 2021

Sustainability Analysis for Epidemic Control: Tanzania

Epidemic Type: Generalized
Income Level: Lower middle income

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43	5.33	9.50	9.79
2. Policies and Governance	3.85	6.96	7.83	7.18
3. Civil Society Engagement	4.17	3.83	7.08	6.67
4. Private Sector Engagement	4.86	4.13	9.03	8.50
5. Public Access to Information	5.00	6.00	7.33	8.56
National Health System and Service Delivery				
6. Service Delivery	3.38	3.98	6.11	6.59
7. Human Resources for Health	5.00	5.60	6.96	6.51
8. Commodity Security and Supply Chain	4.94	4.25	5.40	5.22
9. Quality Management	5.19	5.62	5.76	6.71
10. Laboratory	4.33	5.83	6.56	4.98
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	1.94	3.21	5.32	5.48
12. Technical and Allocative Efficiencies	3.17	4.67	4.93	3.60
13. Market Openness	N/A	N/A	9.33	9.50
Strategic Information				
14. Epidemiological and Health Data	4.70	4.17	6.35	6.66
15. Financial/Expenditure Data	4.58	5.00	8.33	8.33
16. Performance Data	5.99	6.97	7.00	6.50
17. Data for Decision-Making Ecosystem	N/A	N/A	6.33	6.43

2.4.2 Sustainability strengths

As noted above, the sustainability landscape as demonstrated by SID 2021 assessments reveal areas of slight improvements and some areas of slight decline as compared to SID 2019 across the four domains. Under the *Governance, Leadership and Accountability domain* strengths include the presence of the national multi-year strategy to respond to HIV, the system for

planning and coordination which is participatory across stakeholders, and engagement of the private sector in both policy and strategy. The policies and guidelines for service delivery are also aligned to international standards as per WHO guidance. The process of reviewing the National Multi-Sectoral Strategy and development of the Health Sector HIV Strategy to align with the Global AIDS Strategy and Political Declaration is currently underway.

The National Health System and Service Delivery is another area of emerging sustainability, but few changes were noted from the SID 2019 scores. Slight improvements were observed for *Quality Management* from SID 2019 due to increased accountability in service delivery at health facilities which has improved quality management of HIV services. The National Quality Improvement Framework has also been implemented successfully. Improvement and utilization of the DHIS-2 system, to capture data on various programs including HIV, and supervision visits have improved the capacity of healthcare workers to identify quality gaps and act accordingly.

On the *Strategic Financing and Market Openness*, there were some improvements from SID 2019 with the highest scoring being Market Openness (9.5). This increase was due in part to the fact that there are no policies that limit the ability of licensed private providers from offering HIV services, or that limit the ability of local manufacturing of HIV commodities if they are pre-qualified by WHO.

Other areas of sustainability strength worth noting under the ***Strategic Information*** domain is the progress made in the Financial and Expenditure Data element**.** The Government of Tanzania continued to demonstrate strong leadership, through Ministry of Health (MOH) and TACAIDS, to collect HIV expenditure data as well as 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), 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. Phase one of ABC/M identified opportunities for increased efficiency such as continues patient centric care with differentiated service delivery models between stable and non-stable patients, reducing patient waiting time by improving the patient flows and further integration of HIV services in the service delivery system. It was noted that consumables represent 84 percent of the overall cost for service delivery hence PEFAR/T will continue to focus on the supply chain to improve efficiency and logistics management systems using a bottom-up approach.

2.4.3 Sustainability vulnerabilities

The SID exercise also helped identify critical issues that require further investments and ownership to ensure sustainability. Within the ***Governance, Leadership and Accountability*** domain, it is noted that ART and other HIV commodities, including Procurement and Supply

Management (PSM) costs are primarily externally funded. There is an acute lack of domestic funding through government budget to support the implementation of HIV/AIDS program. The ATF has increased their ability to create more incentives for the private sector to finance HIV services but still the mobilization is low. The GOT provides medicines for opportunistic infections based on the essential medicines list. In times of stock-out, clients are offered prescriptions and must access the medication elsewhere. This highlights a need for improvement in adequate funding for the supply chain systems and commodities availability. The recently developed CSO Engagement Strategy provides an opportunity to strengthen collaboration with CSO and expand their role in the HIV program. Availability of National Strategies for HIV such as the presence of the national multi-year strategy puts Tanzania in a good SID Score. However there still more work required to support integration of these strategic documents and guidelines in the healthcare delivery systems by building capacity of Health Care Workers (HCWs) to apply them in service delivery.

On the ***Strategic Financing and Market Openness*** domain, there was a decline in the **Technical and Allocative Efficiencies** element (3.60 in 2021 as compared to 4.93 in SID 2019) due to the lack of systems that could provide routine costing data through the Government of Tanzania.

Another area of sustainability vulnerability is in the **Domestic Resource Mobilization.** While national budgets have explicit funding for HIV/AIDS, only a small percentage of the national HIV response is financed with domestic resources, and often the funds budgeted aren't disbursed. Data in the UNAIDS' Investment Case (2021), and the draft reports of the National Health Accounts (2019/ 2020) indicate that external sources (PEPFAR and GFATM) accounts for over 88% of financing for HIV/AIDS from 90% in prior year.

Although there were demonstrated improvements in the ***National Health System and Service Delivery*** from SID 2017 to 2019 due to an increased capacity of service providers to deliver HIV services, no significant improvements were observed in SID 2021. This underscores the need for strategic thinking amongst stakeholders and national authorities. A call to action for more domestic funding for systems strengthening and human resources in service delivery is needed. Specific areas include service delivery which did not show significant improvements from SID 2019. DSD models are being implemented in the country for HIV services. Community structures for HIV services have improved in the past two years, but challenges remain in the domestic financing for HIV services as per recent National AIDS Spending Assessment (NASA) report which affects both planning and monitoring of HIV services.

Also, it is worth noting a significant drop in the Laboratory score from 6.56 (SID 2019) to 4.98 (SID 2021). The National Laboratory Strategic Plan 2016- 2021 is operational (with laboratory being a directorate at the Ministry of Health) which helps to institute national regulations and standards for laboratory services in the country. Nevertheless, funding for laboratory strengthening is quite insufficient with less than 50% coming from domestic resources. The number of laboratory technologists and scientists is also inadequate to support the whole country. A scale up plan for viral load services is externally driven and focuses on reaching

people and maintenance of testing capacities. This implies the need for further investment to sustain these structures and systems for laboratory strengthening.

Another element showing vulnerability is performance data under the Strategic Information domain. While the Government of Tanzania plays a key role in collection and reporting on service delivery through several health information systems (HMIS), namely, care and treatment center (CTC)2, CTC3, and the District Health Information System (DHIS). The resources needed to collect service delivery data by the Government of Tanzania is not a straightforward calculation. Many data collection technicians, from council levels and upwards, are supported by government, but at facility level, operational costs are also covered by IPs (funded through PEPFAR or GFATM).

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 oversees the creation of an enabling environment and incentive for the private sector to support the HIV response via domestic resources 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. Faith based organizations (FBOs) primarily fit into the latter category. Tanzania has made progress engaging with the private sector and creation of incentives for their contribution to ATF such as the exemption of income tax for companies that contributes to ATF. However, challenges still exist with disproportional domination by the 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 to support the HIV response, but capacity is limited for most facilities and TACAIDS can take leadership and coordinate these efforts.

In COP22, PEPFAR Tanzania will continue to engage all stakeholders, especially GOT, to optimize key HRH needs to sustain the gains amid disruptions to the health system and the healthcare workforce across the HIV continuum of care caused by COVID-19. The implementation of 6MMD and Community Based Programs are expected to easy the workload of the health facility staff and increase community led monitoring. PEPFAR Tanzania will continue to optimize performance of the existing contracted health care workers (HCWs) in all PEPFAR sites and support additional workers where needs arise with the understanding and expectation that GOT will absorb these HCWs into public service.

2.4.4 Funding for the HIV epidemic

In COP22, PEPFAR Tanzania's budget decreased by $1M (0.2%) from the COP21 budget. The Government of Tanzania continues to implement GFATM grants for the 2021 – 2023 implementation period. In the current GFATM HIV grants, Tanzania is receiving US$380,599,183 for the three-year cycle, although, 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 United States Government (USG) and GFATM for ARV procurement. The fiscal environment, together with the elements of *Domestic Resource Mobilization* and *Technical and Allocative Efficiencies***,** is 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 COP22 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. The new TACAIDS technical working group focused on sustainability will provide a forum for more focused discussions on sustainability with the goal of pulling together a roadmap to ensure Tanzania can maintain epidemic control once achieved.

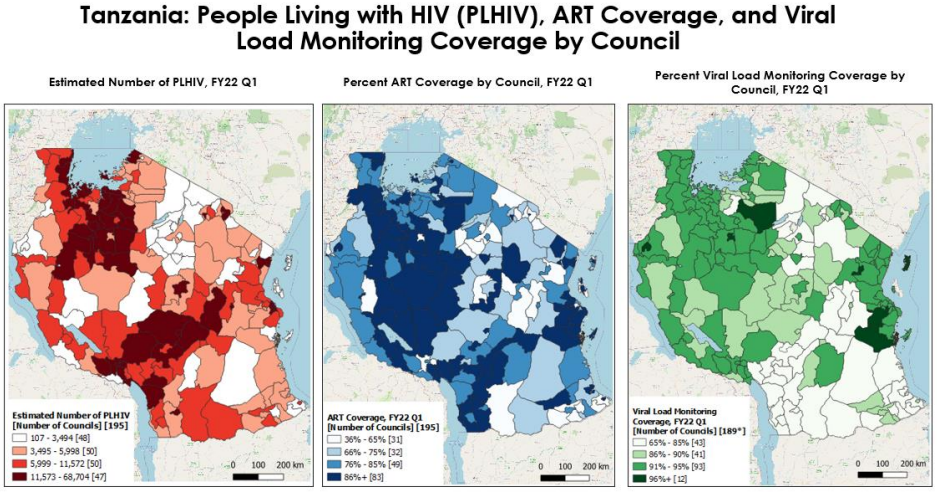
2.4.5 Transition to indigenous partners

PEPFAR/T is committed to continuing and protecting the progress that has been made over the past 19 years in Tanzania. In COP22 USG agencies will continue to promote local capacity development, and to responsibly transition to indigenous organizations that will effectively fulfill PEPFAR's mandate. PEPFAR/T is strategically positioning to contribute to the global goal of having 70% of funds transitioned to local partners in COP22. PEPFAR Tanzania 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 Tanzania will expand broad based community service interventions and human resources provision through local partners. 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 stream. PEPFAR/T will also conduct a landscaping analysis of local partners and CSOs that are currently receiving PEPFAR funding with the goal of identifying additional partners that are ready and/or would require minimal capacitating to receive funding directly. As part of this landscaping, and emphasis will be placed on identifying KP-led and women-led CSOs.

2.5 Alignment of PEPFAR investments geographically to disease burden

The map in 2.5.1 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 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 testing capacity in recent years resulted in clear improvements although COVID-19 has impacted continued progress over more recent months.

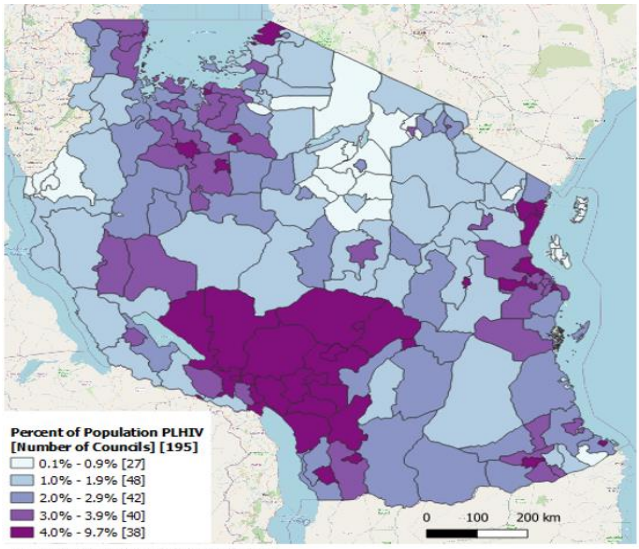
2.5.1: PLHIV, ART coverage and viral load coverage by council



Sources: PEPFAR COP22 Datapack, DATIM FY22 Q1 TX_CURR, GoT CTC3 Database

The map in 2.5.2 displays PLHIV as a proportion of the estimated population from Spectrum models in each council (estimated prevalence). Councils in the Lake Zone, the Southern Highlands and around Dar es Salaam tend to have the highest proportions of PLHIV compared to total population estimates.

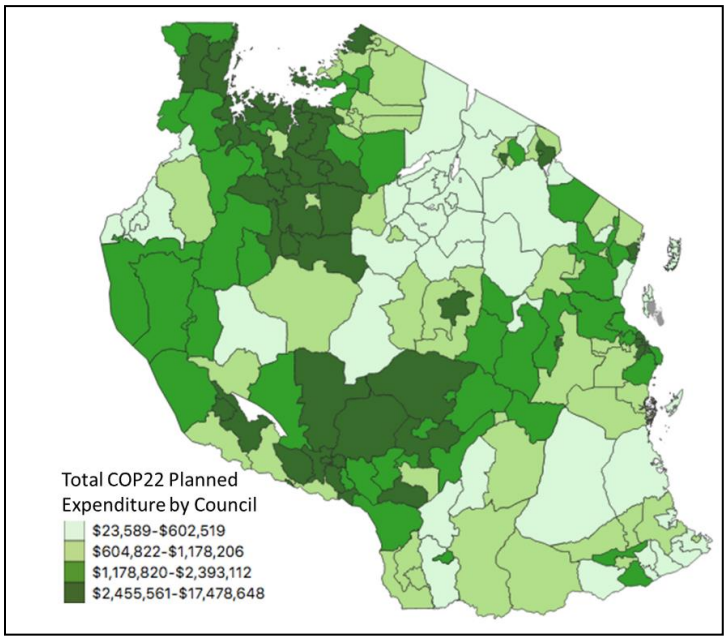
2.5.2: Estimated percentage of PLHIV by council



Sources: PEPFAR COP22 Datapack

To determine if budgets appropriately aligned with HIV disease burden in Tanzania, 2.5.3 map display COP22 planned expenditures. These can be compared with the most recent Spectrum PLHIV estimates in Map 1. Many PLHIV reside in the Lake Zone, the Southern Highlands, and Dar es Salaam. Therefore, a proportionate amount of the COP22 budget will continue to be invested in those geographic areas.

2.5.3: COP22 Planned Expenditures by Council



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 follow up THIS 2022-2023 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 COP22 beginning in December 2021 when the COP22 draft guidance was shared with GOT representatives, CSO representatives, development partners, United Nations (UN) agencies, and IPs. These stakeholders were encouraged to provide feedback to OGAC through the designated channels.

In mid-December 2021, PEPFAR/T leadership shared the COP22 timelines with all stakeholders - GOT (TACAIDS, Presidents Office Regional Authority and Local Government (PO-RALG), MOH), CSOs, and Development Partners. Stakeholders were requested to select representatives to attend the COP22 Virtual Planning meeting, scheduled for early March 2022 as well as for the Stakeholder meetings scheduled in mid-January, to ensure their full

participation in COP22 planning process. In mid-January 2022, the final COP22 Guidance and the Planning Level Letter (PLL) were shared with all stakeholders.

During the week of January 31, 2022, PEPFAR/T held a COP22 Strategic Planning Workshop during which the COP22 programmatic, technical, policy priorities, various COP inputs, and tools were discussed. More than 150 stakeholders attended the meeting. Participation on the first day of the meeting was limited to PEPFAR, WHO, UNAIDS, and GFATM and focused on discussion of minimum program requirements and identifying programmatic and policy areas of mutual interest and advocacy with an emphasis on program equity and sustainability. On the second day of the meeting, participation expanded to include senior leadership from GOT, TACAIDS, PO-RALG, and GOT-Zanzibar who joined COP planning for the first time officially in more than five years. Discussion on this day was focused on clarifying PEPFAR priorities, discussing progress towards minimum program requirements, addressing the new minimum program requirement and other PLL guidance, as well as discussing GOT priorities. On the subsequent days of the meeting, participants expanded to include civil society, and additional staff from GOT, development partners, and PEPFAR. These days were focused on small group technical discussions to make strategic plans and decisions for COP22 implementation. Three of the small groups were dedicated respectively to discussing sustainability, the new minimum program requirement focused on stigma and discrimination, as well as program equity for key populations. Time was also 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 COP22 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), KVP Forum, National Council of People Living with HIV (NACOPHA), and the Adolescent and Young Adults (AYA) Steering Committee elected representatives to attend the COP22 Virtual Planning Meeting. A total of seven CSO representatives from these constituencies were identified for focused engagement on COP22 planning, including attendance at the Virtual Planning Meeting. The CSO representatives worked with their constituencies to develop a presentation on COP22 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 that also considered priorities outlined in Tanzania's "People's COP" document, which had been developed as part of COP21 planning. These updates were shared during a CSO-led meeting in late February 2022 and ultimately formed the basis for their presentations and discussions during the Virtual Planning Meeting.

The GOT selected a delegation of representatives to attend the Virtual Planning Meeting, including the Deputy Minister of Health, Chief Medical Officer at MOH, several representatives from NACP, a representative from TACAIDS, and PO-RALG, and one representative from the MOH in Zanzibar. A small meeting with this delegation and PEPFAR was convened prior to the VPM to delve further into GOT priorities and seek alignment on key programmatic and policy items on the COP 22 agenda. 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 and engage in further discussion on COP22 priorities.

As the COP is finalized and throughout FY22 and FY23, 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. Monthly meetings between PEPFAR/T and the MOH technical staff will continue to share and review monthly PEPFAR/T data, review policy adoption and implementation, and ensure implementation continues during COP21 and COP22. PEPFAR/T will continue regular engagement with the GFATM to coordinate procurement of commodities procurement, supply chain coordination, and to ensure program activities are complementary.

2.7 Stigma and discrimination

Tanzania has laws and policies that condemn stigma and discrimination. Tanzania's National HIV Policy of 2001 promises to combat stigma, while the HIV/AIDS Prevention & Control Act (HAPCA) 28/2008 prohibits discrimination against PLHIV. More recently, the National Multisectoral Strategic Framework (NMSF) for 2019-2023 aims to eliminate HIV stigma and discrimination and calls for a national strategy to address these issues. This new national strategy will be spearheaded by TACAIDS and meetings to kick-off strategy development commenced in March 2022. In addition, laws and policies exist that criminalize acts associated with KPs, such as commercial sex work and sex between men (e.g., Penal Code [Chapter 16], 1981). The Tanzania Stigma Index surveys, conducted in 2013 and 2021, indicate that the proportion of PLHIV who have experienced stigma and discrimination has decreased from 28% to 5.5% in just eight years' time. While this is significant progress, the 2021 Stigma Index indicated that there are still certain regions of Tanzania that experience high rates of stigma (e.g., 19.5% in the Kilimanjaro region) and that individuals still experience difficulties disclosing their status. Notably, this survey did not include female sex workers, people who inject drugs, or men who have sex with men, who often face higher rates of stigma and discrimination. This gap will be corrected in COP22. GFATM has agreed to support supplemental stigma index surveys for these important sub-populations.

UNAIDS will assess Tanzania's legal and political environment to inform advocacy and sensitization efforts to affect policy change. NACOPHA will engage lawmakers through quarterly educational reviews on legislation that reduces stigma, and advocate for changes to discriminatory laws and policies. PEPFAR will advocate for TACAIDS to create a sub-TWG on stigma and discrimination to monitor implementation of the new policy, once finalized. PEPFAR/T will also explore possible synergies with existing USG platforms that monitor human rights abuses and develop rapid response strategies that focus on HIV-related stigma and KP issues. This will include support for a KP Crisis Committee. In addition, PEPFAR/T will help develop, implement, and monitor workplace policies on stigma and discrimination, including issues related to disclosure, in both the private and public sector. Finally, PEPFAR/T will increase legal literacy among PLHIV and KP and will facilitate access to relevant legal and social protection services.

To ensure that these policy changes have a positive impact on stigma and discrimination, PEPFAR will work with local community leaders in regions with the highest reported rates of stigma. In 2020, NACOPHA convened the five main religious denominations in Tanzania to sign a national commitment to fight HIV stigma and discrimination and reduce sexual violence. Building on this momentum, in COP22 PEPFAR/T will expand its engagement with faith leaders and the media, using materials and lessons learned from the Faith & Community Initiative (FCI). PEPFAR will educate communities on stigma and discrimination by using HIV Ambassadors and PLHIV groups to expand U=U messaging. PEPFAR will also integrate stigma and discrimination awareness into health care worker trainings. This will including pre-service training as well as developing an e-learning module for in-service training for current practitioners. As part of Site Improvement Through Monitoring Systems (SIMS) and other site-level monitoring efforts, clinical partners will ensure that the Patient's Bill of Rights is posted and visible in all PEPFAR-supported health facilities, and PEPFAR will continue to advocate for the adoption of user-friendly HIV service delivery options, including community ART refill options led by PLHIV expert clients. Lastly, NACOPHA will increase social accountability by expanding CLM into additional councils and foster a systematic process for KP-led CLM. NACOPHA will also review the current CLM data collection tools to ensure that stigma and discrimination are assessed and addressed through continuous quality improvement activities.

To optimize and coordinate PEPFAR's efforts against stigma and discrimination in Tanzania, PEPFAR will identify stigma and discrimination focal persons within each agency and IP.

3.0 Geographic and Population Prioritization

Table 3.1 below summarizes ART saturation and progress towards 95/95/95 across all mainland regions, and geographic areas accordingly. PEPFAR/T is set to attain 88% ART coverage in the highest PLHIV burden regions by the end of FY22. Total ART coverage for all regions by the end of FY22 is also expected to reach 88%. COP22 program planning will continue to prioritize these regions through ambitious targets in the same regions that we focused in COP21, with an expectation to achieve coverage level of 93.1% in these highest prevalence regions. Focused technical programs within these high prevalence regions will look to focus on harder to reach populations for increasing ART coverage, including 15–30-year-old with the goal of achieving 95% VLS. Furthermore, expected expansion of key community-based programs for OVC, KP, and DREAMS beneficiaries into other high burden councils within these regions, will ensure increased coverage and support for critical facility-community linkages. In addition, PEPFAR/ T will conduct THIS 2022-2023 that will provide updated accurate information related to where we need to focus, moving forward for future COP23 planning.

The THIS 2016-2017 found 57% men aged 15-29 were circumcised, leaving a remaining gap of 1.7 million men to be reached. Since 2017, PEPFAR/T conducted more than one million circumcisions.. Despite this overall success, challenges have been reported. Factors affecting adult male uptake of VMMC services include distance to facility, concerns over privacy when seeking the service at facilities, economic constraints, emotional reservations, perceived irrelevance, and traditional and cultural norms. Available data suggest we have achieved

saturation in almost all regions hence the need to obtain new estimates through THIS 2022-2023. In COP22, our strategy is to focus on regions/ councils where we have continued to find and successfully circumcise large numbers of uncircumcised men.

In COP22, PEPFAR/T will continue to be operational in 197 councils in the country. Comparisons for COP21 estimates versus COP22 Spectrum Naomi estimates show a decrease of roughly 15,000 PLHIV from COP21 based on updated inputs of national ART data, ANC surveillance data, as well as supplemental auxiliary data sources. Decreases in PLHIV were noted in Rukwa, Simiyu, Njombe, and Katavi, while increases were noted in Mjini Magharibi, Kilimanjaro, Manyara, and Mara. COP21 CLHIV estimates versus COP22 NAOMI estimates show a decrease of 7% from 92,569 to 85,357, respectively. While estimates for CLHIV <1year remained relatively stable over time, other age bands have fluctuated, with a notable 7% decrease for estimates for the 5-9 age band and a 37% decrease within estimates for the 10-14 age band. Despite these fluctuations, PEPFAR/T aligned programming efforts with epidemiologic data and burden of disease at the council level, including population density and total number of PLHIV and unmet need for ART.

Progress made in service delivery over the last three years will be maintained in COP22. PEPFAR/T will continue to implement key interventions in priority districts with the 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 continue to have the highest PLHIV burden and are being prioritized for enhanced activities in COP22. Among the 35 districts within the Lake Region, seven districts (across four regions) maintain the largest coverage gaps and will be prioritized for enhanced programming including KVP activities.

Following impressive progress made in reaching and surpassing the 90-90-90 goal of community VLS in COP20 Tanzania has embarked on the 95-95-95 goals with a focus on gaps that have been identified during COP21 FY22 Q1. In COP22, PEPFAR/T will continue to prioritize case finding among men, KP, infants, children, AGYW, where performance is lagging. PEPFAR Tanzania will enhance efforts to target men 15-49 years old in Dodoma, Kilimanjaro, Kaskazini, Pemba, and Kusini Pemba regions which show the highest gap in treatment coverage for men according to newest estimates. 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, while also taking into consideration differentiated service delivery models for KP amongst this population. In FY23, PEPFAR/T will continue supporting the scale-up of the HIVST to cover all regions, targeting men, key and vulnerable populations.

Table 3.1 The status of ART saturation and progress towards 95/95/95 across all regions

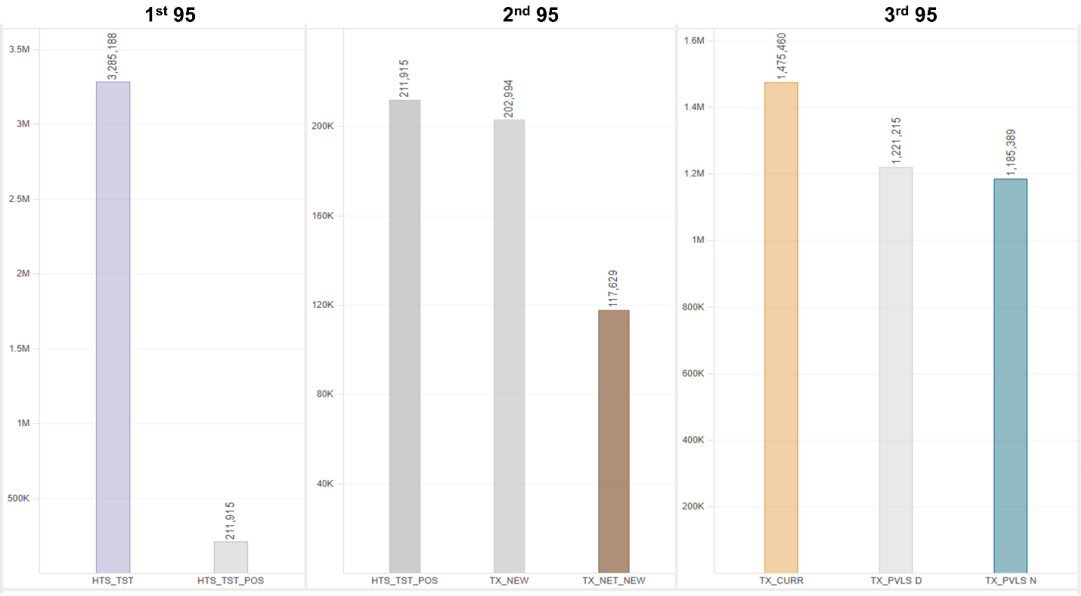
Region	COP21 PLHIV	FY22 Target	FY22 ART Coverage	COP22 PLHIV	COP22 New infections	COP22 PLHIV + New Infections	FY23 TX_CURR Target	FY23 ART Coverage of PLHIV (+ New Infections)	FY23 PVLS_D	FY23 PVLS_N
Dar es Salaam	220,782	185,042	84%	225,365	5,820	231,185	196,313	84.9%	168,785	168,785
Mwanza	144,977	127,746	88%	141,942	3,899	145,841	136,482	93.6%	118,326	115,788
Mbeya	142,492	124,620	87%	136,670	3,268	139,938	130,213	93.0%	102,898	100,083
Kagera	99,573	87,000	87%	98,409	2,466	100,875	96,661	95.8%	85,197	83,811
Tabora	90,281	78,603	87%	88,537	2,266	90,803	86,080	94.8%	72,034	71,078
Iringa	86,475	75,938	88%	81,283	1,706	82,989	76,767	92.6%	53,421	52,299
Geita	81,005	70,518	87%	75,726	2,054	77,780	74,598	95.9%	64,797	63,607
Morogoro	79,106	70,135	89%	74,483	2,062	76,545	70,560	92.2%	45,171	43,593
Shinyanga	77,298	72,173	93%	76,789	1,948	78,737	73,113	92.9%	48,967	48,049
Njombe	70,755	62,148	88%	65,102	1,365	66,467	63,371	95.3%	51,015	49,836
Ruvuma	63,505	55,928	88%	63,084	1,475	64,559	58,267	90.3%	43,813	42,169
Tanga	62,591	56,695	91%	63,437	1,636	65,073	62,875	96.6%	51,139	49,911
Mara	59,434	55,101	93%	66,436	1,873	68,309	60,517	88.6%	55,162	53,639
Dodoma	48,749	42,429	87%	52,851	1,593	54,444	47,923	88.0%	41,921	40,693
Pwani	48,223	47,821	99%	46,158	1,109	47,267	48,155	101.8%	33,953	33,177

Songwe	47,917	41,874	87%	46,285	1,135	47,420	45,249	95.4%	39,144	38,102
Simiyu	43,356	34,011	78%	39,544	1,118	40,662	37,359	91.9%	31,291	30,594
Mtwara	41,056	35,890	87%	43,920	1,141	45,061	41,407	91.9%	31,302	30,164
Kilimanjaro	40,169	35,865	89%	45,306	1,405	46,711	42,896	91.8%	30,478	29,604
Arusha	38,493	33,456	87%	38,318	1,115	39,433	36,380	92.3%	26,795	25,856
Rukwa	34,507	30,025	87%	30,064	792	30,856	32,109	Wwdrftr4cx78	26,552	25,768
Lindi	28,795	25,195	87%	28,748	713	29,461	27,456	93.0%	24,445	23,655
Singida	27,142	23,658	87%	29,333	936	30,269	27,598	91.2%	20,518	20,004
Kigoma	26,023	22,117	85%	28,299	844	29,143	24,777	85.0%	22,277	21,827
Katavi	24,499	21,906	89%	22,593	608	23,201	24,403	105.3%	18,734	18,283
Manyara	18,498	16,401	89%	20,716	663	21,379	18,991	88.8%	16,117	15,505
Military	N/A	26,478	N/A	N/A	N/A	N/A	24,202	N/A	23,065	21,912

4.0 Client-Centered Program Activities for Epidemic Control

An emphasis on COVID-19 mitigation will continue to cut across all PEPFAR/T's interventions, as part of our client-centered approach to services and activities. COVID-19 vaccination is the most effective public health tool to prevent COVID-19 and its severity in the current pandemic context. Therefore, PEPFAR/T has been working with GOT to expand access to COVID-19 vaccines in CTCs to make it convenient for PLHIV to get vaccinated and reduce missed opportunities for vaccination. Targeted efforts have also been leveraged by PEPFAR/T to get health workers vaccinated against COVID-19. In many regions in Tanzania, PEPFAR/T has supported GOT to fully vaccinate more than 50% of PLHIV and 90% of health care workers. In COP22, PEPFAR/T will continue leveraging integrated platforms in coordination with ongoing initiatives to accelerate COVID-19 vaccination through Global VAX, COVAX, GFATM, and Africa CDC. Moreover, PEPFAR/T will continue ensuring appropriate infection prevention and control measures are functional in PEPFAR-supported facilities. It should be noted that scaling up of MMD has substantially decongested CTCs, which contributes to an enabling environment for COVID-19 mitigation. More broadly, PEPFAR/T remains committed to leveraging its supported infrastructure and systems to strengthen COVID-19 mitigation, preparedness, and response in Tanzania.

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



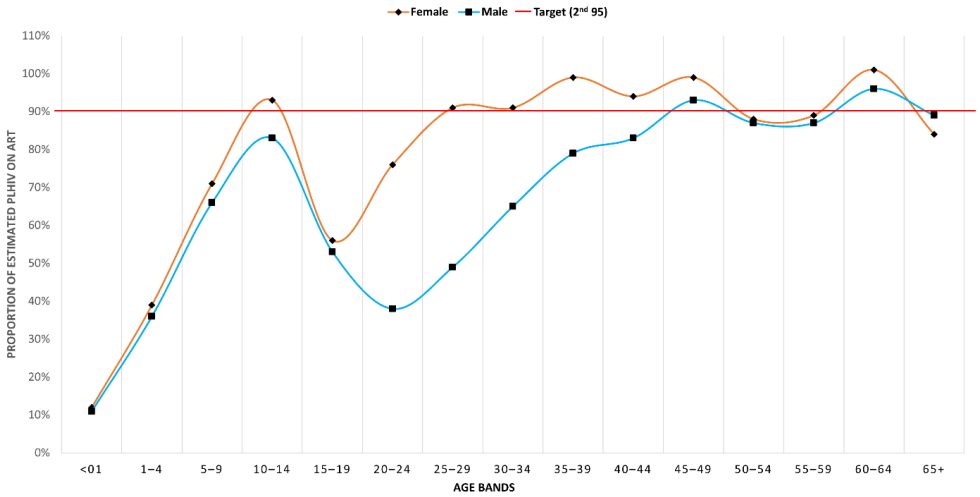
The THIS 2016-2017 showed that in 2016-2017, only 61% of PLHIV in Tanzania knew their status, which was the lowest among all countries with substantial PEPFAR investment. Tanzania has since made remarkable progress towards UNAIDS 95-95-95 targets for HIV epidemic control by using client-centered approaches to identify PHLIV, link them to treatment, and ensure their continuity of care. For example, in FY21, Tanzania tested 3,285,188 people for

HIV and identified 211,915 PLHIV, of whom 202,994 were linked to care and treatment (with a proxy linkage rate of 96%). By the end of FY21, there were 1,475,460 clients currently on treatment in Tanzania. Viral load testing was conducted for 1,221,215 of clients, of whom 1,185,389 (97%) were virally suppressed (Figure 4.0.1).

In FY23, client-centered program activities will be re-emphasized as a core pillar of delivering targeted and equitable HIV services in Tanzania. Part of this client-centered approach will include use of granular data to identify people at greatest risk for HIV and reach them with targeted interventions. PEPFAR/T has already seen success with these methods and will continue to adapt them to address client needs. PEPFAR/T will leverage lessons learned from maintaining activity implementation during the COVID-19 pandemic to enhance progress to date. PEPFAR/T was successful in adapting to the COVID-19 pandemic by delivering client-centered services and in FY21, despite the ongoing pandemic, Tanzania added 202,994 people on ART. The successes in identification and linkage in Tanzania during this period is attributable to the implementation of high-quality index testing, optimized PITC, and targeted community-based testing approaches. Preliminary data from the second Tanzania HIV Impact Survey 2022-2023 are expected by FY23 Q2. Preliminary data insights from the THIS 2022-2023 will be rapidly used to recalibrate the delivery of client centered programming in FY23 Q3 and Q4 and will be used to inform COP23 planning.

Although the gaps across the clinical cascade are improving, there is still inequity by age, sex, and geographic regions. The most recent ART coverage estimates show that the treatment gap is largest among children ages 0-14 years, AGYW, and young boys and men (Figure 4.0.2). PEPFAR/T will continue working with MOH and IPs to optimize HIV testing and linkage to care with an emphasis on young adults and KVPs. To reach Tanzania's goals of achieving UNAIDS 95-95-95 targets, a combination of HIV testing services (HTS) approaches will be sustained and scaled-up in FY23. These include index testing and HIV self-testing to increase identification of PLHIV through client-centered approaches at facility and community-based settings, including the use of social network testing to reach KVPs more effectively. In addition, continued attention to pediatric identification efforts will continue through the AP3, with an emphasis on testing of HIV-exposed infants and index testing of biological children of mothers living with HIV. Enhanced tracking of mother-baby pairs will be scaled up nationally.

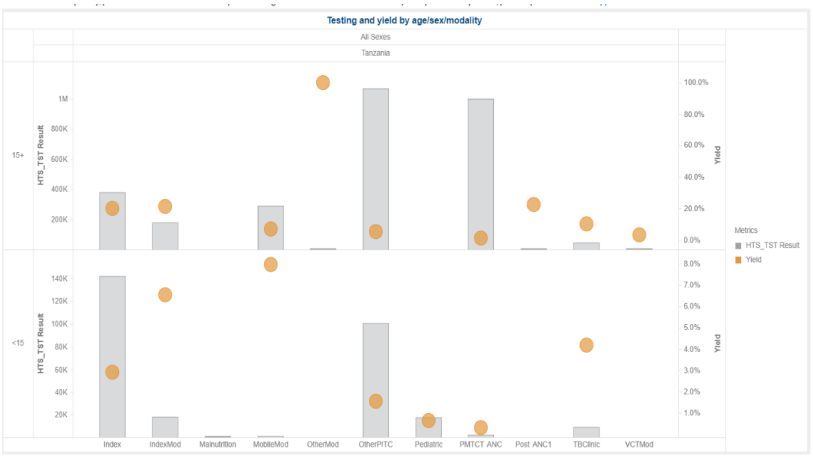
Figure 4.0.2 Estimated ART coverage by Sex and Age, FY22 Q1



Note: Denominator = Estimate from Naomi model; Numerator = TX_CURR from FY22 Q1

4.1 Finding people with undiagnosed HIV and getting them started on treatment

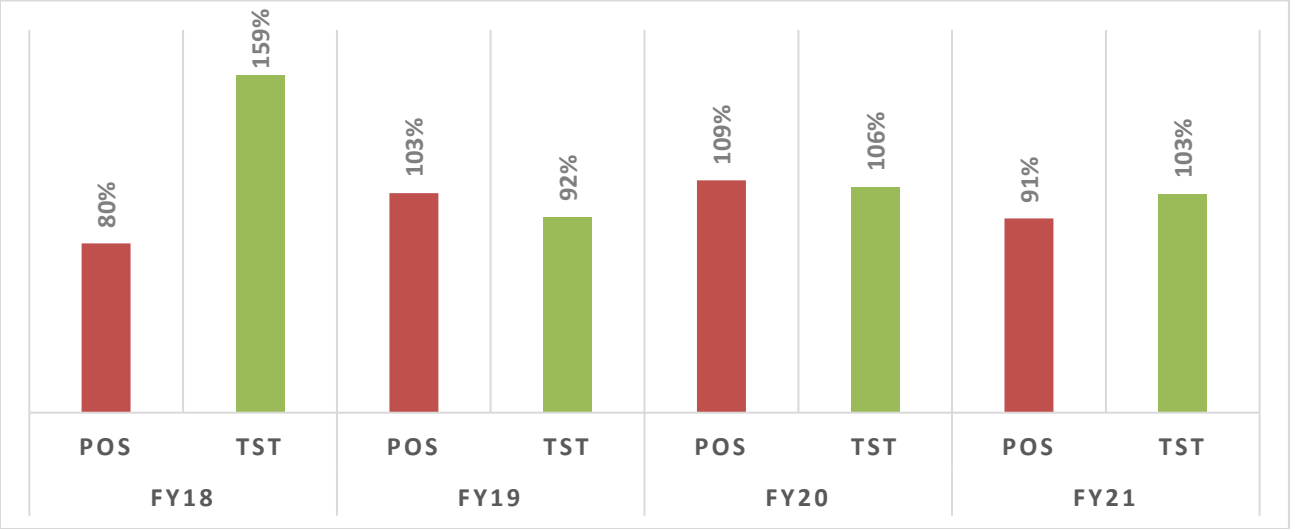
Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



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

Triggered by the THIS 2016-2017 results PEPFAR/T increased the quality and focus of HIV testing, care, and treatment services leading to improved identification, linkage, and maintenance of PLHIV in treatment services. Multiple targeted and high yield HTS approaches, such as safe and ethical index testing, optimized PITC, community mobile testing including social network testing, and scale up of HIV self-testing have improved case identification especially among hard to reach and priority populations. Due to continued focused testing efforts, PEPFAR/T has maintained high positive identification achievement in FY21 with continued reduction in over testing as seen in Fig 4.1.1A.

Fig. 4.1.1A: HIV Testing and Positive Achievements Against Target Trends

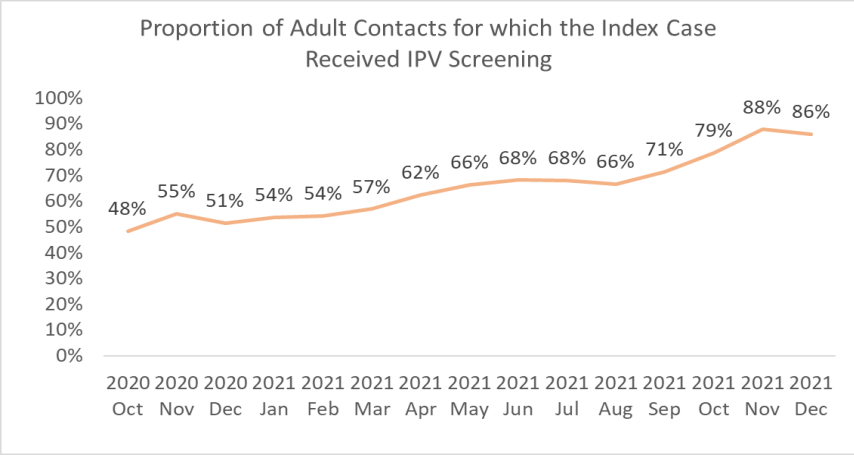


In COP22, PEPFAR/T will continue to monitor and scale evidence-based, high yield, targeted testing modalities with specific focus on underserved population groups to ensure equitable access to testing, prevention, and treatment services. Index testing in community and facility settings continues to be the primary contributor to positive case identification, hence we will continue to ensure the services are scaled in line with confidentiality and ethics requirements. Furthermore, we will integrate HIV self-testing services with other testing approaches, such as index testing, to better reach index contacts, male partners of ANC clients, and KPs. PEPFAR/T is currently scaling pediatric index testing services and has been able to increase testing services to children including those who were otherwise missed through other HTS modalities such as EID, PITC and pediatric inpatient testing. In COP22, PEPFAR/T will continue strengthening pediatric case identification efforts, ensuring all biological children under 19 years of age elicited from women living with HIV as well as biological siblings of OVC living with HIV are reached for HTS services.

In COP20, PEPFAR/T, in collaboration with IPs, local government health officials, NACP, PORALG, and CSOs, completed an assessment of safe and ethical index testing at all PEPFAR sites and subsequently addressed gaps identified. For example, PEPFAR/T established a system to monitor IPV pre- and post-partner notification. These data are tracked monthly (Figure 4.1.1B) and has been instrumental to identify further areas for remediation in IPV screening practices and reporting. PEPFAR/T will continue working closely with IPs and healthcare workers to ensure that 100% of index clients receive IPV screening services pre-and post-partner notification in COP22. In COP22, community and facility partners will also strengthen gender-based violence (GBV) management by rolling out GBV screening and referrals in HTS settings. Providers at all PEPFAR sites will be capacitated to effectively advocate for positive gender norms and to assess GBV/IPV using the standardized screening questionnaire and provide first-line response to survivors of violence, using the Listen, Inquire, Validate, Enhance safety, and Support (LIVES) approach. PEPFAR will ensure that there are adequate post-IPV services available for PLHIV – either by referral or directly at the health

facility – prior to implementing index testing at any facility. All PLHIV who are screened will be offered information on IPV, and IPs will actively track all referrals. Partners will also work on improving the quality of post-violence care services. All health workers will be trained in IPV risk assessment. Trained providers will be able to provide appropriate referrals to safe space/shelters and linkages will be created with support groups and legal services. PEPFAR/T will monitor index testing implementation to ensure that sites are ensuring client safety during contact elicitation.

Fig. 4.1.1B: IPV Screening Trends



In FY20 and FY21, despite the limitations of COVID-19, PEPFAR/T demonstrated resilience in index testing as seen in the contribution of index positive clients identified and testing yield (see figures 4.1.1 C and 4.1.1D below), while deploying COVID-19 risk mitigation strategies. Although the absolute positive identification decreased from FY20 Q3 after COVID-19 emerged in Tanzania, index yield was maintained above 20%.

Fig 4.1.1C: Trend of Positive Identification and Index Testing Contribution Overt Time

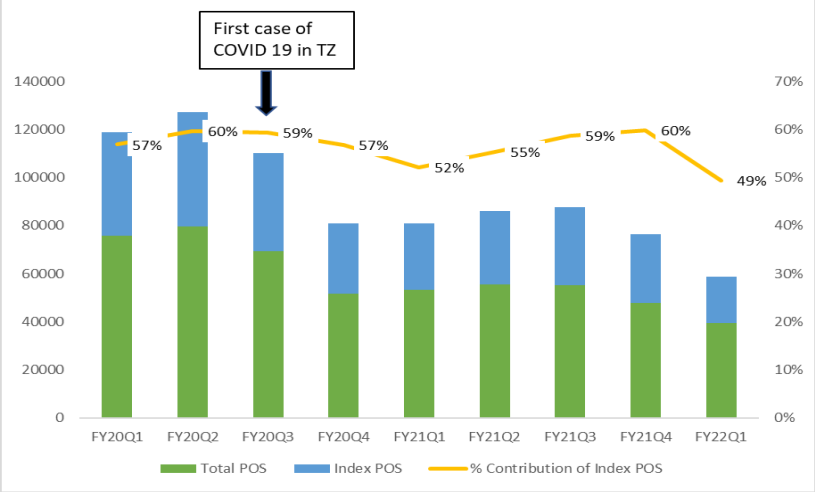
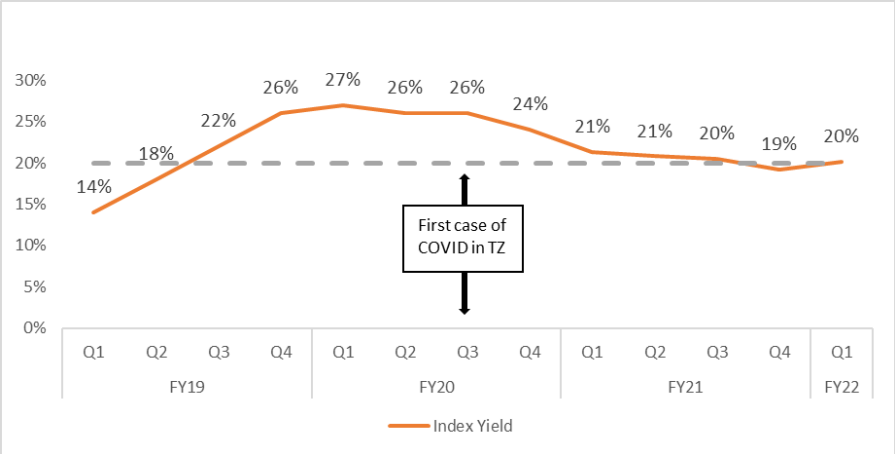


Fig. 4.1.1D: index Testing Yield Trend



All PEPFAR/T supported sites implement index testing, with a focus 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, PEPFAR/T monitors index testing services through the cascade approach, i.e., data on the number of sexual contacts identified per index case, the proportion tested, and the yield is tracked to determine performance at facilities and to identify the specific gaps requiring improvement. This approach demonstrated success in improving results.

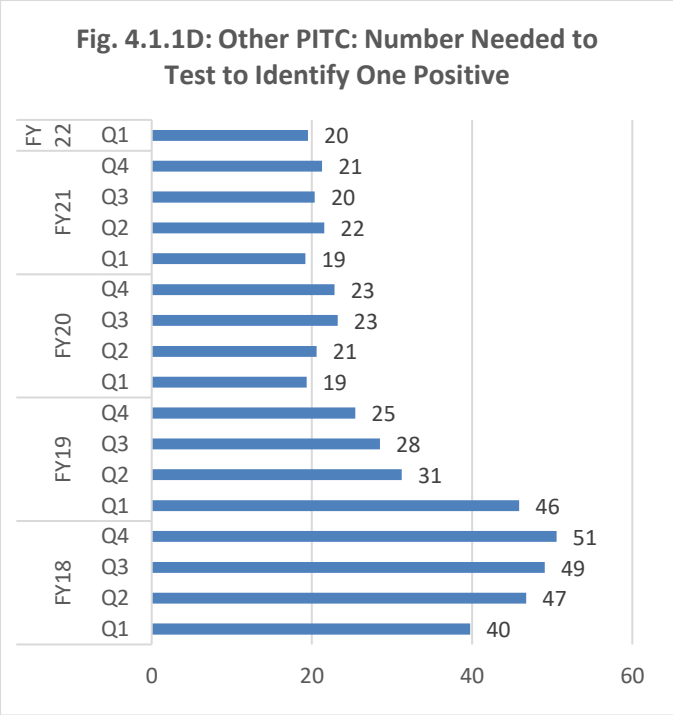
Successful Identification Strategies with COVID-19 risk mitigation measures

- Client centered index testing in 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 beneficiaries
- HIV self-testing scale up country-wide

As of COP21, the post-contact tracing adverse event screening for index clients includes physical and non-physical violence, undesired disclosure of status, identity, and conditioning of services on participation in index testing, and was developed with input from civil society organizations. The site-level assessment tool of *Index Testing Minimum Requirements* continues to be used to ensure sites are implementing index testing safely and ethically. Site level data from this assessment is shared with civil society and other stakeholders. Sites will undergo remediation measures if they do not meet the minimum requirements including joint review with PEPFAR staff, and index testing will be paused if remediation measures aren't immediately implemented. Results of adverse event tracking are monitored regularly along with performance against other indicators, triggering immediate action and reported in PEPFAR /T monthly reporting portal through partners, program oversight and accountability response team (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.

PEPFAR/T in collaboration with MOH, completed the development of an HIV risk screening tool training package, training of healthcare workers and country wide scale up of HIV risk screening for HTS among pediatric, adolescent, and adult clients attending facility outpatient department (OPD). Close monitoring of optimized PITC services is on-going through various platforms, to ensure quality screening and testing services. PEPFAR/T will continue to use regular quarterly implementing partner meetings to review reports on index testing site assessments, the index testing cascade, and IPV screening indicators.

This monitoring includes assessment of the number of clients needed to test to identify one HIV positive client (NNT). The figure on the right shows how this number declined with the introduction of the screening tool and has remained relatively constant since FY20. In COP22, PEPFAR/T will continue ensuring the use of the national HIV risk screening tool across supported facilities. Furthermore, in collaboration with MoH, PEPFAR/T will finalize validation of the national adult HIV risk screening tool.

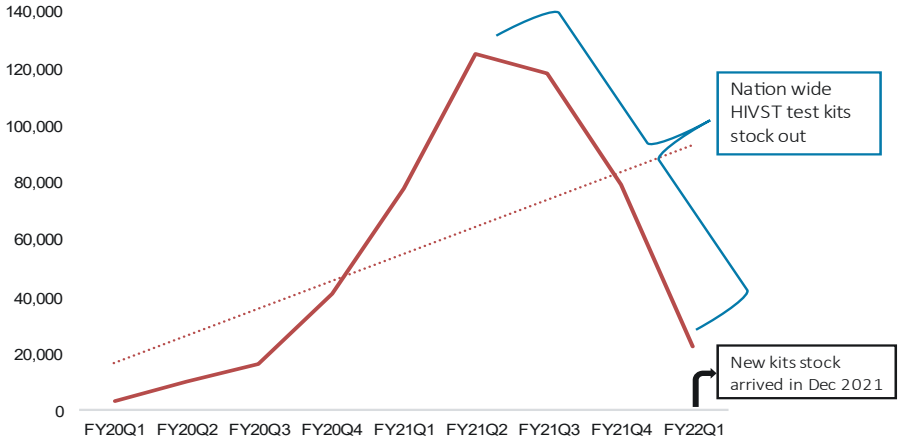


PEPFAR/T will continue to strengthen targeted client-centered, facility-led, community case finding strategies with high yield, focusing on KVP in community settings. PEPFAR/T has also introduced Social Network Strategy (SNS) as an HTS modality in facility and community settings, which focuses on testing networks of contacts (social, sexual, and drug-injecting) of HIV-positive KVP. SNS is a peer-led approach has led to a positive contribution of about 9% and a yield of 7%. PEPFAR/T will continue to scale up SNS whilst integrating it with other modalities like index testing and HIVST. Close monitoring of high-risk networks will be deployed to ensure we are reaching the targeted populations through SNS.

In COP22 client-centered, facility-led, community-based testing will continue to focus on high-risk areas informed by mapping of KVP hotspots, concentrations of PLHIV, and recent HIV infection surveillance data. These interventions will sustain positivity yield and will decrease testing in low burden areas. PEPFAR/T will continue to use community-based testing strategies as a best approach to close testing gaps among men. PEPFAR/T will also continue to employ nighttime and moonlight testing activities to reach KVP and communities surrounding KVP hotspots, integrating these efforts with other HTS modalities such as SNS and HIVST. IPs will utilize venue-based testing, social network testing, and mobile clinic trucks providing comprehensive HIV services (including clinical and lab services) to access hard-to-reach communities.

PEPFAR/T, scaled up HIVST services in community and facility settings with a focus on high risk and hard to reach populations, including men. This includes an approach to distribute HIVST kits in the context of index testing. Currently, nearly 80% of HIVST are distributed to females, including FSW. The figure 4.1.1F below, shows the successful scale-up of HIVST through FY21 Q2. Unfortunately, due to a country wide HIVST kits stock-out, services were disrupted through FY22 Q1. Stock is currently available, and PEPFAR/T is working closely with GFATM and the GOT to ensure continuous availability of HIVST kits and to draft a national operational plan to guide future distribution. In COP22, as we will leverage and integrate HIVST distribution into other HTS modalities. PEPFAR/T will also support HIVST awareness campaigns to increase knowledge of self-test kit use and create demand for HIVST. PEPFAR/T will embrace innovative approaches such as digital solutions to enhance HIVST distribution and tracking of results.

Fig. 4.1.1F: HIV Self-test Kits Distribution Trends

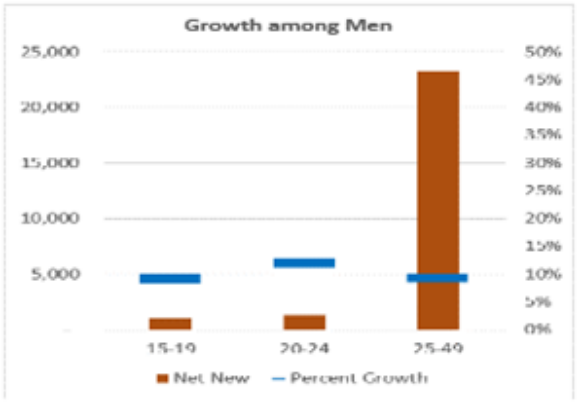


PEPFAR/T, in collaboration with GOT, will continue to support client-centered, facility-led, community ART initiation and refills services with a focus on KP. We will continue strengthening and supporting PLHIV-support groups and networks to improve adherence to achieve VLS for adults and children living with HIV. PEPFAR/T will implement the evidence-based LCM model, assigning all newly initiated PLHIV to a PLHIV expert client to support adherence to ART and promote early retention to care and treatment. LCM has enabled PEPFAR/T to address the high attrition observed among PLHIV within the first six months of ART. Additionally, IPs will emphasize bi-directional referral systems, particularly for PLHIV, to increase access to care and treatment services, as well as for HIV-negative individuals to ensure linkage to prevention programs that reinforce risk reduction. PEPFAR/T will bolster M&E efforts 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 utilized services. IPs will monitor data weekly and monthly and adapt the HTS program accordingly. PEPFAR/T will continue to analyze program progress by population sub-groups, age, and gender to identify and address program challenges and use the data to improve client-centered targeted testing and linkage to treatment services.

Adult men

Based on FY22 Q1 program data, PEPFAR/T continues to struggle with identification of HIV-positive men and initiating these men on treatment. Finding men was a priority in 2020. However, this was impacted by overall decreases in testing in the context of COVID-19. Despite this decrease, the data shows growth in "new clients on treatment," (TX_NEW) resulted in the person-level benefit of increasing the number of men on ART. Figure 4.1.2 illustrates the "net new clients on treatment," 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 continue to emphasize the use of Social Network Testing as one of the new client-centered intervention targeting men, complementing index testing and HIVST.

Finally, targeted testing through private sector workplace programs has demonstrated success to improve HTS access among men and is an area when continued attention for elimination of stigma and discrimination is vital. PEPFAR/T will intensify distribution of HIVST in male-dominated workplaces, both public and private (as well as formal and informal) workplaces.

PEPFAR/T's FY21 annual report showed that VLS is consistently lower among males than females across all age groups. To improve treatment outcomes among males, PEPFAR/T will build on past 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 do not miss their appointments. Optimal DSD models that include 6MMD and community ART distribution will also be targeted to men. PEPFAR/T will engage and adopt the evidence based male-focused interventions to address ongoing gaps in reaching men.

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 index testing that promotes more complete enumeration of sexual partners, by engaging expert clients (ECs) for index contact elicitation and notification. Based on recent data, ANC HIV testing coverage is very high, with 99% of pregnant women receiving HIV testing at the first ANC visit. The program will introduce HIVST for high-risk females in facility and community–based settings. PEPFAR/T will resume reporting in the eight regions where HIV testing services had been transitioned to GoT to track PMTCT program performance across all PEPFAR-supported regions. Strengthening systems for maternal re-testing will also strengthen PMTCT efforts. PEPFAR/T will strengthen retention counseling through same-day and weekly tracking of clients

to ensure they are linked and maintained on treatment. This will include regular updates of national tools, as well as monthly, data driven, patient follow-up among beneficiaries of PMTCT. Furthermore, PEPFAR/T will strengthen and integrate viremic clinics in facilities with high volume to promote VLS. Lastly, PEPFAR/T will continue to support family-centered approaches and GBV/IPV screening services as part of these testing activities.

Pediatrics

The 2021 program data show persisting gaps in identifying pediatric populations living with HIV despite increases resulting from efforts to scale up pediatric index testing. 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) testing for OVC and siblings of HIV positive OVC, and (4) risk screening for children aged 2 to 14 years.

In FY20 PEPFAR/T achieved 81% of EID testing coverage at two months, which is an increase from 72% in FY19. This achievement is attributed to an increase in the number of facilities offering point of care testing (POCT) particularly in hard-to-reach locations; mentoring health care workers on collection of quality dry bloodspot (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 improved documentation in mother-child cohort registers, HIV-exposed infant (HEI) cards and individual electronic records.

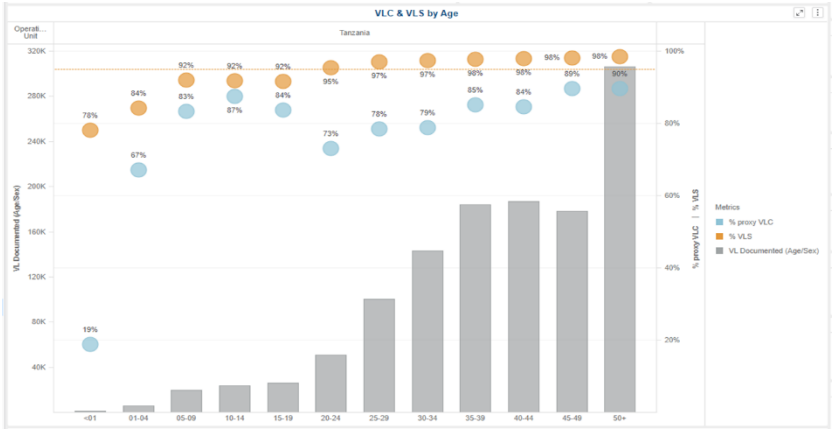
PEPFAR/T is working to maintain all the approaches that worked over the past years to ensure a systematic approach is used to identify all HEI through screening, use of immunization cards, and increasing EID sample collection at six weeks immunization visit. PEPFAR/T will also work to monitor and improve 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 will review files of mothers and children at PEPFAR supported sites to track and ensure linkage and to ensure that mother-baby pairs are on the same scheduling cycle to avoid multiple trips to the facility. 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 with the goal of ensuring that all children born to HIV-positive mothers are tested before they are 2-months of age.

HEI testing is currently conducted using Roche CAP/CTM platforms – which are being phased out - and GeneXpert platforms (near point of care). DBS continues to be the standard sample collection method for EID and the MOH has finished a pilot on the use of whole blood for EID in POCT platforms. Guidance from MOH on the way forward for this method is forthcoming. Staff at facilities are trained for DBS collection and sample management based on standard operating procedures. The results from the planned DNO will inform use of GeneXpert platforms for TB, EID, and VL for special groups, and multiplexing will be an important consideration. PEPFAR/T will continue to support mentorship and supervision on the use of the mother-child cohort

register to improve EID data quality and will leverage the OVC platform to increase HEI referrals for EID.

As per 2022 UNAIDS estimates, the estimated number of CLHIV aged 0-14 in Tanzania has steadily declined over time which can be attributed, in part, to PEPFAR/T's PMTCT program. PEPFAR/T is working to close critical gaps in the current response to the HIV epidemic in children in Tanzania, notably in the first and third 95s, which includes strengthening index testing for children below 19 years, strengthening person-centered services, bolstering the mentor-mother model, and bidirectional referrals with OVC services. PEPFAR/T has also initiated comprehensive community outreach to provide DBS, HVL testing, COVID-19 vaccination for adults, ART, and immunization services to reach remote populations.

During COP22, PEPFAR/T will enhance optimized PITC at inpatient, TB, and malnutrition wards and increase the use of risk screening tools in outpatient among 2–14-year-old children while simultaneously monitoring the mother's HIV risk and testing status for children under two years of age. PEPFAR/T will strengthen pediatric and adolescent friendly services to improve retention and VLS. In addition, viremia clinics will address challenges faced by unsuppressed children.



VLS is another key area of focus for children and adolescents. We have seen progress in VLS since we started rolling out DTG 10mg to children weighing at least 20kg. Children aged 0-4 lag behind their older peers. Improvements are expected with the roll out of DTG 10mg to start mid FY22. Tanzania is on track for DTG 10mg introduction and rollout and supports complete optimization of pediatric ARV regimens to ensure full uptake of DTG 10mg with immediate linkage to services (in line with Test and Start guidelines) for infants who test HIV-positive. The DTG 10mg is included in Tanzania's National HIV/TB Treatment Guidelines. PEPFAR/T will work with GOT and GFATM to ensure no stock out of pediatric ARVs. Nevirapine regimens have already been phased out.

Strengthened site mentorship will ensure HCWs understand and are competent in ART dose adjustment and guidance for transition to optimal regimens. To improve VLS, PEPFAR/T will also conduct site-level analyses to assess for timely identification of adolescents and children who may still be using inferior ARV regimens and fast track enhanced adherence counseling and regimen changes to eligible pediatric and adolescent clients.

In COP22, PEPFAR/T will continue to support PLHIV-led community-level treatment literacy support for PBFW on the importance of treatment and adherence for CLHIV. Mother-to-mother mentor programs will ensure WLHIV are recruited as peer mothers and emphasize the need for viral load testing for both babies and mothers to ensure that mothers and children with high viral

load receive immediate support. Use of POCT for VL among pediatric clients will improve timeliness of treatment support, especially for those with VLS challenges.

Focusing on cities with high burden

Based on THIS 2016-2017 results PEPFAR/T has been focused on increasing the quality and coverage of HIV testing and care and treatment services in high burden cities. Targeted community testing approaches will be implemented with fidelity in these cities, with a focus on reaching 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 testing will be integrated into 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.

Intensified TB case-finding, optimized TB/HIV care and treatment and TB prevention

People living with HIV are approximately 20 times more likely to develop TB disease than those without HIV. In 2021, WHO estimated 28,000 PLHIV developed TB disease in the country, but country data shows that only 18,300 people received TB and HIV integrated services. Furthermore, 30% of all HIV-related deaths were due to TB. Ensuring early detection and treatment for TB as well as preventing TB among all people living with HIV is crucial for reducing morbidity and mortality.

Looking in the TB cascade among PLHIV for FY21 in PEPFAR/T supported areas, 1.8% of PLHIV in HIV clinics screened positive for TB which is on par with FY20 data. All PLHIV, including CLHIV, in community and health facility settings will be screened for TB using the WHO four symptom screening and/or chest x-ray. Those identified as presumptive for TB will have sputum rapid molecular testing. Health care workers at PEPFAR supports sites will be capacitated to perform TB screening in every client encounter, including in the context of MMD and COVID-19 activities. Integrated specimen referral systems will be strengthened to ensure access to rapid molecular testing among PLHIV in accordance with WHO recommendation. The GOT guidance currently does not include the introduction of TB-LAM in routine practice. The GOT will consider use of stool for rapid molecular diagnosis through operations research in a small set of pilot sites. PEPFAR/T will work with GOT towards revising TB screening guidelines to include Chest X-ray, especially for inpatients, as well as offering C-reactive protein and TB LF-LAM for eligible patients.

In FY21, PEPFAR/T was able to support TB identification of 8,578 (18% of those screened positive for suspected TB) PLHIV. This is relatively lower compared to 9,306 TB identification among PLHIV in FY20. There has been increase in access to GeneXpert platforms for TB molecular testing, but sub-optimal utilization remains to a problem. Underutilization is due to erratic supply of GeneXpert cartridges and frequent breakdown of GeneXpert modules. In the next implementation period, PEPFAR/T will monitor utilization of GeneXpert machines for TB diagnosis among PLHIV, functionality of GeneXpert platforms, and will use DNO results to identify additional strategies to improve access and utilization. PEPFAR/T will continue conversations with GFATM and GOT to increase resource allocation for GeneXpert cartridges.

Since the country is considering introduction of Truenat plus, PEPFAR/T will use lessons on the implementation of the Truenat plus pilot to explore approaches for the scale up.

Once TB disease is ruled out, people living with HIV are evaluated for and provided TPT as part of comprehensive package of HIV care. TPT coverage increased from 45% (FY19) to 74% (FY21). It is important to note that TPT completion among PLHIV has consistently hovered at around 88% for the last three fiscal years. Adverse effects, prolong period of treatment, and high cost of patient travel to the facilities for drug collection are the major factors for low completion rates. In COP22, PEPFAR/T in collaboration with GOT and IPs will reach 100% of all eligible PLHIV on ART. In COP22, all eligible PLHIV, including CLHIV, will be initiated on TPT and monitored until completion. CLHIV will also initiate cotrimoxazole, where indicated. In addition, PEPFAR/T will support implementation of shorter TPT regimens for adults while phasing out Isoniazid with minimal wastage. PEPFAR/T will also work with GOT to finalize the Latent TB Infection policy guide and ensure different models are in place for the delivery of TPT services among PLHIV. PEPFAR/T will also support introduction and scale up of delivery of TPT in the context of Differentiated Service Delivery for ART among PLHIV.

In PEPFAR/T supported sites HIV identification and ART initiation in TB clinics is at 99% for children, adolescents, and adults. To sustain this performance, PEPFAR/T will continue to drive patient-centered care for all TB and HIV co-infected patients and support implementation of differentiated service delivery for these patients. PEPFAR/T will continue to integrate TB care into ART service delivery including PMTCT, MCH, KVP, and adolescent program settings. Treatment monitoring will be central to ensure adverse events related to treatment are detected early and managed.

4.2 Ensuring viral suppression and ART continuity

During FY21, PEPFAR/T had overall VLS of 96%. The suppression rate has shown a consistent upward trend since FY19. This success is attributed to successes in ARV optimization among pediatric and adult PLHIV on treatment; utilization of regional, district and facility multidisciplinary teams to improve the quality of services through intensive monitoring of client adherence; close follow up of clients needing enhanced adherence counselling and prioritizing their repeat viral load tests; engaging expert clients to promote awareness and support other clients to achieve and maintain VLS.

The overall VLC for FY21 was 86% which is a 10% increase compared to FY20. This improvement is attributed to improved quantification and availability of viral load laboratory reagents in country; establishing viral load champions at sites, who review all files to ensure eligible clients that are attended on each day are not missed for samples collection before leaving the site. Additionally, monthly triangulation of viral load data between the laboratory information system (LIS) and CTC2 database to address undocumented results, use of stickers to label month for sample collection and demand creation through provision of viral load health talk has also contributed to the FY21 performance. Although the viral load testing backlog has been cleared, EID backlogs remain a challenge. PEPFAR/T will work with the MOH to ensure these backlogs are cleared and will continue to collaborate with the MOH to address the remaining supply chain challenges by working towards use of the Global RFP and advocating

for review of shelf-life requirements to ensure they are in line with WHO guidance. We will also strengthen monitoring strategies that will increase GOT accountability, including regular supply review meetings, and quantification exercises that include all components of the HIV response including commodities for cryptococcal meningitis.

VLS and VLC among CLHIV <15years has increased in FY21, however it is still lagging compared to adults, particularly in children below five years of age. Specific strategies to address this challenge include enhancing U=U by introducing specific demand creation messages and activities targeting caregivers, pregnant women, and the young population and transition of all remaining children to optimal ARV regimens including the use of DTG10mg among the young age group. PEPFAR/T will strengthen adherence counselling and psychosocial support and include outreach to schools. The program will continue to expand viremia clinics for children. As noted earlier, PEPFAR will support PLHIV-led, community-level treatment literacy support for PBFW, strengthening the mentor-mother program, and strengthen POCT of viral for children.

During FY21, PEPFAR/T had a 12-month retention rate of 96% among established clients and a 12-month retention rate of 90% among new clients. Retention in both these groups has shown a consistent upward trend since FY19 Q2. This improvement is the result of successful coverage of continuity of treatment responses to all PEPFAR supported facilities. This included appointment reminders; 3 and 6 MMD for eligible clients; same day tracking for missed appointments; enhanced community tracking through facility-community collaboration; close tracking of site level indicators to improve appointment adherence and reduce recent loss; extend linkage case management beyond 6 weeks up to six months for individuals at high-risk.

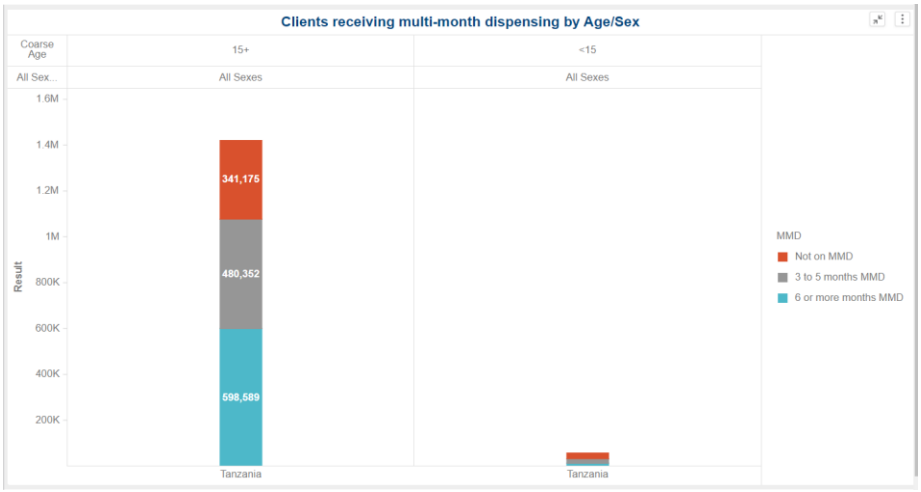
A continuity of treatment analysis of FY21 shows that of clients with IIT are those who have been on ART <3 months. At the end of FY21, IIT was also high among young adults aged 15-39 years at less than 3 months on treatment, with 12% of 15–19-year-olds experiencing IIT. Treatment continuity in key populations ranges as low as 41% in MSM to 73% in PWID in FY21.To address and prevent IIT in this group, PEPFAR/T will strengthen client-centered differentiated care including multi-month dispensing, expand community ART refill targeting young population; introduce special clinics with peer support and conduct client exit interviews to identify barriers and solutions for the areas that are affecting adherence.

In COP22, PEPFAR/T will ensure the implementation of tailored linkage and treatment continuity interventions by client/population through real-time data analysis, targeted case management approaches, and population-specific health education/literacy. Specifically, PEPFAR/T will strengthen the LCM and same day initiation of ARV to maintain 99% linkage to treatment. PEPFAR/T will continue to strengthen responses to IIT through expansion of monthly site level monitoring where quality improvement activities will address identified gaps. PEPFAR/T will also continue to expand multi-month dispensing and community-based ART refills to all eligible clients. PEPAR/T will also strengthen pre-appointment SMS reminders and approaches to track clients who miss clinical appointments. This will include the three-box model to reach out to clients the same day of a missed appointment, phone calls, and home visits. Health facilities will use on-transit registers to ensure immediate feedback to facilities. Data verification and triangulation between different data sources such as CTC2 and the

pharmacy module will be employed to track missing clients. Strengthening last desk verification of client contact information at each visit, including updating mapping data will ensure that clients are contactable.

PEPFAR/T will integrate ART and viral load sample collection in community outreach services and aim to synchronize appointments for different services to ensure multi-month dispensing is tied to facility and community viral load sample collection to avoid testing interruptions. Viral load champions will mark the dates for viral load sample collection and remind both clients and providers on their sample collection dates. Lastly, PEPFAR sites will ensure enhanced counselling on the importance of viral load sample collection dates during dispensing and at last desk to empower recipients to own their care.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21



This visual comes from: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

Figure 4.2.2 Viral Load Outcomes, FY21

This visual comes from: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

PEPFAR/T has conducted analysis on IIT at the district level and will implement strategies to improve continuity of care with a focus on clients new on treatment and young adults. PEPFAR is working with the GOT to improve morbidity and mortality outcome tracking, including infectious and non-infectious morbidities. An update on this progress and next steps can be found in Appendix D: Minimum Program Requirements. Efforts to strengthen treatment literacy at the community level is a key component of PEPFAR/T's strategies to promote adherence, track missing clients, and ensure VLS.

4.3 Prevention, specifically detailing programs for priority programming: HTS

In COP22, PEPFAR/T will continue to focus on HIV case identification in both facility and community settings. This will include scaling up index testing with fidelity and focusing on returning HTS services to pre-COVID-19 levels. PEPFAR/T will continue to ensure that index testing is implemented in a safe and ethical manner, aiming to increase IPV screening and support to 100% of clients. PEPFAR/T scaled up pediatric index testing services across supported sites and closely monitored the number of children elicited compared to testing rates to ensure 100% of children of women living with HIV (WLHIV) in supported facilities received index testing services. PEPFAR/T will continue leveraging other platforms such as immunization and under 5-year-old clinics, the OVC program, pediatric wards, and community outreach services to expand HTS services to other at-risk children. All children identified HIV positive will be linked to treatment services.

In COP21, PEPFAR/T introduced and scaled-up community and facility-based SNS across supported regions. This program was formally a component of community mobile testing but is now a separate HTS modality. In COP22 PEPFAR/T will continue to scale-up this program and will closely monitor different risk networks to ensure we are reaching targeted, high-risk populations. Through the SNS risk referral method, we aim to reach more high-risk negative individuals to be able to link them to prevention services, in addition to the HIV positive clients reached who will be linked to treatment. PEPFAR/T will continue to strengthen facility based SNS which aims to reach additional at-risk clients beyond elicited index contacts.

Scale-up of HIV self-testing has helped PEPFAR/T reach KPs, priority populations, male partners of ANC clients, serodiscordant couples, self-testing index contacts, mobile communities such as fisher folks and miners. These groups were then linked to conventional testing for confirmatory tests and then linked to either treatment or prevention services. In COP21 PEPFAR/T continued to observe high HIV self-testing return rates of approximately 90% with an average yield of 6%. In the beginning of COP21 services were interrupted due to supply shortage. Now that supplies are in country, PEPFAR/T will continue to ensure distribution of HIV self-test kits in a variety of settings including community outreach services, in-patient and outpatient service delivery, immunization services, ANC, index testing, and SNS. PEPFAR/T is currently fast-tracking distribution of HIVST kits considering the supply shortage earlier this year. Through close monitoring of the population groups reached by different distribution modalities, PEPFAR/T will continue to strategically expand the distribution of HIVST while also

strengthening linkage to treatment or prevention services. PEPFAR/T will work closely with stakeholders such as GFATM and GOT to ensure continuous, adequate stock is available within country and strong monitoring systems are in place to support efficient distribution of test kits across sub-national units (SNUs) and priority sub-national units (PSNUs). As noted earlier, PEPFAR will support HIVST awareness campaigns to improve understanding and uptake of HIVST.

HTS is also offered routinely for AGYW enrolled in the DREAMS program. PEPFAR/T will continue to strengthen identification efforts within the DREAMS programs including integrating other HTS approaches such as HIV self-testing, SNS, and index testing to ensure we reach additional at-risk AGYWs and their sexual partners. Linkage and continuous monitoring of DREAMS beneficiaries receiving prevention services such as PrEP will continue through the DREAMS programs with routine HTS according to national guidelines. All clients who test negative will be linked to on-going prevention services and will be enrolled on PrEP if indicated. PEPFAR/T continued sustaining high linkage rates of 95% among identified HIV positive clients to treatment services, and the same efforts are on-going in COP21. Using data, we will monitor and address identification and linkage gaps among KP subgroups.

DREAMS

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 provides a comprehensive package of core interventions to address behavioral factors, family dynamics, and structural barriers that have been proven to reduce the risk of HIV in AGYW. In COP22 these efforts will include expanding and deepening coverage within the existing priority councils, implementing a maintenance plan in councils that have reached saturation status amongst certain age groups, and expanding geographic coverage to three new councils with combination prevention interventions, and continue to reach the most vulnerable girls.

To ensure AGYW are identified and offered a core package of services at community and facility levels, the Tanzania DREAMS initiative leverages the capacity of key partners for OVC, community prevention, and facility-based interventions. Primary beneficiaries are targeted through OVC programming (age 10-14), intensive peer and community-based outreach (age 15-24), and by adolescent friendly-trained health providers at health facilities. Once identified, a vulnerability assessment is used to understand the level of risk of the beneficiary which guides service prioritization. Beneficiaries are split into three distinct age categories:10-14-year-olds; 15-19-year-olds; 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 COP22, it is expected that 216,774 new AGYW (age 10-24) will be reached with DREAMS primary interventions. These targets represent newly enrolled DREAMS girls, actively enrolled girls who will not have completed the program by Q4, and maintenance targets for saturated age bands. Approximately 89% 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
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 COP19 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

In COP22, the OVC program, as part of the DREAMS initiative, will continue to implement modules on sexual violence and prevention for 10-14-year-old girls integrated into the *Huru* curriculum which focuses on menstrual hygiene management, reproductive health, risk avoidance, and GBV prevention alongside a complementary parenting program, (*Furaha),* which is part of DREAMS secondary package.

A robust M&E system, the DREAMS Auxiliary M&E System (DAMES) is in the final stages of development to assure DREAMS girls are receiving the packages of interventions as intended based on her unique risk factors and age. DAMES will be rolled out before the end of COP21 to track each individual girl across the package of services using a unique identifying code. This will improve PEPFAR/T's ability to provide programmatic oversight and assure the program is being implemented with fidelity across all partners. DAMES also provides a routine and standardized way to track the layering of services at an aggregate level. In the long term, PEPFAR/T will work with the MOH to integrate DAMES functionalities into government health information systems.

To ensure equitable access to DREAMS, inform programming for potential expansion, and to utilize funds in the most efficient way, the DREAMS team estimated the number of vulnerable girls in each SNU. National population estimates, and risk factor-data fi were used to estimate the number of vulnerable girls in each DREAMS SNU. For the 10-14 age group vulnerability estimates were based on national level estimates of the percent of those out of school, married/sexually active before 15, or orphans. Regional level estimates of girls who ever engaged in sex without a condom or reported having multiple sex partners in the past year and estimated population as per National Bureau of Statistics (NBS) data of 2022 were used to estimate the number of vulnerable AGYW aged 10-14, 15-19, and 20-24 years in each district, and the results range from 70-73%, 63-78%, 79% to 88% respectively. These estimates were updated in September 2020 and included in our analysis across the DREAMS initiative. Saturation calculations showed coverage of greater than 75% in three current DREAMS PSNUs, justifying extension into new councils. The following table includes estimates of vulnerable girls from the current eleven DREAMS councils.

Number of Vulnerable Girls and DREAMS Reached at FY19 -FY21: Table 1.2

	# AGYW at Risk			Cumulative Performance + COP21 Target			% at-risk AGYW who will complete primary + secondary package at the end of COP21		
Council	**10-14y**	**15-19y**	**20-24y**	**10-14y**	**15-19y**	**20-24y**	**10-14y**	**15-19y**	**20-24y**
Msalala DC	16,457	15,183	12,803	7,696	15,014	11,151	47%	99%	87%
Ushetu DC	18,213	15,822	12,903	8,830	15,241	14,067	48%	96%	109%
Shinyanga MC	10,026	10,686	10,166	4,813	9,582	8,966	48%	90%	88%
Shinyanga DC	21,866	19,013	15,927	12,080	15,700	11,366	55%	83%	71%
Kahama TC	15,019	15,950	15,226	5,531	11,981	8,980	37%	75%	59%
Muleba DC	34,328	26,105	27,250	14,540	11,562	19,340	42%	44%	71%
Kyela DC	11,686	10,819	10,037	6,435	3,783	5,680	55%	35%	57%
Mbeya CC	19,595	23,158	25,961	8,159	7,679	8,230	42%	33%	32%
Mufindi DC	13,982	10,263	11,287	5,363	1,949	2,055	38%	19%	18%
Mbarali DC	15,328	12,510	13,629	5,516	1,588	1,947	36%	13%	14%
Nyamagana MC	21,453	22,360	25,244	4,550	1,971	2,604	21%	9%	10%

Based on past performance and reaching saturation in several councils and age bands, in COP22, DREAMS will increase coverage by targeting 216,774 vAGYW in new and expansion SNUs. Expansion councils were selected using a strict criterion as highlighted in the COP22 and DREAMS guidance to identify a small number of high priority expansion councils for COP22 that are feasible and low impact on IPs. PEPFAR/T reviewed the epidemic profile across all

PEPFAR-supported councils. Final selection was based on identifying councils with a population of HIV positive AGYW greater than 500, an HIV prevalence greater than 2.5% and an estimated number of Female PLHIV 15-24 that was more than double the estimated number of male PLHIV in the same age group. This resulted in a limited number of eligible councils which were systematically reviewed in comparison with the existing DREAMS platform to identify high priority areas within the current DREAMS regions, resulting in the three COP22 expansion councils of Iringa MC, Bukoba MC and Tunduma TC. Expansion to these new councils will begin enrolled new beneficiaries in COP22 Q2 to allow for proper preparation and scale-up to the new geographic areas.

All DREAMS-supported girls will access HIV testing as part of a core package of services and as a starting point for additional prevention interventions and to facilitate index testing as appropriate as well as early linkage of HIV-positive girls to HIV care and treatment services. Since COP18 PEPFAR/T DREAMS IPs have been ensuring health providers are trained on standard operating procedures, job aides, partner 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 may pose a risk for intimate partner's violence.

Once a SNU reaches saturation of at least 75% of vAGYW in each DREAMS age band, a maintenance package will be adapted to ensure DREAMS has a continuous presence, reaches girls who "age-in" to the program, and to assure DREAMS's impact is sustained. In COP22, each of the councils and age bands reaching this 75% saturation threshold will have targets that align with at least 20% of the eligible vAGYW population to ensure coverage as the population "ages-in" each age band. The package of services available in the maintenance councils and age bands will not be affected in COP22. This demonstrates Tanzania's unique ability to expand the DREAMS program efficiently and methodically in limited geographic areas while maintaining the core package of services that beneficiaries will receive. As part of this approach, PEPFAR/T will programmatically document qualitative lessons learned from the DREAMS implementation and its limited expansion to inform a more robust mixed-methods evaluation in the future.

DREAMS COP22, Targets 1.3

DREAMS Councils	**Targets (10-24 combined)**
Kahama TC	22,684
Kyela DC	10,831
Mbarali DC	17,786
Mbeya CC	18,803
Msalala DC	15,342
Mufindi DC	19,092
Muleba DC	22,554
Nyamagana MC	28,809
Shinyanga DC	20,871

Shinyanga MC	9,365
Ushetu DC	14,090
Bukoba MC	5,439
Iringa MC	6,014
Tunduma TC	5,094

DREAMS reaches the most vulnerable AGYW who have increased risk of violence. To help connect those experiencing violence to available resources and support in the community, in COP22 IPs staff involved in direct service delivery will continue to be trained on how to enquire about violence and offer first line support (LIVES) in response to disclosure 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 aggressively scale-up PrEP services among vAGYW with a 71% target increase from COP21 (from 3,500 to 12,896). DREAMS partners will support DREAMS beneficiaries to take control of their sexual health and reduce their HIV risk through PrEP. Expanding PrEP services among vAGYW will involve increased demand creation and de-stigmatization of PrEP services to include enhanced education for health care workers and potential beneficiaries, and re-branding the PrEP bottle so it does not resemble other ARV packaging. The use of PrEP ambassadors at DREAMS safe spaces and other community spaces will increase awareness to the AGYW and general population. PrEP services information will also be integrated with DREAMS core package of services for AGYW to receive correct and appropriate information that will enable the decision making on self-protection.

PEPFAR/T will have 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 six services, including: HTS, social and behavior change (SBC) interventions, GBV screening, socio-economic strengthening, better parenting interventions, and community mobilization and norms change. Community-based mobile health units provide a one-stop suite of services including HIV testing, family planning (FP), screening for GBV, TB, and substance/alcohol use, and escorted GBV referrals.

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 ongoing DREAMS targets and the three expansion councils, PEPFAR/T will work with TACAIDS to ensure effective coordination of AGYW activities. PO-RALG will 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. In addition, to better align the DREAMS initiative with the most vulnerable population in Tanzania, in the remainder of COP21 and beginning of COP22, DREAMS will prioritize rolling out the AGYW Vulnerability Index tool across PEPFAR-supported councils. The tools, developed by the United Nations International Children's Emergency Fund (UNICEF) in collaboration with TACAIDS, was designed in part to determine the level and types of vulnerabilities of AGYW in a certain geographic area. As the PEPFAR/T program evolves and looks beyond COP22, this data will allow the DREAMS program to shift in hopes of reaching vulnerable AGYW populations before prevalence or HIV burden peak.

In COP22, PEPFAR/T will ensure enhanced economic strengthening education is provided in all DREAMS councils with age-appropriate materials. For the 10-14-year-old age band, this includes financial literacy using a contextually adapted model from BRAC, and NGO focused on poverty eradication, 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 a model for economic empowerment adapted from the Association of Volunteers in International Service known as the Women's Income Generating Support (WINGS) program. Application of WINGS will be informed by a youth labor market assessment, to all DREAMS councils to provide knowledge on financial literacy, savings, and business startup to DREAMS beneficiaries. This model places emphasis on entrepreneurship, business mentoring, and access to markets for DREAMS participants. The program also will link AGYW with business fora like trade fairs, and apprenticeship programs.

Throughout COP20 and COP21 the DREAMS program has been impacted by COVID-19 restrictions on in-person gatherings, however, PEPFAR/T DREAMS continued to adapt programming to meet local gathering requirements and innovating to sustain the gains made in reaching this vulnerable population.

In COP22 PEPFAR/T will deploy strategies to address community engagement, program improvements, and coordination to reach the most vulnerable AGYW with the comprehensive DREAMS package. DREAMS will employ a mentorship approach to provide skills, resources, and social and economic capital that AGYW need to reach their full potential. In COP22 DREAMS IPs will also utilize the updated vulnerability tool to ensure the program reaches the most vulnerable AGYW. IPs will also work to employ more DREAMS Coordinators and Ambassadors to improve advocacy at the regional and district levels. In COP22 PEPFAR/T will improve adolescent and youth friendly services (AYFS) through training and mentoring health care workers and will expand sites providing AYFS. This approach will improve bi-directional linkages between facility and community DREAMS partners to ensure quality comprehensive prevention, care, and support.

Orphans and Vulnerable Children (OVC)

Tanzania has 2.3 million OVC affected by HIV.[18] There are 92,677 C/ALHIV on ART in 125 priority PEPFAR-supported councils where the OVC program will be implemented in COP22. As

[18] MEASURE Evaluation, 2018.

of FY21Q4, the OVC program has served 868,177 OVC and caregivers and enrolled 51,436 C/ALHIV in the OVC program; 99.9% of C/ALHIV in the OVC program were reported to be on ART. This represents 123% OVC proxy coverage of TX_CURR <15y/o and 79% OVC proxy coverage of TX_CURR<20y/o.

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 by improving access to and utilization of HIV/health, nutrition, education, protection, psychosocial, and economic strengthening services. PEPFAR/T will continue its strong coordination and collaboration with GoT, particularly the new Ministry of Social Welfare, and strengthen their capacity to plan and deliver high quality care while advocating for increased local resource investment in vulnerable children and families. Through the OVC program, PEPFAR/T works to ensure that all OVC know their HIV status, have been assessed for HIV risk, and that newly identified C/ALHIV are immediately linked to treatment and provided retention and adherence support. The signing of memoranda of understanding (MOUs) between OVC and clinical partners in COP21 supports overall collaboration between partners to identify C/ALHIV for enrollment in the OVC program through bi-directional referrals and ensuring linkage to HIV services.

In COP22 planning, the OVC program applied both the COP21 OVC TDY recommendations and COP22 PLL directives to further align the OVC program with the TX_CURR <18 years. This resulted in allocating optimal council level targets and re-distributing remaining targets to an additional 31 new COP22 councils while ensuring continued care and support for the OVC comprehensive active caseload. The COP22 OVC targets reflect interagency discussion and consensus. To ensure program efficiency, the program has generally maintained COP21 OVC targets, but expanded to the 31 additional councils identified, despite a decrease in funding compared to COP21. The OVC program will ensure 95% coverage of all C/ALHIV and all HEI in the OVC councils. In COP22, PEPFAR/T also prioritizes the sibling and caregiver's of C/ALHIV and HEI beneficiaries in the OVC program. Other priority OVC subpopulations include children of PLHIV, child survivors of sexual violence, and children of FSW and PWID.

In COP22, PEPFAR/T will use an intergenerational approach to serve OVC and their caregivers. In COP22, PEPFAR/T will continue to support 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 (including support to transition children to optimized ART), and reinforce age-appropriate and positive family disclosure. PEPFAR/T will ensure that community case workers (CCWs) are trained to support and track HIV clinical outcomes such as VLS, prevent service interruption, and make referrals for CLHIV with TB symptoms. The CCWs will follow up at households to ensure the CLHIV with TB adhere to treatment; when CCWs administer the risk screening tool and identify children with TB symptoms, they will ensure referrals for TB testing as well as monitor results and treatment adherence among TB cases. Preventing and responding to sexual violence is also an OVC program priority.

PEPFAR/T will ensure 100% of OVC in the program have awareness of their HIV status and have their HIV status documented in their case files. The OVC program will continue to use the

OVC HIV risk assessment tool which has proven effective in targeting children at risk of HIV. PEPFAR/T will also continue to strengthen testing of biological children of HIV-positive clients (ensuring systematic assessment of 100% of HIV-positive 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. In COP22, the OVC program will ensure that 100% of CLHIV *already enrolled in HIV care and treatment services* will also be enrolled in the OVC program across all geographic councils where the program is implemented.

Reaching OVC is a key programmatic component of the AP3 surge plan. Through this initiative, PEPFAR/T will strengthen case management for HIV-positive mothers, CLHIV, and HEI, provide tailored economic strengthening services, educational support for adolescent mothers, support to mothers of HIV positive and HIV-exposed children struggling on treatment, and train case workers on index testing of biological children, age-appropriate HIV disclosure, and DTG 10mg ART optimization.

DREAMS interventions are integrated within the OVC program and implemented as part of the OVC package in all DREAMS SNUs (11 existing and 3 planned expansion councils in COP22). The program integrates sexual violence messages into interventions for parents and caregivers. Emphasis will be placed on implementing and reinforcing child safeguarding policies and procedures to prevent and respond to violence against children (VAC) and GBV, and work with the legal sector to ensure justice for children.

Collaboration between OVC IPs, religious leaders, the faith community, and other partners have enhanced opportunities for the OVC program to improve HIV case identification, treatment linkage, retention, and VLS. Faith-based organizations are key to addressing GBV and VAC as well as the stigma that often prevents children and adolescents from accessing HIV services. In COP22 PEPFAR/T will continue partnering with religious leaders and faith communities to develop and disseminate messages on sexual violence prevention throughout their networks.

Finally, to improve the pediatric continuum of care and prevention of new infections among children, PEPFAR/T 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, MMD, and family disclosure support. Active referrals such as accompaniment by a case worker to HTS and ART sites has improved referral to service completion by over 90%. PEPFAR/T will scale-up these proven interventions across the OVC scale-up SNUs. The OVC IPs will also collaborate with demand creation programs to generate demand and increase uptake of HIV services among C/ALHIV and on delivering key messages to prevent sexual violence.

Primary prevention of HIV and sexual violence among 10–14-year-olds:

The OVC prevention program will target girls and boys 10-14 years in high burden SNUs. This preventative program will implement evidence-based interventions, such as *IMPOWER* and *IM*

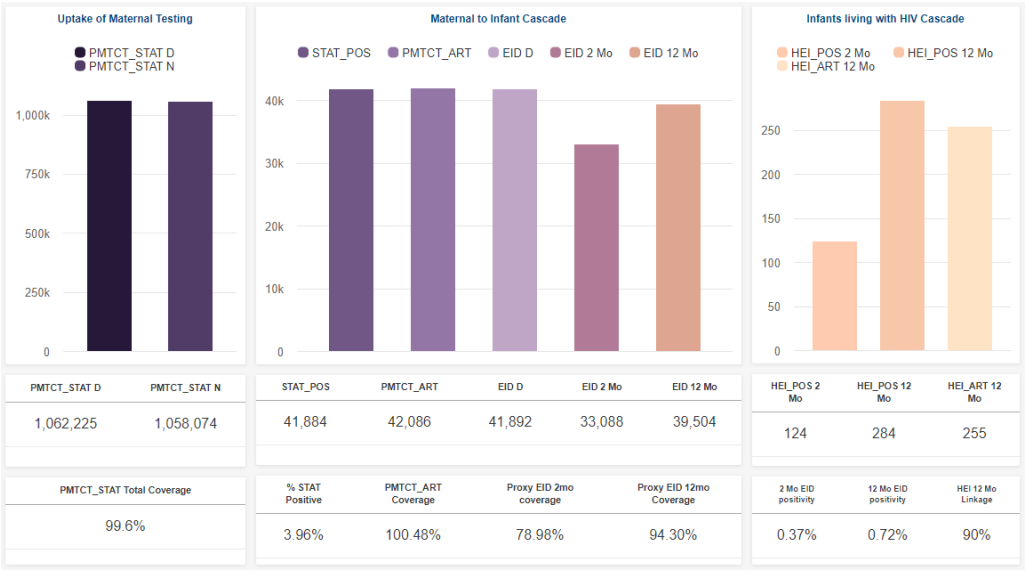
Safer, that aim to reduce sexual violence as well as Coaching Boys into Men (CBIM), and "Furaha," which addresses parenting and violence prevention. Specific activities include prevention of forced, coerced, or non-consensual sex; linkage to post-GBV care, and ensuring justice for children. In addition, the OVC program has translated and integrated three supplemental modules (*Healthy and Unhealthy Relationships, Making Decisions About Sex, and Sexual Consent*) into the DREAMS Huru program, a sexual violence and HIV curricula for girls aged 10-14. The DREAMS Huru package now includes education subsidies/support (education subsidies are provided once AGYW have completed at least 80% of the 11 Huru sessions), and an integrated Huru Kit - which includes prevention of sexual violence and HIV education for 10-14 years old, reusable menstrual hygiene kits, and financial literacy module/curriculum. OVC and DREAMS IPs will also incorporate demand creation programs to increase uptake of HIV services among adolescent living with HIV. To date the OVC Program has enrolled 86,626 athletes into CBIM with twelve ongoing CBIM sessions. These activities will occur in school and community settings, including faith networks, youth sports clubs, and community centers. These interventions will be implemented in DREAMS SNUs, as well as other PEPFAR SNUs with high incidence and/or prevalence of HIV and sexual violence against children). In SNUs with both OVC and DREAMS programs, PEPFAR and IPs will work together to coordinate activities between the two programs.

In COP22, PEPFAR/T will support interventions that help to reduce incidents of violence against children in schools and communities. PEPFAR/T IPs will conduct community meetings to encourage dialogue between youth and parents to improve relationships and create safe spaces for raising issues and opinions. They will also work with local school authorities and teachers to advocate to reduce the practice of corporal punishment and other forms of abuse and violence against children in schools by capacitating teachers to understand alternative methods of discipline. PEPFAR/T IPs will also introduce the safe school model to identify culturally appropriate ways to address issues that threaten the safety of youth at school and in the community at large. Furthermore, IPs will introduce children's clubs that build capacity of in-school and out-of-school children to learn how to respond and to report abuse. Finally, IPs will introduce programs that strengthen the referral system between schools and child protection officers in the community.

As part of COP22, PEPFAR/T IPs will work to build capacity and empower children's committees to advocate for child's rights within government and parliamentary platforms and aid these groups to advocate for adequate resources for child protection and child rights initiatives. In addition, PEPFAR/T will host trainings for faith leaders to educate about child rights and child rights governance to empower faith leaders to be champions of child protection to safeguard children's rights in their communities. To combat negative gender norms that may lead to violence against children, IPs will train parents and caregivers in positive parenting methods. Finally, IPs will build the capacity of police gender desks to support efficient and effective operations to respond to cases of child abuse and violence against children.

Children / PMTCT

Figure 4.3.1 PMTCT Cascade FY21



PEPFAR/T is working to substantially improve service delivery for children, with a focus on EID at two months, case identification, and VLS. PEPFAR/T will use a surge approach to address the gaps in pediatrics and PMTCT by rapidly implementing a key package of services and enhanced monitoring to quickly identify and address gaps as part of the AP3 surge. PEPFAR/T will use a strategic mix of approaches that will simultaneously build capacity for sustainable activities, intensify activities that have been successful to date, and introduce innovative approaches to address persistent challenges. In addition, a PMTCT cascade evaluation will be conducted in a nationally representative selection of sites across Tanzania mainland to identify and quantify gaps in the cascade from the ANC period to 2- and 12-month EID. The results from the evaluation will rapidly inform targeted efforts to close identified gaps (upstream and downstream) in the PMTCT cascade using a data-driven approach.

Despite progress made in treatment growth, program data show major gaps in identification, retention, and VLS among pediatric populations. In FY21, PEPFAR/T achieved 66% of the annual target for EID, with EID coverage of 79% (if compared with HIV positive pregnant women identified during the reporting). Among HEI tested by 12 months, 84% were tested below 2 months of age. Based on FY21 results, 41,884 pregnant women tested positive for HIV, and 39,504 HEI were tested at 12 months. Of the 39,504 HEI, 284 (0.7%) tested HIV-positive, and 255 (90%) were initiated on ART. VLC among pregnant women was 94%. Challenges contributing to this EID gap include, poor retention of mother-baby pairs, ineffective integration of EID in immunization platforms, erratic supply of commodities (DBS Kits, POCT for EID, and lab reagents), missed opportunities to enroll HEI in the OVC program and among adolescents and young mothers, and sub-optimal use of peer mothers to monitor and track clients lost to follow-up. PEPFAR/T will intensify maternal retesting at third trimester and in the breastfeeding period and link at risk pregnant/breastfeeding women to PrEP, and prevention services.

Furthermore, PEPFAR/T will scale up distribution of HIVST at MCH settings as a strategy to reach pregnant/breastfeeding women with PMTCT services.

PEPFAR/T will continue to support LGAs and partners to ensure that all PEPFAR-supported 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 will also scale up the mother-mentor model and the *Mother2Mother* program to address stigma and discrimination issues in the community for improved retention of mother-baby pairs. PEPFAR/T will support dissemination of the newly developed national guideline for mother mentors and ensure that all sites are sensitized to its content. PEPFAR/T will scale-up the use of GeneXpert – near POCT – 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 continue strengthening integration of EID in immunization platforms and enhance efficiency in DBS sample and results transportation. In addition to that PEPFAR/T will ensure constant availability of commodities by supporting regional and community health management teams (R/CHMTs) on how to forecast commodities and order timely to mitigate frequent stockouts. PEPFAR/T will also extend technical assistance support to 190 non-PEPFAR, non-GFATM PMTCT sites to rapidly bridge gaps in PMTCT/EID and pediatric services. PEPFAR/T working with the IPs and the R/CHMTs, will offer a defined package of technical assistance to address health care providers capacity and skills for quality service provision and provide a platform for cross learning and scaling up successful interventions. 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 has been designed to prioritize enrollment of HEI of mothers with IIT, HIV-positive adolescent mothers younger than age 19 with tracking of all mother-baby pairs via case management to improve EID at two and 12 months. The OVC case management model will be used to develop monthly 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.

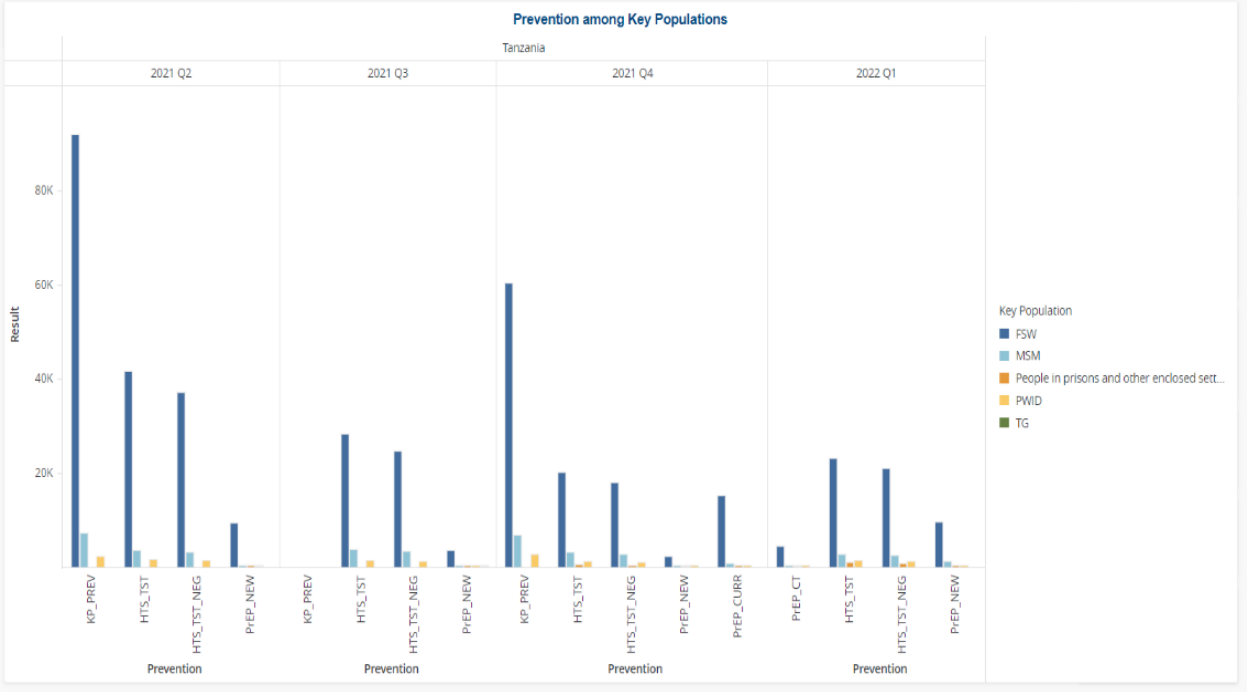
In COP22, PEPFAR/T will continue to scale up index testing as a key intervention to identify CLHIV. Through its “maximizing index testing” approach, PEPFAR/T will ensure all biological children of HIV-positive women are offered the opportunity to test and be linked to treatment. All clinical partners will have MOUs with the OVC partner by the end of COP21. This will strengthen collaboration with clinical partners to improve case identification, linkage, and treatment adherence, and VLS among CLHIV enrolled in the OVC program. Optimized PITC will be modified where needed to address findings from the pending 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 AYFS to improve retention and VLS. 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.

Improving VLS is a key area of focus for C/ALHIV on ART. Despite improvement in both VLC and suppression over the years, FY21 program data show that VLC suppression rate was 90%

among children aged 0-14 who had viral load test data, which is below the UNAIDS and PEPFAR targets of 95%. In addition to implementing approaches to improve ART coverage among this group, PEPFAR/T will continue to support GOT in its transition to optimal pediatric regimen. Despite progress made to provide 94% of pediatric clients on ART with optimal regimens, children weighing less than 20kg had limited options for optimal regimen. In COP22, PEPFAR/T will support GOT to transition children at least 4 weeks of age and weighing 3kg to DTG10mg. Currently, DTG10mg commodities are in the country and transition meetings to finalize roll-out timeline are planned to begin in April 2022. The OVC program, in collaboration with clinical partners, will track and support the transition to optimized ART among enrolled C/ALHIV, including DTG10mg. Site mentorship will be included to ensure service providers understand and are competent in ART dose adjustment and transitioning of regimens. To improve VLS, 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.

Key Populations

Figure 4.3.2 Prevention Continuum by Key Population Group



PEPFAR/T provides targeted interventions for KP including FSW, MSM, transgender people, PWID, and at-risk individuals within KP sexual networks. Activities reaching KP are currently implemented in all 147 councils (including Zanzibar) with known hotspots.

In FY21, IPs reached 142% of the annual target (175,483 KP) with the core intervention package, comprising services for HIV testing, HIV care and treatment, sexually transmitted infection prevention, screening, and treatment, TB screening and referral to treatment, family

planning and sexual reproductive health services, peer education, emergency contraception, condom provision, and PrEP.

In COP22, PEPFAR/T will employ an equity lens to ensure that marginalized populations are receiving quality client-centered services that meet their needs by addressing structural barriers, enhancing bio-behavioral surveillance and size estimation, and improving KP-friendly services. This will be complemented by efforts to address widespread stigma and discrimination as described in our efforts to address the new minimum program requirement. PEPFAR/T will prioritize inclusion of KP beneficiaries in the development and roll-out of anti-stigma and discrimination efforts and expanding the focus of our ongoing CLM activities to assess stigma and discrimination more comprehensively and KP services at health facilities to ensure services meet the needs of these communities. As part of our comprehensive condom programming efforts and in line with the total market approach, PEPFAR/T will support distribution in hotspot locations to ensure KP and other vulnerable populations have access to condoms in a stigma-free context.

In COP22, PEPFAR/T will work together with KP beneficiaries and civil society groups to improve the quality of KP interventions, including service delivery, and to address the structural barriers that compromise access to and uptake of HIV services among KPs and their sexual networks. In addition, PEPFAR/T will expand the scope of the ongoing BBS. The BBS, which assesses HIV burden, behavioral risk factors that contribute to HIV infection among key and vulnerable populations, population size estimation, and progress towards UNAIDS 95-95-95 targets will be expanded in COP22 to reach all KP groups in an expanded set of geographic areas. In consultation with the established BBS steering committee and technical workgroup (which includes CSOs representation), the BBS will be expanded to three additional regions on the mainland, bringing the total to 6 mainland regions. In addition, Zanzibar BBS will be implemented using similar methods to mainland BBS in selected regions. Findings from BBS in Zanzibar and Mainland Tanzania will inform data-driven approaches to recalibrate client-centered approaches in the KP program and enhance provision of comprehensive and equitable services to ensure interventions are tailored for marginalized groups that have not yet fully experienced the benefit of HIV epidemic control.

Specifically, in COP22, PEPFAR/T will aim to strengthen KP programming across the clinical cascade. In the context of case finding, PEPFAR/TZ will continue to scale-up safe and ethical index testing in community settings for improved case finding among KP. As part of efforts to ensure safe and ethical index testing, PEPFAR Tanzania monitors IPV screening of index clients before and after reaching out to their sexual contacts for testing services. The proportion of adult clients receiving IPV screening has been improving over time and in COP22, PEPFAR/T will reach 100% coverage of IPV screening in both facility and community index testing settings. In COP22, PEPFAR/T will continue to expand other testing modalities, particularly social network testing and HIVST, among KP. In the context of treatment, we see that community ART initiation at the point of diagnosis reduces barriers to enrollment in care. In COP22, in line with MOH guidance, PEPFAR/T will continue scale-up of community ART provision with fidelity across all councils to improve linkage and retention to HIV care for newly diagnosed KP clients. PEPFAR/T will continue to rely on enhanced peer navigation and

escorted referrals to ensure service uptake and linkage. PEPFAR/T will also improve monitoring of and strengthen support systems for VLC and suppression among KP groups and will strengthen U=U messaging to promote adherence. Across the cascade, PEPFAR/T will also reach children of key populations by screening KPs during HIV testing for having any children. The children of KPs will then be tested for HIV, and those found positive will be linked to treatment and the OVC program to receive further services.

In COP22, PEPFAR/T will continue supporting comprehensive service delivery for condom provision and promotion, linkage to PMTCT, post exposure prophylaxis, PrEP community initiation and refill, cervical cancer and TB screening and treatment, viral Hepatitis screening, sexually transmitted infection (STI) screening and treatment, harm reduction for PWID, and targeted community prevention interventions for KP in COP22. Addressing gender norms and gender-based violence will also be prioritized in many of the structural interventions described below. KP beneficiaries and KP-led CSOs will be routinely involved in designing, implementing, and assessing the progress of KP services in Tanzania. PEPFAR will prioritize availability of GBV services for KPs who have experienced GBV at all PEPFAR supported sites, either on-site or by referral. Working in collaboration with KP-led organizations, PEPFAR will strengthen GBV services for marginalized populations and sensitize law enforcement and community and religious leaders to ensure stigma-free support. PEPFAR/T continues to be committed to ensure that 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.

In COP22, PEPFAR/T will also scale-up access to PrEP services for KP. Since approval of the National PrEP Framework in September 2021, PEPFAR/T has enrolled more than 34,000 new PrEP clients and will continue to exponentially initiate eligible clients in the coming months ensuring that COP21 targets are met. In COP22, PEPFAR/T plans to increase targets by more than 80% while simultaneously working with KP beneficiaries to intensify demand creation activities and explore innovative PrEP packaging options to reduce stigma associated with this important prevention product. PEPFAR/T will ensure Truvada commodity needs for the PrEP program are met and maintained and will work with the GOT to intensify data quality assurance efforts to ensure accuracy of program data. PEPFAR/T is also supportive of exploring the feasibility of new PrEP technologies in collaboration with the GOT. PEPFAR/T will also explore simplified approaches to PrEP implementation through DSD, community PrEP refills, and PrEP MMD (as appropriate) in support of the new WHO Guidelines on Simplified PrEP Implementation.

There are a range of structural barriers that hinder KP populations from seeking, accessing, and staying in HIV prevention and care and treatment services. Specifically, stigma and discrimination at health care facilities is common, there are policies criminalizing KP behaviors, and service accessibility is not always equitable. Tanzania’s KP Guidelines clearly state that it is the policy of the Government of Tanzania not to discriminate against people seeking health services based on sexual orientation or other behavioral factors. In COP22, PEPFAR/T will expand its portfolio of structural interventions to address these issues. In COP22, PEPFAR/T has advocated for the GFATM to support a supplemental Stigma Index Survey for KP to include all populations omitted from the recent survey. GFATM has agreed to prioritize this in their

ongoing reprogramming. PEPFAR/T will also support a review of current workplace, health care worker, and other training curricula to assess and update content on stigma and discrimination. PEPFAR/T will also support UNAIDS to conduct an updated legal and policy assessment to ensure a better understanding of this environment to help identify additional areas for policy change and advocacy. PEPFAR/T will also establish an emergency response committee that will be poised to address KPs in crisis situations and assess a current FSW hotline for expansion in terms of population reach and information provided. PEPFAR/T will conduct a landscape analysis of KP-led CSOs in Tanzania – both those that receive PEPFAR funds and those that do not – as a first step to identify organizations that might be able to receive funding directly. IPs that currently subaward to KP-led CSOs will have a capacity-building mandate to ensure that CSOs have good governance and financial systems in place to manage and absorb PEPFAR funding. Finally, PEPFAR/T will also explore GOT-supported vocational training opportunities and look to establish systems for linkage with KP programs.

In FY21 PEPFAR/T placed 9903 PWID on medication assisted therapy (MAT) services. This is 86.7% of the annual targets (11,423). Among those reached, 8495 (85.8%) were male and 1408 (14.2%) were female. This success is in part attributable to engagement with KP-led CSOs (through the Key Populations Investment Fund) that conduct outreach and peer education that helped drive demand to MAT clinics in Pwani and Dar es Salaam. In COP22, PEPFAR/T will capitalize on this success by expanding partnerships with PWID-led CSOs that support counseling, outreach, demand creation, and psycho-social support for PWID program beneficiaries. PWID-led CSOs also play a key role in counseling around HIV by promoting the importance of knowing one's HIV status, immediate linkage to treatment, and adherence support. In COP22, PEPFAR/T will explore options for integrating and/or linking PWID to vocational training opportunities. PEPFAR/T has no plans to expand the number of MAT clinics in COP22; potential future expansion will be informed by BBS results and social mapping in regions. Similarly, while take-home dose for MAT was piloted in Dar es Salaam, the results, which will determine the feasibility of this intervention, have not yet been finalized. Any decisions to implement take-home dose for MAT will be made in conjunction with Tanzania's Drug and Control Enforcement Authority (DCEA) and the MOH. PEPFAR/T will ensure that IPs, CSOs, R/CHMTs, and community teams collaborate for program monitoring.

MAT services are integrated with clinical services which include provision of methadone and management of overdose with Naloxone, STI screening and treatment, sexual and reproductive health, family planning services, HIV testing, care, and treatment, TB screening and treatment, PrEP and post-exposure prophylaxis services, mental health assessments and referral or treatment. A community package of services including, MAT referral, risk reduction education, legal support follow-up, outreach services, economic empowerment interventions, family reintegration, psychosocial support, health insurance packages, and community HTS, is also provided. PEPFAR/T has recently renewed its focus on quality MAT program monitoring. In the beginning of COP21, DCEA reviewed and updated all MAT monitoring reporting tools which should improve the ease and quality of data collected. In COP22, IPs will continue doing data quality assessments through physical count of files and pharmacy reports to verify clients in MAT services and to prevent double counting. Furthermore, PEPFAR IPs implementing MAT services will continue scaling up the use electronic biometric systems in the pharmacy

dispensing area to ensure controlled access to MAT. In addition, in COP22, DCEA will review and disseminate an updated National Guideline for MAT services provision in Tanzania.

VMMC

According to the THIS 2016-2017, the national MC prevalence was nearly 80% among 15-29-year-olds in 2016-2017. However, as coverage increased following PEPFAR/T's scale-up of VMMC in regions that had high unmet need, pockets of low coverage remain in the country. Program data continue to highlight MC 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 agricultural and mining sectors, nomads, and fisher folk). Low coverage for the older age band justifies the continuing to target adult men with VMMC services.

In Tanzania, the VMMC program is a priority in councils with low MC 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.

As with much our programming, target setting for the VMMC program has been challenging due to outdated data. THIS 2016-2017 results are more than five years old, and the modeling data does not align with programmatic insights and on-the-ground experiences from implementers. To illustrate this point, Figure 4.3.4 shows a subset of regions with an estimated VMMC coverage among men >15 years greater than 100%. The continued identification and medical circumcision of men in councils that are purportedly saturated point to inaccuracies in the denominator of uncircumcised men, resulting in an under estimation of the unmet need. Therefore, PEPFAR/T's target setting for VMMC in COP22 strongly factored current and past achievements as a proxy for ongoing demand and unmet need.

Figure 4.3.3 VMMC Quarterly Trends by Age

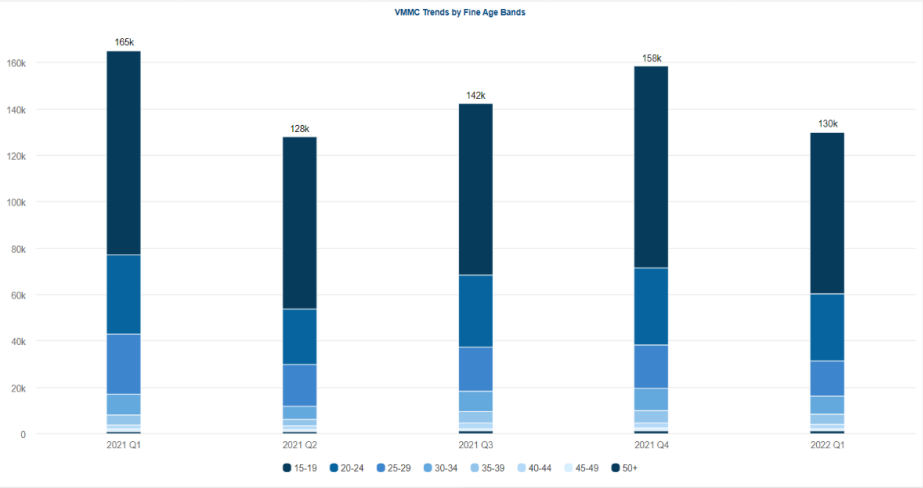
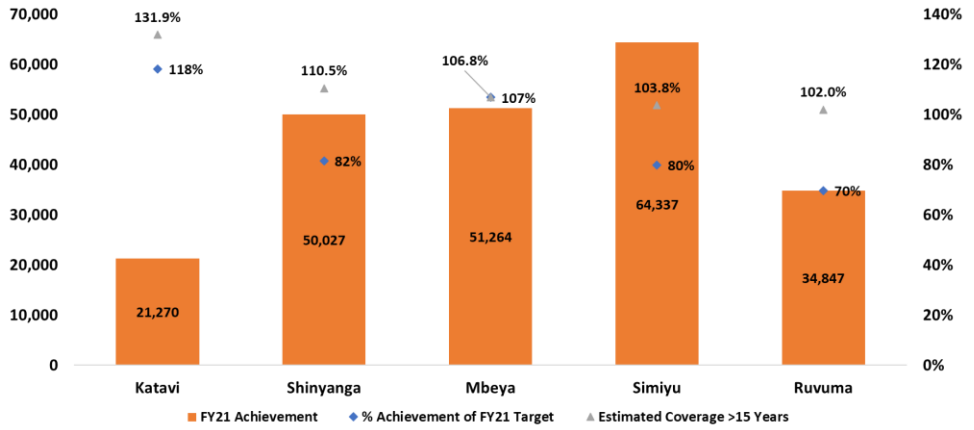


Figure 4.3.4 FY21 VMMC Achievements in Regions with Estimated VMMC Coverage >100%



However, these are regions where PEPFAR/T is still meeting and exceeding targets. We are optimistic that results from the ongoing Demographic Health Surveys (DHS) and the upcoming THIS 2022-2023 will provide the program with the evidence needed to target our VMMC activities in the geographic areas of the greatest need and guide us towards an appropriate sustainability plan for the VMMC program. During COP22, PEPFAR Tanzania allocated VMMC targets based on performance over the last three fiscal years, which points us to geographic areas where we are still seeing a lot of clients. Accordingly, the targets have been allocated to agencies in the following proportions: 55% by Centers for Disease Control and Prevention (CDC), 13% United States Agency for International Development (USAID), and 32% Walter Reed Army Institute of Research Department of Defense (WRAIR/DOD).

In FY21 PEPFAR/T supported 594,000 circumcisions, which accounted for 84% of the annual target 707,982. This performance was a significant improvement from previous year (total VMMCs 429,627) is due to the lift COVID-19 pandemic related implementation restrictions, that limited travel and large gatherings. To date, the VMMC program still relies on campaigns at the community level and large outreach events.

The total COP22 VMMC target is set at 401,505. Our COP22 VMMC strategy will continue circumcision for males aged >15-year-old men. In addition, PEPFAR/T will ensure VMMC are performed in line with the minimum package of required services, including age-appropriate sexual risk reduction counseling, counseling on the need to refrain from sexual activity or masturbation during the healing process, medical history to include bleeding risk, physical examination with STI screening as clinically indicated (with deferral of surgical circumcision until treated) and treatment/referral, HIV testing prior to circumcision for men and their partner as indicated and linkage to care and treatment for those testing positive in HTS, post VMMC follow-up, including adverse event assessment and management, and distribution of condoms. Men with ongoing high-risk sexual behavior testing negative for HIV will be offered or referred for PrEP.

In FY21 PEPFAR partially reopened services at static sites by ensuring adherence to PEPFAR COVID 19 prevention guidance. The program continued to implement activities using no-contact and limited-contact demand creation approaches leveraging the use of technology (mobile platforms) and interpersonal communication through Community Based Organizations (CBOs) that support 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 infection prevention and control (IPC) 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 COP22, 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. PEPFAR/T will continue to focus on scaling up VMMC services among older males age >15 years by addressing key barriers to service uptake. These obstacles include economic constraints related to lost time to work, other barriers include emotional reservations, service delivery convenience, structural set-up of facilities, and traditional and cultural norms. Program experience shows that older men prefer mobile vans, male service providers, and tents that provide privacy to minimize possible stigma.

PEPFAR/T will use person-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 can have for women and their key role as mothers and partners in the decision-making process; involvement of traditional circumcisers in demand generation, especially for older adults; 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 systems, such as helpline services, as well as peer networking, promotion through satisfied clients, local radio jingles, house to house mobilization, use of personal announcing systems, and a focus on reaching female spouses and sexual partners.

In COP22 PEPFAR/T is planning to implement Shang Ring device (SR) in some VMMC priority regions to increase service uptake among older males. The total COP22 VMMC target through SR device is set at 4500.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 COP22 PEPFAR guidance emphasized. In line with WHO guidance, PEPFAR will work with the MOH on a roll out strategy: a national roadmap for the introduction of the Shang Ring for VMMC implementation, training of trainers, adjustment of monitoring and evaluation, and demand creation tools.

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.

In the context of sustainability discussions planned for COP22, PEPFAR/T will begin discussions with GOT about the future of the VMMC program and explore opportunities for GOT program ownership and transition. PEPFAR/T will support the sustainability process to ensure VMMC services are integrated in routine services offered at all health facilities. The transition from disposable to reusable VMMC kits has already transitioned some of the burden for commodity support away from PEPFAR.

PEPFAR/T will focus on strengthening the quality of VMMC services through 1) provision of standard VMMC training/refresher training for VMMC providers based on the national training module and practicum 2) coordinated supportive supervision and mentorship, (3) ensuring the incorporation of continuous quality improvement (CQI) in VMMC program implementation by IPs working with R/CHMTs and facility level staff to secure facility-led QI processes with local managers and stakeholders, (4) VMMC site re-certification, and (5) 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. In COP22, PEPFAR/T will also continue supporting integration of VMMC in its youth and adolescent basic minimum package for HIV prevention which includes reproductive health counseling, condom promotion, STI management/referrals, ART services, and psychosocial services. PEPFAR Tanzania will continue supporting NACP to coordinate all the VMMC trainings/refresher trainings and quarterly CQI and supportive supervision and technical consultations through the national VMMC technical working group. Lastly, PEPFAR/T will work in collaboration with GoT to include commodities and supplies in comprehensive council health plans and MSD and have VMMC services as part of insurance packages accepted by the National Health Insurance Fund (NHIF) for longer term sustainability.

Condom programming

In COP22, 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. This includes participating in national condom forecasting activities. PEPFAR/T will participate in and work through the National Condom TWG to ensure that condoms are available at health

facilities, are distributed by community-based organizations, and are integrated into KP hotspots.

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

In COP22, PEPFAR/T will focus on several priority areas as detailed in the planning level letter. Several of these are the focus of subsequent sections and discussed in detail in later chapters of this document. One of these priorities is gathering more current epidemiological data through a new THIS 2022-2023 as well as bio-behavioral surveillance (BBS). These surveys will allow PEPFAR/T, the GOT, and other stakeholders to better understand and program for the status of the HIV epidemic in Tanzania. Programmatically, as indicated in the PLL, PEPFAR/T will prioritize improving PMTCT and pediatric coverage, particularly when it comes to identification of new cases and VLS. Rolling out DTG 10mg for pediatrics is an ongoing priority that should be fully available in COP22, further improving outcomes for HIV positive children.

Per the PLL, further consideration will be given to KVP, including adolescents and young adults as well as KP. In COP22, PEPFAR/T will employ an equity lens to ensure that marginalized populations are receiving quality services that meet their needs by addressing structural barriers, enhancing behavioral surveillance and size estimation, improving KP-friendly services, and expanding PrEP access. This will be complemented by efforts to address widespread stigma and discrimination as described in our efforts to address the new minimum program requirement. Systems priorities include improving VLC and strengthening oversight and coordination for reliable supply chain systems to ensure uninterrupted testing. This includes working with the GOT to implement the DNO and Global RFP, both projects currently being discussed and led by GOT. While sustainability considerations have always been at the forefront of many of the above site interventions, PEPFAR's increased focus on sustainability will lead the team to prioritize the formation of a sustainability working group to develop a road map for the future of HIV financial and functional responsibility.

In addition to those priorities, other priorities not addressed in subsequent sections of this document include:

6MMD scale up: 6MMD began in the Dar es Salaam region in March 2020 and PEPFAR/T successfully reached 90% of eligible clients by December 2021. Once sufficient commodities were in-country, nationwide 6MMD scale-up began in August 2021. As of FY22 Q1 over 600,000 PLHIV were enrolled on 6MMD, an increase of over 400,000 from the previous quarter and equivalent to 41% of TX_CURR. PEPFAR/T is on track to reaching its goal of 60% of TX_CURR by FY22 Q2. Through the remainder of COP21 and into COP22, PEPFAR will continue to provide intensified support to sites, councils, and regions lagging behind benchmarks and ensuring that all eligible clients – including those who are hard to reach - are not missed. PEPFAR/T will continue to ensure that breastfeeding women are eligible to qualify as stable clients for MMD and that ARV stock can maintain continuity of the program.

HIV Recency Surveillance: The Government of Tanzania incorporated recency surveillance in its HTS Guidelines as a routine HIV surveillance activity to be implemented in select sites. PEPFAR/T had activated a total of 15 recency testing sites before recency surveillance was paused in April 2020 due to the COVID-19. As of December 2021, PEPFAR/T had reactivated

all 15 previous sites and activated additional 47 sites by April 2022 – bringing the total to 62 activated recency sites across Tanzania. In FY22, the main objective has been to build sustainable capacity for the rapid test for recent HIV infection (RTRI), obtaining informed consent from clients, entering data in CTC2 Recency Module database, and ensuring quality assurance and quality control. The capacity building for recency surveillance has been co-led by the GOT, PEPFAR/T, and implementing partners. In COP22/FY23, PEPFAR/T will support at least 100 recency surveillance sites across Tanzania mainland and Zanzibar. With support from GOT, in FY22Q4, PEPFAR/T will start integrating confirmatory VL testing for all those with a recent RTRI result. The VL testing is needed to accurately reclassify long-term infections among patients on ART who may retest. Instead of a more rapid expansion of recency, PEPFAR/T will focus on high-quality recency surveillance including integration of confirmatory VL in the recent infection testing algorithm (RITA) in in 100 sites supported by CDC, DOD, and USAID. It is estimated that approximately 6,000 – 10,000 VL tests will be performed as part of the RITA in FY23. Lessons learned and data insights from recency testing in FY23 will inform recalibration of COP23 recency surveillance plans

WHO recommended molecular testing for TB diagnosis: In FY21, PEPFAR/T supported TB identification of 8,578 (18% of those TB screened positive) PLHIV. Although access to GeneXpert platforms for TB molecular testing has increased, sub-optimal utilization of the platform remains a challenge. In FY21, 52% of TB specimens were tested by GeneXpert due to erratic supply of GeneXpert cartridges and frequent breakdown of GeneXpert modules. PEPFAR/T will monitor the use of GeneXpert machines for TB diagnosis among PLHIV, the functionality of GeneXpert platforms, and ensure the implementation of the DNO findings as an approach to further improve access and utilization. PEPFAR/T will continue conversations with GFATM and the GOT to increase the allocation of resources for GeneXpert cartridges. Further, the country is considering introduction of Truenat plus for POCT. PEPFAR/T will use lessons from small-scale implementation of the Truenat plus POCT to guide approaches for scale up.

PrEP: National PrEP scale-up in Tanzania began in October 2021 after the National PrEP Framework was endorsed in September 2021. PEPFAR/T's vision for PrEP in COP22 is to continue scale-up beyond the 34,000 PrEP new clients that have been enrolled in the last four months with a focus on reaching key populations, vAGYW, and pregnant and breastfeeding women. Achieving COP22 will ensure the program reaches 20% of the estimated PrEP-eligible population and reflects an 88% increase in targets from COP21. For AGYW, PrEP scale-up continues to be prioritized in DREAMS PSNUs, accounting for 30% of the total vAGYW PrEP target. In COP22, PEPFAR/T will intensify PrEP demand creation activities and engage beneficiary communities in the development and roll-out of key messages. PEPFAR/T will explore innovative PrEP packaging options to reduce stigma associated with this important prevention product. PEPFAR will ensure Truvada commodity needs for the PrEP program are met and maintained as well as creatinine supplies in line with WHO guidance. PEPFAR/T will also work with GOT to intensify data quality assurance efforts to ensure accuracy of program data. PEPFAR/T is also supportive of exploring the feasibility of the DVR and CAB-LA as additional options for pre-exposure prevention and will work with the GOT and WHO to explore adoption and integration of these new technologies.

HPV DNA testing: GOT incorporated human papilloma virus (HPV) DNA testing in the most recent cervical cancer prevention and control strategic plan as well as service delivery guidelines. Phased implementation will begin in COP22 with the goal of reaching 10% of eligible women living with HIV (35,000) using the updated screen, triage, and treat approach to cervical cancer prevention. PEPFAR will support training for health service providers and lab technologists on sample collection, preservation, and transportation. PEPFAR will procure reagents and relevant supplies for testing using the Roche COBAS 4800 platform.

4.5 Additional program priorities

Policy or guideline changes: The endorsement of the PrEP framework in September 2021 and scale up of 6-month MMD are two policy/guideline changes that have had a positive impact on PEPFAR/T programming. Achieving these milestones has enabled PEPFAR/T to meet two additional Minimum Program Requirements. In COP22, PEPFAR/T will further scale up both PrEP and MMD to eligible populations. PEPFAR/T expects an 80% increase in targets for new clients on PrEP COP22 and will reach 75% of clients eligible for 6MMD by FY23 Q2.

The Tenofovir, Lamivudine, and Dolutegravir (TLD) transition for adults moved quickly to reach 96% of all eligible clients (including 97% of all eligible women of child-bearing age) as of July 2021. The planning for the operational transition to DTG 10mg for pediatric clients will begin in April now that commodities have arrived in country. PEPFAR/T has worked closely with the GOT and GFATM to quantify commodity needs and will work to ensure that the transition to the new regimen is smooth, and that there are no supply-side challenges.

In the context of TB, the GOT has approved the introduction of 3-months of Isoniazid-Rifapentine (3HP) and 3-months of Isoniazid-Rifampin (3HR) regimens and has developed a transition plan for TPT to these shorter regimens. Although PEPFAR/T has successfully scaled up TPT, with completion rates of 88% during FY21 Q4, the current TPT regimen has a higher pill burden and requires frequent health facility visits. A transition to these shorter regimens will enable PEPFAR/T to more effectively and efficiently reach TPT targets. In COP22, PEPFAR/T will continue to advocate for the introduction of differentiated service delivery for TPT while collaborating with MOH, the National TB and Leprosy Program (NTLP), and other stakeholders to transition to the shorter regimens.

While there have not been any formal policy changes related to key populations, the operational and political environment is more open which will enable PEPFAR to address structural barriers and work towards equitable service provision. PEPFAR/T will expand its investment in BBS and size estimation assessments to cover all KP groups to improve understanding of these sub-populations that can inform evidence-based approaches to reaching them with equitable HIV prevention and treatment services in a safe, respectful, and sustainable fashion. PEPFAR/T will continue to support the KVP Forum to advocate for a human rights approach to service provision. PEPFAR/T will also work together with KP program beneficiaries to improve strategies to address stigma and discrimination, including supporting TACAIDS to develop a *Zero Stigma and Discrimination Strategy* for Tanzania. In the planned THIS 2022-2023, stigma will be assessed among the public to pinpoint societal drivers of stigma and inform stigma

reduction interventions. Moreover, among those who self-report as PLHIV in the planned THIS 2022-203, their experiences of stigma and discrimination will be assessed to quantify the impact of these adverse experiences on clinical outcomes.

Ensuring scale-up of index testing: In COP22, PEPFAR/T will continue to prioritize safe and ethical index testing to all people living with HIV, prioritizing individuals newly diagnosed and previously diagnosed individuals without VLS. In FY23 Q1, half of the newly identified HIV-positive cases were from index testing in both facility and community settings, underscoring the importance of this modality in reaching the first 95. As part of efforts to ensure safe and ethical index testing, PEPFAR Tanzania monitors IPV screening of index clients before and after reaching out to their sexual contacts for testing services. The proportion of adult clients receiving IPV screening has been improving over time and in COP22, PEPFAR/T will reach 100% coverage of IPV screening in both facility and community index testing.

In COP22, PEPFAR/T will strengthen safe and ethical index testing by offering HTS to biological children of parents living with HIV and ensuring integration of index testing with other modalities particularly SNS and HIVST. We will also continue to use monthly program monitoring data to identify and address service gaps. We are also working with MOH to finalize a protocol to validate the adult risk screening tool to ensure we are not missing opportunities for new diagnoses. PEPFAR/T will continue to train health care workers on ethical index testing and screening for IPV and will ensure to engage KP, including peer counselors, in programmatic strategy and activity implementation. PEPFAR/T will employ a person-centered approach to allow interested clients to select their preferred notification method.

Program Direction for COP22 based on COP20 Results: PEPFAR/T used past performance data to identify areas of best practice and to inform remediation strategies. During the COVID-19 pandemic, quarterly data reviews and POART discussions were particularly important to identify how the pandemic affected service delivery. Continued progress despite these challenges has indicated that, broadly speaking, Tanzania has chosen effective interventions and implementation strategies to continue towards the goal of epidemic control. Now that restrictions have lessened, quarterly data reviews have helped determine whether services have resumed, and where gaps remain.

Performance to date has impacted COP22 strategies and budgeting in many ways. For example, prioritizing PMTCT and pediatric interventions in COP22 due to ongoing performance gaps in these areas. PEPFAR/T has also initiated a DNO in response to continuous supply chain and laboratory network challenges. Utilizing past quarterly performance data informed our decision to shift VMMC targets in COP22 from regions of under-performance to regions that are successfully meeting targets. Finally, due to strong performance of the DREAMS program and saturation that will be reached in several councils in COP22, PEPFAR/T used evidence to propose expansion of the DREAMS program to three additional councils

Implementing Partner Alignment: For ensuring alignment with the PEPFAR strategy, PEPFAR/T uses several approaches. First, partners are given the opportunity to discuss the COP guidance and provide feedback on implementation strategy and target setting. Costed IP work plans are then 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. Monthly data reviews with IPs have been expanded to include pediatric indicators across the clinical cascade so staff and partners can track progress on identification and VLS for timely course correction.

In COP22, PEPFAR/T will continue to use a comprehensive set of information to assess partner performance, paired with several key approaches to improving that performance. PEPFAR/T utilizes data to effectively track partner performance down to the PSNU level. 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. Through regular data performance reviews with IPs, GOT officials, and other stakeholders, PEPFAR/T ensures both transparency and accountability. Quality management and integrated analysis are applied to identify facility and community sites that are under-performing; this improves implementation fidelity and supports the achievement of outcomes to drive epidemic control.

Community-led monitoring (CLM) plans: CLM will continue in COP22 to ensure that project implementation and service delivery meets the needs of people who seek prevention, treatment, and care services. PEPFAR/T will transition CLM activities away from the PEPFAR Small Grants to an implementing mechanism implemented by NACOPHA who has also been supporting CLM work and was at the forefront of developing data collection tools and approaches along with other CSOs including KP and women-led groups. PEPFAR/T will continue to foster a grassroots network of indigenous organizations that include PLHIV groups, KP groups, and other CSOs through NACOPHA to monitor and provide feedback to R/CHMTs, facilities, and IPs to improve performance. PEPFAR/T will ensure that CLM activities meaningfully involve KP representatives to assess KP service delivery and that CLM also assesses PMTCT and pediatric programs to track improvements and challenges over time from a community perspective. KP, PLHIV, and other beneficiaries will continue to be involved in CLM planning and high-level coordination of CLM will be supported by UNAIDS.

4.6 Commodities

The availability of and accessibility to life-saving health commodities is a cornerstone of HIV epidemic control and achieving the 95-95-95 objectives. The demand for commodities has risen as programs have expanded to reach more patients. This has increased both the financial and management burden to handle large volumes of commodities. Global shortages of commodities and supply chain disruptions, especially during COVID 19 pandemic, have introduced complex challenges in Tanzania's ability to secure commodities timely, and in sufficient quantities to meet programmatic needs. Although the global supply chain has become more stable, disruptions to the system outside of PEPFAR/T's control remain a risk. To mitigate some of these risks, PEPFAR/T facilitates the commodity, equipment, and technology TWG that is composed of all the supply chain stakeholders in Tanzania. In addition to this TWG, PEPFAR/T agencies and IPs have established a separate TWG to provide a forum to share challenges and best practices to overcome some of the commodity's issues within the supply chain systems in Tanzania.

For example, in FY22, there were shortages of blood collection tubes and examination gloves. PEPFAR/T is working with the GOT to ensure orders are placed early to allow for sufficient time

to identify and lock in a supplier that can meet the country's requirements. The lack of visibility on health commodities movement between MSD and the facilities is another challenge. PEPFAR/T is working with the GOT on a strategy to increase transparency in the supply chain and track the real time consumption data. PEPFAR/T has recommended that NACP increase frequency of orders of smaller volumes of commodities to remain within the min-max levels and reduce risk of expiration. This approach allows the country to maintain good stock levels if there is a delay with a consignment. Quarterly reviews of the National Supply Plan and sharing demand data with the ARV Procurement Working Group and suppliers also helps mitigate risk for any potential shortages.

Ritonavir is now administered with Paxlovid, an oral treatment for COVID-19 for non-hospitalized patients with mild to moderate COVID-19.[19] If this product is scaled up further it could impact availability for ARVs. The supply base is currently not reporting shortages and Global Health Supply Chain Procurement and Supply Management (GHSC-PSM) - the PEPFAR/T supply chain partner - continues to address the topic monthly with suppliers to avoid any future problems. That said, the overall demand for Ritonavir-based ARVs has declined in the past two quarters as patients continue to transition to DTG-based regimens. Supply risk for PrEP products remain low, however, orders need to be placed well in advance as the lead times are longer than other first line ARVs. In COP22, PEPFAR/T is committed to working closely with the GOT to monitor PrEP supplies and consumption to ensure sufficient supply while this intervention is being rapidly brought to scale.

In country, there have been some concerns related to commodity stockout due to possible funding gaps. This includes TPT commodities and TB GeneXpert cartridges. To mitigate this gap GFATM has committed to support a portion of these commodities in Tanzania’s forthcoming GFATM reprogramming. Even in this context, lack of visibility on consumption and other data for POCT remains a risk and would impact testing among HIV-positive pregnant mothers in hard-to-reach areas. PEPFAR/T will rely on the DNO to look for opportunities to improve supply chain and consumption data transparency and collaborate with the GOT to develop solutions for laboratory platform efficiency, including POCT. PEPFAR/T will also rely on the DNO results to make evidence-based decisions about the commodity needs for laboratory testing platforms. PEPFR/T participated in the November 2021 national quantification exercise and is currently participating in the April 2022 update. Based on the 2021 quantification, the GOT included several platforms – point of care and Hologic – without commitment from donors to support the appropriate reagents. It should be noted that PEPFAR/T will wait to commit support for any new testing platforms until the findings from the DNO exercise are available to inform optimized platform decisions.

Tanzania has fully transitioned to the all-inclusive model for conventional molecular VL/EID testing. This will help achieve the greatest cost-saving by committing appropriate volumes and securing a more sustainable market necessary to ensure availability of commodities in the country.

[19] National Institutes for Health. Ritonavir-Boosted Nirmatrelvir (Paxlovid). 2022. Available from: https://www.covid19treatmentguidelines.nih.gov/therapies/antiviral-therapy/ritonavir-boosted-nirmatrelvir--paxlovid-/

For condoms, the recent Reproductive Child health Services quantification exercise included all key stakeholders from the public and private sector that are managing condoms to discuss opportunities for improved availability. They combined insights from different stakeholders and social marketing partners who reviewed forecasts for male condoms for the private sector. These were used to inform COP 22 condom quantification.

4.7 Collaboration, integration, and monitoring

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

Accelerating progress toward HIV epidemic control requires coordination and innovation across technical areas with intensified focus on measurable outcomes and impact. PEPFAR/T's guiding principles include interagency collaboration, data transparency, efficient programming, and accountability. The PEPFAR program in Tanzania is implemented through USAID, CDC, WRAIR/DOD, and Peace Corps and is coordinated and managed by the PEPFAR Coordination Office which ensures, teamwork, results sharing, and data-informed decision making across the interagency. Technical teams within and across the agencies interact and strategize through Goal Teams categorized based on PEPFAR/T's goals to reach epidemic control: Identify, Link, and Retain, Measure and Ensure Viral Load Suppression, Ensure KVP are Reached and Engaged, Eliminate Mother-to-Child Transmission, Reduce Mortality, and Prevent New Infections. Additional Cross Cutting Core Groups focused on cross cutting issues such as supply chain, health information systems, and reporting also provide fora to address these issues individually and members join Goal Team discussions and planning meetings to ensure these cross-cutting issues are addressed in the context of specific epidemic control objectives. Collectively, these interagency teams foster constructive technical and policy dialogues among agencies, stimulate innovation, and enhance program standardization. Interagency Action Pillar Groups lead strategic coordination and prioritization with a focus on ensuring that program activities are generating data to drive performance, ensuring all sites perform, ensuring effective policies are in place and ensuring effective tools and implementation approaches are available. Collectively, these elements are critical for programmatic success. At the management level, the PEPFAR COMPASS team provides regular opportunities for Agency senior leadership to update on activities and initiatives, monitor program progress, and explore remediation approaches for programmatic gaps. This group helps ensure that best practices identified are applied across the interagency.

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. Monthly meetings initiated in FY20 chaired by the Chief Medical Officer continue to take place consistently and provide an opportunity for PEPFAR leadership and technical staff to interact with their GOT counterparts to track progress on PEPFAR's Minimum Program Requirements as well as any other programmatic priorities. PEPFAR/T also engages in monthly coordination meetings with the Development Partners Group for HIV/AIDS (DPG-AIDS) that includes UNAIDS, Clinton Health Access Initiative, WHO, GFATM,

UNICEF, and other UN organizations. This group ensures alignment of policy priorities across development partners, advocates with GOT for policy change, and ensures a collective and unified approach to addressing programmatic barriers and gaps. Currently the DPG-AIDS group is co-chaired by UNAIDS and PEPFAR. In addition, PEPFAR/T is engaging with a broader selection of health sector stakeholders in monthly and quarterly coordination meetings through DPG Health and Technical Committee of the Sector Wide Approach, respectively.

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 donor constituencies. In the spirit of collective planning to maximize program synergies and minimize duplication in funding the GFATM Country Team 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. This includes joining supply forecasting and quantification exercises, meeting regularly to track commodity consumption and order timelines, and jointly advocating for strategies to strengthen and improve transparency within Tanzania's supply chain system. With respect to implementation of community services, including those targeting KVPs, PEPFAR/T works closely with GFATM principal recipients to geographically align partners and programs to prevent duplication.

b. Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods

After monitoring partner management virtually during the height of the COVID-19 pandemic, PEPFAR/T has already reintroduced intensive in-person site monitoring activities, which will continue in COP22. Drawing on effective partner management practices that were developed in COP18 and COP19, as well as lessons learned from virtual monitoring in COP20 and the beginning of COP21, PEPFAR/T will continue to strengthen approaches and processes to ensure highly effective, timely, and standardized partner management down to the PSNU level. In COP22, PEPFAR/T will also intensify DQAs to ensure that partner reporting is accurate, and data systems are functioning effectively. PEPFAR/T will develop a standard approach to DQAs that will be implemented by all agencies.

PEPFAR/T will focus on data utilization and use of data at a granular level to improve performance. This will include utilization of data to identify underperformance and best practice. In COP22, PEPFAR/T will continue to use a comprehensive set of information to assess partner performance, paired with several key approaches to improve performance when needed. The assessment of partner performance starts with standard

PEPFAR metrics, including use of the PEPFAR MER, SIMS, and financials by reviewing outlays and budget analysis, all of which are currently available on a quarterly basis. 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. Additionally, PEPFAR/T will continue using high frequency data that is collected monthly to track progress of activities including index testing, multi-month dispensing, PrEP enrollment, and the pediatric cascade.

Use of granular data to improve performance: 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. Drawing on the success of the regional strategy that was used after the COP19 approval meeting, PEPFAR/T will continue with Regional teams to closely track performance and identify remediation measures based on site-specific performance. High-volume and low performing sites will continue to be prioritized for intensive site visits. 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. Formal Partner Performance Improvement Plans will be implemented in cases of prolonged underperformance.

In addition to partner management that is conducted by USG, CLM will continue in COP22 to ensure that project implementation and service delivery meets the needs of people who seek prevention, treatment, and care services. PEPFAR/T will continue to foster a grassroots network of indigenous organizations and CSOs, particularly KP and women-led organizations, to monitor and provide feedback to R/CHMTs, facilities, and IPs to improve performance. Engagement will also continue through continued collaboration with and support for the KVP Forum.

Given the ongoing COVID-19 pandemic, if there is a need to return to virtual monitoring, PEPFAR/T will revisit practices that were developed in response to restrictions faced earlier in 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.

c. Improving integration of key health system interventions, including HRH and laboratory activities across the cascade

Building on COP21, in COP22 PEPFAR/T will continue to collaborate and coordinate with GOT and development partners to address crucial health systems 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 availability of skilled healthcare workers and their performance in reaching the set clinical service targets. PEPFAR/T will continue to institutionalize and align PEPFAR HCWs support with GOT human resources processes for transitioning and 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 and COP22 targets. HCWs safety, fair pay, scaling the capacity of human resource HIS, application of client-centered approaches, performance management, and formalization of data and community cadres using the recent approved community healthcare workers implementation guideline will be focused on in COP22. Other health systems strengthening activities including health financing, health management information systems, supply chain and participation of the private sector will be implemented to support the integration of HIV services, promoting transparency, effective coordination, and sustainability. PEPFAR will continue to collaborate with the GOT to use the HRH Inventory to guide decisions about filling human resource gaps. PEPFAR/T recognizes that there is a healthcare worker shortage and will seek opportunities to sustainably address this issue. PEPFAR/T will continue to advocate for the use of community health care workers to support tasks at the community level.

For Laboratory services, PEPFAR/T will maintain certification and accreditation standards of 44 laboratories to meet the required operational standards for quality testing while continuing to mentor 15 laboratories towards ISO15189 accreditation. The program will continue to expand the HIV proficiency testing (PT) program to cover 100% HIV rapid testing sites for continuously improved quality of diagnostic HIV testing services. In addition, the program will support training, competency assessment, and certification of testers at all PEPFAR/T supported sites. PT support for HIV molecular testing services, in addition to TB testing will also continue to be supported by the PEPAR/T program to maintain access to reliable testing for all PEPFAR/T clients.

Improving EID testing coverage has been a key focus of PEPFAR/T and will continue to be so in COP22 maintaining gains made in COP21 and implementing novel EID diagnostic assays to maximize testing efficiencies, enabling faster linkage to care and improved patient outcomes. PEPFAR/T will continue to support quality VLC to ensure that all eligible patients receive at least one viral load test per year. In collaboration with health care providers and IPs, PEPFAR/T will scale-up viral load demand creation activities, support integration of CTC3 within laboratory information systems to improve result turnaround time and continue to support the DNO and multiplexing strategies for viral load testing, EID, and TB. The DNO reassessment exercise to be undertaken in COP21 will lead the way forward for optimized testing methods for HIV detection and

viral load monitoring in COP22, reducing patient testing backlogs through implementation of short-term and long-term strategies led by the GOT. PEPFAR/T will also support the optimized utilization of high throughput molecular testing platforms, and work with the MOH and in-country stakeholders to improve data transparency, coordination and oversight of commodity availability, equipment functionality, and utilization of integrated sample referral systems for HIV, TB, and other diseases including COVID-19.

PEPFAR/T will continue to advocate to the GOT for the full adoption of the Global RFP for HIV molecular testing reagents, commodities, and servicing of testing systems. The full adoption of the Global RFP by the GOT would result in considerable cost-savings for the PEPFAR/T program, increase data visibility, minimize instrument down time, reduce sample backlogs with the improved visibility and coordination of testing reagents and associated commodities.

d. Improving integration of quality and efficiencies in service delivery through improved models of care delivery across community and facility sites

PEPFAR/T is focused on key principles that have been essential to the accelerated progress toward epidemic control that Tanzania has demonstrated over the past several years. 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 has had to continuously adapt its approaches to closely monitor implementation and progress.

Collaboration between PEPFAR/T and GOT at the national-, regional-, and council-level is paramount to have in place the right policies for greater effectiveness, efficiency, and sustainability of the program. Collaboration with and across IPs and site staff allows for the appropriate translation of policy and programming to services that impact PLHIV and result in lives saved. Last, but most importantly, through collaboration with recipients of care through community led monitoring efforts, and interpersonal communication, PEPFAR/T adopts and scales out person-centered differentiated service delivery to facilitate continuity of treatment and better health outcomes. In recent years, these collaborations have facilitated the successful scale-up of 6MMD of ARVs, the expansion of community outreach ART, HIV self-testing, index testing, and social network testing – models that have been crucial to the recent successes and sustained progress of the PEPFAR/T program despite challenges posed by the COVID-19 pandemic. Differentiated service delivery is further leveraged by integrating services for one-stop-shop service provision, including medication refills, clinical assessment and care, viral load sample collection and other essential services.

PEPFAR/T continues to utilize a CQI approach, supported by the focused use of granular data and monitoring at national, subnational, health facility and IP levels. PEPFAR/T works in close collaboration with GOT counterparts at the national, regional,

and local levels on partner performance monitoring, programmatic oversight, and quality improvement to ensure accountability for the PEPFAR program down to the site level. To support these efforts, PEPFAR/T has been able to utilize routine and in-depth data to make agile, incremental improvements in the scale-up of key interventions and the implementation of strategies to support improved models of care delivery across community and facility sites. For example, PEPFAR/T was able to effectively monitor and drive the successful scale-up of 6MMD and PrEP over the course of FY22 Q1 and in to FY22 Q2. Overall, PEPFAR/T supports cohesive and holistic health information systems for measuring population- and person-level health outcomes.

In addition to CQI, PEPFAR/T prioritizes the implementation of CLM to ensure quality services by listening to the voices of the beneficiaries directly. The CLM process through PEPFAR/T is implemented by local community-based organizations who gather quantitative and qualitative data about HIV services and develops and advocates for solutions to the gaps identified during data collection to integrate quality improvement into the service delivery process. Feedback through CLM in COP21 have resulted in initiatives such as increased opinion boxes placed in CTC to collect further feedback from beneficiaries directly at service delivery locations.

PEPFAR/T system investments focus on strengthening the service delivery systems in the public, faith-based, and private sectors to be resilient and responsive to program needs. These investments have ensured the maintenance of effective service delivery and policies to support the scale-up of life-saving interventions. This has proven to be particularly important in facing the challenges of the COVID-19 pandemic while continuing to maintain, expand and improve services for PLHIV in Tanzania. Throughout the pandemic, we have continued to use the Project ECHO Tanzania platform 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 COP22, 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 person- 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.

e. 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 gained valuable experience since introducing CLM in FY21. PEPFAR/T, in collaboration with UNAIDS, developed and validated national CLM tools and indicators. PEPFAR/T piloted CLM in 18 high burden, low performing councils through the NACOPHA and the PEPFAR small grants program. PEPFAR/T's CLM program

reached 167 health facilities, trained 290 PLHIV to serve as Community Monitors, collecting 3,612 responses from clients and healthcare workers. NACOPHA and the civil society organizations implementing the CLM small grants have begun compiling both positive and negative feedback received and discussing corrective actions with healthcare providers and managers.

In COP22, building on these experiences, PEPFAR/T will strengthen and expand an inclusive and coordinated approach to CLM. Programmatically, the funding and management will shift away from the Ambassador's Small Grants, and be housed exclusively under USAID's IP, NACOPHA, who can, in-turn subaward to appropriate CSO partners based on CLM focus and need. This shift will allow NACOPHA to institutionalize this approach for greater sustainability and improve national-level coordination through its existing network as well as an expanded network of beneficiary-led CSOs based on CLM focus and need.

The plans for COP22 include expanding CLM to a total 251 health facilities. PEPFAR/T will take a more inclusive approach to CLM by incorporating indicators related to priority groups such as KP, HIV-positive pregnant women, and pediatric clients. To better address the needs of KP, NACOPHA will capacitate KP-led and KP-competent organizations to conduct CLM. PEPFAR/T will review council selection criteria to prioritize areas for CLM expansion, focusing on priority councils for the AP3 and KP programming. PEPFAR/T will review council selection criteria annually based on epidemiology and programmatic priorities. PEPFAR/T will also develop a process and milestones to graduate councils that are no longer considered a priority to allow for greater expansion. PEPFAR/T will also expand CLM to private health facilities in pediatrics/PMTCT priority councils in COP22.

Furthermore, PEPFAR/T will streamline data collection tools, integrate questions related to programmatic priorities (e.g. pediatrics, KP, PMTCT) and introduce methods for group data collection, such as focus group discussions and community scorecards. NACOPHA will create a centralized database to consolidate CLM data collection and analysis and to triangulate these data with other data sources. Likewise, NACOPHA will hold quarterly data reviews with local government authorities, UNAIDS and other IPs to coordinate learning, problem solving and the identification of corrective actions. Institutionalizing CLM under one organization will facilitate collaboration with clinical partners to implement these corrective actions.

f. Ensuring above-site program activities are mapped to key barriers and measurable outcomes related to reaching epidemic control; and monitored in an ongoing manner

Above-site system strengthening are the foundation of the PEPFAR/T's efforts to strengthen the GOT's long-term capacity to manage the HIV response and ensure the sustainability of investments made. Critical above-site programmatic elements include building data systems, fostering a culture of real-time data utilization for program

monitoring and strengthening HIV-related surveillance systems. Ensuring a robust supply chain system for which the GOT is accountable is an essential step towards HIV program ownership. A focus on HRH that includes competency-based skills building and knowledge sharing to continuous quality improvement for improved service delivery is necessary in addition to ensuring that health care system has sufficient staff. Advancing domestic resource mobilization, will also ensure that GOT resources are utilized for shared responsibility to sustain epidemic control. In this regard, PEPFAR/T COP22 activities are aimed toward integrating and aligning key functions of the HIV program for institutionalization within existing government systems.

In COP22, PEPFAR/T will continue to map above-site level activities to key barriers through measurable indicators and linked to site level (service & non-service delivery) activities and deliverables as described in section 5. This is accomplished using documented outcomes from the implementation of COP21 and consideration of prior Table 6/above site investments alongside key data points from the SID 2021 results, MER, and SIMS results. In addition, guidance from the PLL that highlights the key programmatic challenges, partner performance issues, and Minimum Program Requirements were also considered to identify and prioritize above site activities for COP22.

In COP22, PEPFAR/T will continue to address barriers to sustainability as identified in the most recent SID from 2021. This includes service delivery efficiency and quality, 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 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 is committed to continuous strengthening of three out of the five subsystems of the HIS system, namely the Routine Service Reporting, Program Information, and Epidemiological Surveillance. This will be achieved through renewed focus to integrate unique identification within the health information systems.

PEPFAR/T will continue to ensure that during development of above-site polices and plans, inbuilt monitoring and evaluation systems are part of the design. For instance, during the roll of out the task sharing policy an electronic M&E tool was created which enabled the GoT to track the 8 policy recommendations of the 5-year implementation plan (2017-2022). This ultimately informed to monitor development of the next task sharing policy.

PEPFAR/T will continue to work collaboratively with MOH and PO-RALG through existing GOT platforms to ensure COP22 implementation reflects all relevant priority policies and guidelines. Specific policy developments that support implementation include further scale-up of community outreach ART, transition to DTG 10mg, differentiated service delivery including 6-month MMD, nurse-initiated management of ART (NIMART), HIV case-based surveillance (CBS), enabling lay workers to perform HIV testing, TPT for all PLHIV, including a transition to 3HP, completion of EID laboratory optimization, and deployment for community health workers as a key component of task sharing. In addition, PEPFAR/T will continue to support GOT to further scale-up index and HIVST with fidelity and to integrate HIV recency surveillance as part of routine program activities.

In COP22, the budget for above site increased from COP21 due to integration of funding for THIS 2022-2023 into Tanzania's COP funding envelope. Otherwise, funding for traditional above-site activities has stayed at COP21 levels.

g. Use of unique identifiers across sites and programs in clinical settings for monitoring

PEPFAR/T is committed and continues to support unique identification for the approximately 1.5M PLHIV receiving care in Tanzania. Currently, each person receives a unique identifier when initiating care and treatment (CTCID) that is assigned and used within individual HIV clinics. However, this limits the ability to track clients who move between services or facilities or who are registered with multiple CTCIDs. To address this issue, PEPFAR/T has championed the development of the National Health Client Registry (NHCR), a national-level repository of client demographic information and national-level and legally assigned, standardized identifications.

To date, use cases, which are real-world based data exchanges that are used to test data and communication protocols, have been developed and linked through the Health Information Mediator (HIM) with the National Identification Agency (NIDA) and RITA systems and tested with the AfyaCare Electronic Medical Record (EMR) to support unique validation and identification of clients including PLHIV. These use cases inform facilities if the new client was successfully entered and validated. However, implementation in patient-level systems has not yet occurred but roll out is planned in COP22. In COP22, PEPFAR/T will roll out unique identifiers through the implementation of the NHCR within patient-level record systems, including CTC2/3, GoTHOMIS, and AfyaCare, to reach 95% of all installed instances. In addition, PEPFAR/T will advocate for the CTC2/3 data system to support biometrics as a form of identification validation and support activation and implementation.

Biometrics were successfully integrated into the CTC2 system under a PEPFAR/T supported pilot project in Zanzibar. On the Mainland of Tanzania, a biometrics module has also been integrated within the AfyaCare EMR system, but that system is currently

only slated for roll-out in 28 regional and specialized hospitals (among the 3,000+ facilities serving PLHIV). Currently, the biometrics module is not integrated within HIV services in any PEPFAR/T supported facilities on the Mainland. PEPFAR/T has supported the GOT in the integration of biometrics within the general patient-level systems, especially AfyaCare. In COP22 PEPFAR/T will continue to support MOH to roll out biometrics as a form of identification validate within all patient-level record systems.

4.8 Targets by population

Standard Table 4.8.1

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)
Attained	218,678	199,250	2,158	210,016	22,624	**96%**
Scale-Up Saturation	1,203,265	1,057,989	34,128	1,125,290	111,890	**94%**
Scale-Up Aggressive	-	-	-	-	-	-
Sustained	316,486	282,141	19,000	312,451	40,746	**99%**
Central Support	-	-	-	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
Total	1,738,429	1,565,859	55,286	1,671,959	177,772	**96%**

Standard Table 4.8.2

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (FY22)	VMMC_CIRC (in FY23)	Expected Coverage (in FY23)
Arusha CC	15-19	31489	123%	0	95%
Arusha CC	20-24	32905	101%	0	95%
Arusha CC	25-29	30416	93%	0	95%
Arusha CC	30-34	25848	93%	0	95%
Arusha CC	35-39	22342	90%	0	95%
Arusha CC	40-44	16701	99%	0	95%
Arusha CC	45-49	12387	109%	0	95%
Arusha CC	50-54	9277	0%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Arusha CC	55-59	6267	0%	0	95%
Arusha CC	60-64	4012	0%	0	95%
Arusha CC	65+	4237	0%	0	95%
Arusha DC	15-19	25332	97%	0	95%
Arusha DC	20-24	20943	101%	0	95%
Arusha DC	25-29	17475	103%	0	95%
Arusha DC	30-34	14528	104%	0	95%
Arusha DC	35-39	12824	99%	0	95%
Arusha DC	40-44	9877	106%	0	95%
Arusha DC	45-49	7395	115%	0	95%
Arusha DC	50-54	5926	0%	0	95%
Arusha DC	55-59	4735	0%	0	95%
Arusha DC	60-64	3008	0%	0	95%
Arusha DC	65+	4526	0%	0	95%
Ilala MC	15-19	62297	168%	0	95%
Ilala MC	20-24	53337	168%	0	95%
Ilala MC	25-29	64661	118%	0	95%
Ilala MC	30-34	80554	80%	0	95%
Ilala MC	35-39	72697	74%	0	95%
Ilala MC	40-44	61286	73%	0	95%
Ilala MC	45-49	43066	84%	0	95%
Ilala MC	50-54	31491	0%	0	95%
Ilala MC	55-59	19795	0%	0	95%
Ilala MC	60-64	13813	0%	0	95%
Ilala MC	65+	16605	0%	0	95%
Kigamboni MC	15-19	8209	167%	0	95%
Kigamboni MC	20-24	7270	162%	0	95%
Kigamboni MC	25-29	9013	111%	0	95%
Kigamboni MC	30-34	10170	83%	0	95%
Kigamboni MC	35-39	9180	77%	0	95%
Kigamboni MC	40-44	7471	79%	0	95%
Kigamboni MC	45-49	5752	83%	0	95%
Kigamboni MC	50-54	3969	0%	0	95%
Kigamboni MC	55-59	2552	0%	0	95%
Kigamboni MC	60-64	1797	0%	0	95%
Kigamboni MC	65+	2636	0%	0	95%
Kinondoni MC	15-19	46109	180%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kinondoni MC	20-24	44492	160%	0	95%
Kinondoni MC	25-29	55568	109%	0	95%
Kinondoni MC	30-34	65728	78%	0	95%
Kinondoni MC	35-39	57205	75%	0	95%
Kinondoni MC	40-44	46728	76%	0	95%
Kinondoni MC	45-49	31952	90%	0	95%
Kinondoni MC	50-54	22659	0%	0	95%
Kinondoni MC	55-59	15216	0%	0	95%
Kinondoni MC	60-64	10885	0%	0	95%
Kinondoni MC	65+	13448	0%	0	95%
Temeke MC	15-19	63357	160%	0	95%
Temeke MC	20-24	51564	169%	0	95%
Temeke MC	25-29	64345	115%	0	95%
Temeke MC	30-34	76394	82%	0	95%
Temeke MC	35-39	69155	76%	0	95%
Temeke MC	40-44	57139	76%	0	95%
Temeke MC	45-49	41385	85%	0	95%
Temeke MC	50-54	30244	0%	0	95%
Temeke MC	55-59	18536	0%	0	95%
Temeke MC	60-64	13074	0%	0	95%
Temeke MC	65+	14919	0%	0	95%
Ubungo MC	15-19	42175	176%	0	95%
Ubungo MC	20-24	39289	162%	0	95%
Ubungo MC	25-29	48041	113%	0	95%
Ubungo MC	30-34	58472	78%	0	95%
Ubungo MC	35-39	52029	74%	0	95%
Ubungo MC	40-44	42847	74%	0	95%
Ubungo MC	45-49	28283	91%	0	95%
Ubungo MC	50-54	20625	0%	0	95%
Ubungo MC	55-59	12767	0%	0	95%
Ubungo MC	60-64	9112	0%	0	95%
Ubungo MC	65+	10439	0%	0	95%
Kondoa DC	15-19	19301	75%	0	95%
Kondoa DC	20-24	11047	112%	0	95%
Kondoa DC	25-29	8620	123%	0	95%
Kondoa DC	30-34	6886	130%	0	95%
Kondoa DC	35-39	6381	117%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kondoa DC	40-44	5095	121%	0	95%
Kondoa DC	45-49	4797	105%	0	95%
Kondoa DC	50-54	3755	0%	0	95%
Kondoa DC	55-59	3243	0%	0	95%
Kondoa DC	60-64	2335	0%	0	95%
Kondoa DC	65+	3890	0%	0	95%
Kondoa TC	15-19	5625	81%	0	95%
Kondoa TC	20-24	4144	95%	0	95%
Kondoa TC	25-29	2721	123%	0	95%
Kondoa TC	30-34	2336	121%	0	95%
Kondoa TC	35-39	2002	118%	0	95%
Kondoa TC	40-44	1578	124%	0	95%
Kondoa TC	45-49	1545	103%	0	95%
Kondoa TC	50-54	1284	0%	0	95%
Kondoa TC	55-59	1087	0%	0	95%
Kondoa TC	60-64	818	0%	0	95%
Kondoa TC	65+	1284	0%	0	95%
Kongwa DC	15-19	26068	86%	0	95%
Kongwa DC	20-24	18870	103%	0	95%
Kongwa DC	25-29	14800	111%	0	95%
Kongwa DC	30-34	13361	104%	0	95%
Kongwa DC	35-39	10780	108%	0	95%
Kongwa DC	40-44	8371	115%	0	95%
Kongwa DC	45-49	6525	120%	0	95%
Kongwa DC	50-54	4753	0%	0	95%
Kongwa DC	55-59	3909	0%	0	95%
Kongwa DC	60-64	2660	0%	0	95%
Kongwa DC	65+	3970	0%	0	95%
Bukombe DC	15-19	19465	102%	0	95%
Bukombe DC	20-24	15002	125%	0	95%
Bukombe DC	25-29	12658	122%	0	95%
Bukombe DC	30-34	9921	113%	0	95%
Bukombe DC	35-39	8211	91%	81	95%
Bukombe DC	40-44	6027	80%	203	95%
Bukombe DC	45-49	4975	64%	352	95%
Bukombe DC	50-54	3163	0%	682	95%
Bukombe DC	55-59	2403	0%	518	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Bukombe DC	60-64	1669	0%	360	95%
Bukombe DC	65+	2249	0%	485	95%
Chato DC	15-19	31976	124%	0	95%
Chato DC	20-24	23581	137%	0	95%
Chato DC	25-29	18893	120%	0	95%
Chato DC	30-34	15069	101%	0	95%
Chato DC	35-39	12547	83%	348	95%
Chato DC	40-44	9881	73%	493	95%
Chato DC	45-49	8637	61%	672	95%
Chato DC	50-54	5711	0%	1231	95%
Chato DC	55-59	4702	0%	1014	95%
Chato DC	60-64	3070	0%	662	95%
Chato DC	65+	4436	0%	957	95%
Geita DC	15-19	54038	122%	0	95%
Geita DC	20-24	41093	142%	0	95%
Geita DC	25-29	32360	138%	0	95%
Geita DC	30-34	25535	120%	0	95%
Geita DC	35-39	20821	99%	0	95%
Geita DC	40-44	16111	86%	324	95%
Geita DC	45-49	14338	67%	903	95%
Geita DC	50-54	10151	0%	2189	95%
Geita DC	55-59	8373	0%	1806	95%
Geita DC	60-64	5325	0%	1148	95%
Geita DC	65+	7827	0%	1688	95%
Geita TC	15-19	16885	130%	0	95%
Geita TC	20-24	15800	121%	0	95%
Geita TC	25-29	13650	104%	0	95%
Geita TC	30-34	10747	90%	111	95%
Geita TC	35-39	7953	85%	174	95%
Geita TC	40-44	5398	90%	59	95%
Geita TC	45-49	4371	82%	133	95%
Geita TC	50-54	2788	0%	601	95%
Geita TC	55-59	2357	0%	508	95%
Geita TC	60-64	1355	0%	292	95%
Geita TC	65+	1848	0%	399	95%
Mbogwe DC	15-19	17424	108%	0	95%
Mbogwe DC	20-24	12619	125%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mbogwe DC	25-29	9791	118%	0	95%
Mbogwe DC	30-34	7207	106%	0	95%
Mbogwe DC	35-39	6151	83%	165	95%
Mbogwe DC	40-44	4597	74%	222	95%
Mbogwe DC	45-49	4097	55%	373	95%
Mbogwe DC	50-54	2730	0%	589	95%
Mbogwe DC	55-59	2160	0%	466	95%
Mbogwe DC	60-64	1472	0%	317	95%
Mbogwe DC	65+	2178	0%	470	95%
Iringa DC	15-19	18692	111%	0	95%
Iringa DC	20-24	14472	131%	0	95%
Iringa DC	25-29	11917	124%	0	95%
Iringa DC	30-34	11288	93%	256	95%
Iringa DC	35-39	9788	75%	247	95%
Iringa DC	40-44	8336	63%	285	95%
Iringa DC	45-49	6562	59%	250	95%
Iringa DC	50-54	5197	0%	522	95%
Iringa DC	55-59	3989	0%	401	95%
Iringa DC	60-64	2970	0%	298	95%
Iringa DC	65+	4878	0%	490	95%
Kilolo DC	15-19	15537	130%	0	95%
Kilolo DC	20-24	12980	139%	0	95%
Kilolo DC	25-29	11032	125%	0	95%
Kilolo DC	30-34	9560	105%	0	95%
Kilolo DC	35-39	8603	84%	103	95%
Kilolo DC	40-44	7643	69%	208	95%
Kilolo DC	45-49	5426	73%	124	95%
Kilolo DC	50-54	4262	0%	428	95%
Kilolo DC	55-59	3123	0%	314	95%
Kilolo DC	60-64	2420	0%	243	95%
Kilolo DC	65+	3647	0%	366	95%
Mafinga TC	15-19	5835	103%	0	95%
Mafinga TC	20-24	7592	64%	248	95%
Mafinga TC	25-29	5332	62%	187	95%
Mafinga TC	30-34	3991	59%	154	95%
Mafinga TC	35-39	2922	61%	104	95%
Mafinga TC	40-44	2215	62%	77	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mafinga TC	45-49	1498	71%	38	95%
Mafinga TC	50-54	1176	0%	118	95%
Mafinga TC	55-59	836	0%	84	95%
Mafinga TC	60-64	637	0%	64	95%
Mafinga TC	65+	676	0%	68	95%
Mufindi DC	15-19	17774	134%	0	95%
Mufindi DC	20-24	14791	158%	0	95%
Mufindi DC	25-29	12569	150%	0	95%
Mufindi DC	30-34	10837	123%	0	95%
Mufindi DC	35-39	9193	99%	0	95%
Mufindi DC	40-44	7775	80%	122	95%
Mufindi DC	45-49	5787	77%	112	95%
Mufindi DC	50-54	4263	0%	428	95%
Mufindi DC	55-59	3305	0%	332	95%
Mufindi DC	60-64	2446	0%	246	95%
Mufindi DC	65+	3720	0%	374	95%
Biharamulo DC	15-19	25093	112%	0	95%
Biharamulo DC	20-24	22887	98%	0	95%
Biharamulo DC	25-29	15660	98%	0	95%
Biharamulo DC	30-34	11232	94%	108	95%
Biharamulo DC	35-39	9860	82%	356	95%
Biharamulo DC	40-44	8570	68%	571	95%
Biharamulo DC	45-49	6766	60%	603	95%
Biharamulo DC	50-54	5579	0%	1203	95%
Biharamulo DC	55-59	3594	0%	775	95%
Biharamulo DC	60-64	2490	0%	537	95%
Biharamulo DC	65+	3750	0%	809	95%
Bukoba DC	15-19	24057	95%	0	95%
Bukoba DC	20-24	16429	116%	0	95%
Bukoba DC	25-29	12715	105%	0	95%
Bukoba DC	30-34	11539	80%	390	95%
Bukoba DC	35-39	10858	64%	770	95%
Bukoba DC	40-44	10361	50%	1062	95%
Bukoba DC	45-49	7751	50%	788	95%
Bukoba DC	50-54	5606	0%	1209	95%
Bukoba DC	55-59	4577	0%	987	95%
Bukoba DC	60-64	2964	0%	639	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Bukoba DC	65+	5058	0%	1091	95%
Karagwe DC	15-19	27591	93%	146	95%
Karagwe DC	20-24	23826	91%	190	95%
Karagwe DC	25-29	18532	87%	355	95%
Karagwe DC	30-34	14104	79%	516	95%
Karagwe DC	35-39	11914	70%	687	95%
Karagwe DC	40-44	10628	57%	925	95%
Karagwe DC	45-49	8616	50%	882	95%
Karagwe DC	50-54	6300	0%	1359	95%
Karagwe DC	55-59	4433	0%	956	95%
Karagwe DC	60-64	3313	0%	714	95%
Karagwe DC	65+	4266	0%	920	95%
Kyerwa DC	15-19	25668	90%	284	95%
Kyerwa DC	20-24	21091	85%	476	95%
Kyerwa DC	25-29	17044	81%	529	95%
Kyerwa DC	30-34	12700	79%	465	95%
Kyerwa DC	35-39	11021	66%	719	95%
Kyerwa DC	40-44	9681	53%	919	95%
Kyerwa DC	45-49	7467	49%	778	95%
Kyerwa DC	50-54	5250	0%	1132	95%
Kyerwa DC	55-59	3822	0%	824	95%
Kyerwa DC	60-64	2714	0%	585	95%
Kyerwa DC	65+	3602	0%	777	95%
Missenyi DC	15-19	17277	79%	641	95%
Missenyi DC	20-24	13693	92%	106	95%
Missenyi DC	25-29	10411	98%	0	95%
Missenyi DC	30-34	8437	90%	96	95%
Missenyi DC	35-39	7404	77%	300	95%
Missenyi DC	40-44	6897	58%	577	95%
Missenyi DC	45-49	5467	52%	538	95%
Missenyi DC	50-54	4234	0%	913	95%
Missenyi DC	55-59	3186	0%	687	95%
Missenyi DC	60-64	2385	0%	514	95%
Missenyi DC	65+	3573	0%	770	95%
Muleba DC	15-19	45457	103%	0	95%
Muleba DC	20-24	34617	124%	0	95%
Muleba DC	25-29	27422	120%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Muleba DC	30-34	23378	98%	0	95%
Muleba DC	35-39	20625	78%	817	95%
Muleba DC	40-44	17686	62%	1335	95%
Muleba DC	45-49	13786	56%	1228	95%
Muleba DC	50-54	10416	0%	2246	95%
Muleba DC	55-59	7941	0%	1712	95%
Muleba DC	60-64	5166	0%	1114	95%
Muleba DC	65+	8073	0%	1741	95%
Ngara DC	15-19	24195	121%	0	95%
Ngara DC	20-24	20465	116%	0	95%
Ngara DC	25-29	15045	128%	0	95%
Ngara DC	30-34	10679	123%	0	95%
Ngara DC	35-39	9703	94%	16	95%
Ngara DC	40-44	7968	78%	313	95%
Ngara DC	45-49	6652	62%	501	95%
Ngara DC	50-54	5791	0%	1249	95%
Ngara DC	55-59	4346	0%	937	95%
Ngara DC	60-64	2997	0%	646	95%
Ngara DC	65+	3741	0%	807	95%
Mpanda DC	15-19	14468	113%	0	95%
Mpanda DC	20-24	10613	154%	0	95%
Mpanda DC	25-29	8802	156%	0	95%
Mpanda DC	30-34	7585	137%	0	95%
Mpanda DC	35-39	6837	112%	0	95%
Mpanda DC	40-44	5308	103%	0	95%
Mpanda DC	45-49	4353	91%	41	95%
Mpanda DC	50-54	2883	0%	685	95%
Mpanda DC	55-59	2291	0%	544	95%
Mpanda DC	60-64	1532	0%	364	95%
Mpanda DC	65+	2465	0%	586	95%
Mpanda MC	15-19	9799	169%	0	95%
Mpanda MC	20-24	8168	191%	0	95%
Mpanda MC	25-29	6617	184%	0	95%
Mpanda MC	30-34	5900	145%	0	95%
Mpanda MC	35-39	5077	115%	0	95%
Mpanda MC	40-44	3819	102%	0	95%
Mpanda MC	45-49	2681	101%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mpanda MC	50-54	1752	0%	416	95%
Mpanda MC	55-59	1379	0%	328	95%
Mpanda MC	60-64	915	0%	217	95%
Mpanda MC	65+	1433	0%	340	95%
Kigoma Ujiji MC	15-19	21388	102%	0	95%
Kigoma Ujiji MC	20-24	18441	99%	0	95%
Kigoma Ujiji MC	25-29	12862	112%	0	95%
Kigoma Ujiji MC	30-34	10050	121%	0	95%
Kigoma Ujiji MC	35-39	8127	127%	0	95%
Kigoma Ujiji MC	40-44	6582	129%	0	95%
Kigoma Ujiji MC	45-49	4996	137%	0	95%
Kigoma Ujiji MC	50-54	3781	0%	815	95%
Kigoma Ujiji MC	55-59	3325	0%	717	95%
Kigoma Ujiji MC	60-64	2001	0%	432	95%
Kigoma Ujiji MC	65+	2418	0%	521	95%
Uvinza DC	15-19	29556	125%	0	95%
Uvinza DC	20-24	24937	122%	0	95%
Uvinza DC	25-29	20975	116%	0	95%
Uvinza DC	30-34	16990	114%	0	95%
Uvinza DC	35-39	13772	110%	0	95%
Uvinza DC	40-44	10636	111%	0	95%
Uvinza DC	45-49	8409	111%	0	95%
Uvinza DC	50-54	6457	0%	1392	95%
Uvinza DC	55-59	5491	0%	1184	95%
Uvinza DC	60-64	3978	0%	858	95%
Uvinza DC	65+	5293	0%	1141	95%
Moshi DC	15-19	32680	105%	0	95%
Moshi DC	20-24	30806	96%	0	95%
Moshi DC	25-29	24488	103%	0	95%
Moshi DC	30-34	17938	119%	0	95%
Moshi DC	35-39	15572	115%	0	95%
Moshi DC	40-44	14794	100%	0	95%
Moshi DC	45-49	13159	91%	0	95%
Moshi DC	50-54	11606	0%	0	95%
Moshi DC	55-59	9517	0%	0	95%
Moshi DC	60-64	7981	0%	0	95%
Moshi DC	65+	14507	0%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Bunda DC	15-19	19866	112%	0	95%
Bunda DC	20-24	14272	118%	0	95%
Bunda DC	25-29	11022	133%	0	95%
Bunda DC	30-34	8066	137%	0	95%
Bunda DC	35-39	6686	125%	0	95%
Bunda DC	40-44	5679	116%	0	95%
Bunda DC	45-49	4713	116%	0	95%
Bunda DC	50-54	3538	0%	763	95%
Bunda DC	55-59	2879	0%	621	95%
Bunda DC	60-64	2115	0%	456	95%
Bunda DC	65+	3298	0%	711	95%
Musoma DC	15-19	18015	125%	0	95%
Musoma DC	20-24	13880	127%	0	95%
Musoma DC	25-29	11209	130%	0	95%
Musoma DC	30-34	8866	124%	0	95%
Musoma DC	35-39	7168	115%	0	95%
Musoma DC	40-44	5989	110%	0	95%
Musoma DC	45-49	4978	108%	0	95%
Musoma DC	50-54	3531	0%	761	95%
Musoma DC	55-59	2855	0%	616	95%
Musoma DC	60-64	2160	0%	466	95%
Musoma DC	65+	3259	0%	703	95%
Musoma MC	15-19	13407	88%	212	95%
Musoma MC	20-24	10687	99%	0	95%
Musoma MC	25-29	8718	101%	0	95%
Musoma MC	30-34	6132	116%	0	95%
Musoma MC	35-39	4792	123%	0	95%
Musoma MC	40-44	3624	133%	0	95%
Musoma MC	45-49	2918	134%	0	95%
Musoma MC	50-54	2283	0%	492	95%
Musoma MC	55-59	1822	0%	393	95%
Musoma MC	60-64	1247	0%	269	95%
Musoma MC	65+	1589	0%	343	95%
Rorya DC	15-19	21497	61%	1661	95%
Rorya DC	20-24	15183	78%	583	95%
Rorya DC	25-29	13115	77%	549	95%
Rorya DC	30-34	10427	84%	264	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Rorya DC	35-39	8428	89%	119	95%
Rorya DC	40-44	6875	90%	85	95%
Rorya DC	45-49	5372	93%	30	95%
Rorya DC	50-54	4330	0%	934	95%
Rorya DC	55-59	3508	0%	757	95%
Rorya DC	60-64	2486	0%	536	95%
Rorya DC	65+	4148	0%	895	95%
Serengeti DC	15-19	21070	65%	1453	95%
Serengeti DC	20-24	15848	78%	616	95%
Serengeti DC	25-29	12701	83%	357	95%
Serengeti DC	30-34	9123	100%	0	95%
Serengeti DC	35-39	7664	102%	0	95%
Serengeti DC	40-44	6264	103%	0	95%
Serengeti DC	45-49	4776	109%	0	95%
Serengeti DC	50-54	3722	0%	803	95%
Serengeti DC	55-59	2744	0%	592	95%
Serengeti DC	60-64	1874	0%	404	95%
Serengeti DC	65+	2767	0%	597	95%
Tarime TC	15-19	7233	72%	375	95%
Tarime TC	20-24	6244	76%	274	95%
Tarime TC	25-29	4490	89%	59	95%
Tarime TC	30-34	3095	113%	0	95%
Tarime TC	35-39	2648	113%	0	95%
Tarime TC	40-44	1981	125%	0	95%
Tarime TC	45-49	1543	130%	0	95%
Tarime TC	50-54	1169	0%	252	95%
Tarime TC	55-59	934	0%	201	95%
Tarime TC	60-64	564	0%	122	95%
Tarime TC	65+	813	0%	175	95%
Kyela DC	15-19	16553	146%	0	95%
Kyela DC	20-24	12457	169%	0	95%
Kyela DC	25-29	11344	126%	0	95%
Kyela DC	30-34	11278	87%	298	95%
Kyela DC	35-39	8977	74%	617	95%
Kyela DC	40-44	7070	65%	692	95%
Kyela DC	45-49	5253	65%	0	95%
Kyela DC	50-54	3713	0%	1164	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kyela DC	55-59	2957	0%	927	95%
Kyela DC	60-64	2373	0%	744	95%
Kyela DC	65+	4245	0%	1331	95%
Mbarali DC	15-19	19697	131%	0	95%
Mbarali DC	20-24	16306	142%	0	95%
Mbarali DC	25-29	16469	103%	0	95%
Mbarali DC	30-34	14758	78%	847	95%
Mbarali DC	35-39	12297	61%	1365	95%
Mbarali DC	40-44	10372	50%	0	95%
Mbarali DC	45-49	7491	50%	0	95%
Mbarali DC	50-54	5791	0%	1815	95%
Mbarali DC	55-59	4301	0%	1348	95%
Mbarali DC	60-64	3345	0%	1049	95%
Mbarali DC	65+	4467	0%	1401	95%
Mbeya DC	15-19	21587	196%	0	95%
Mbeya DC	20-24	17216	285%	0	95%
Mbeya DC	25-29	15786	254%	0	95%
Mbeya DC	30-34	13475	195%	0	95%
Mbeya DC	35-39	10992	139%	0	95%
Mbeya DC	40-44	9399	94%	44	95%
Mbeya DC	45-49	7470	72%	578	95%
Mbeya DC	50-54	5282	0%	0	95%
Mbeya DC	55-59	4228	0%	0	95%
Mbeya DC	60-64	2797	0%	0	95%
Mbeya DC	65+	4354	0%	0	95%
Rungwe DC	15-19	17214	157%	0	95%
Rungwe DC	20-24	14333	169%	0	95%
Rungwe DC	25-29	11106	152%	0	95%
Rungwe DC	30-34	10137	111%	0	95%
Rungwe DC	35-39	8510	88%	192	95%
Rungwe DC	40-44	8062	61%	901	95%
Rungwe DC	45-49	6485	55%	862	95%
Rungwe DC	50-54	5132	0%	1609	95%
Rungwe DC	55-59	4099	0%	1285	95%
Rungwe DC	60-64	2931	0%	919	95%
Rungwe DC	65+	5952	0%	1866	95%
Magharibi B	15-19	12962	127%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Magharibi B	20-24	11442	123%	0	95%
Magharibi B	25-29	10091	119%	0	95%
Magharibi B	30-34	10787	94%	0	95%
Magharibi B	35-39	9523	89%	0	95%
Magharibi B	40-44	8461	83%	0	95%
Magharibi B	45-49	6707	85%	0	95%
Magharibi B	50-54	4328	0%	0	95%
Magharibi B	55-59	2830	0%	0	95%
Magharibi B	60-64	1710	0%	0	95%
Magharibi B	65+	2117	0%	0	95%
Mjini	15-19	15320	121%	0	95%
Mjini	20-24	15109	106%	0	95%
Mjini	25-29	14007	97%	0	95%
Mjini	30-34	12174	94%	0	95%
Mjini	35-39	8642	112%	0	95%
Mjini	40-44	7375	108%	0	95%
Mjini	45-49	6034	107%	0	95%
Mjini	50-54	5523	0%	0	95%
Mjini	55-59	5060	0%	0	95%
Mjini	60-64	3834	0%	0	95%
Mjini	65+	4959	0%	0	95%
Gairo DC	15-19	14415	92%	46	95%
Gairo DC	20-24	10940	104%	0	95%
Gairo DC	25-29	8349	116%	0	95%
Gairo DC	30-34	7158	114%	0	95%
Gairo DC	35-39	5978	115%	0	95%
Gairo DC	40-44	5829	97%	0	95%
Gairo DC	45-49	3957	116%	0	95%
Gairo DC	50-54	2940	0%	295	95%
Gairo DC	55-59	2004	0%	201	95%
Gairo DC	60-64	1381	0%	139	95%
Gairo DC	65+	2455	0%	246	95%
Kilombero DC	15-19	21548	114%	0	95%
Kilombero DC	20-24	18310	119%	0	95%
Kilombero DC	25-29	15258	116%	0	95%
Kilombero DC	30-34	15310	95%	5	95%
Kilombero DC	35-39	14204	85%	143	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kilombero DC	40-44	12310	79%	209	95%
Kilombero DC	45-49	8804	87%	74	95%
Kilombero DC	50-54	6860	0%	689	95%
Kilombero DC	55-59	5366	0%	539	95%
Kilombero DC	60-64	3983	0%	400	95%
Kilombero DC	65+	5689	0%	571	95%
Kilosa DC	15-19	31214	105%	0	95%
Kilosa DC	20-24	26400	107%	0	95%
Kilosa DC	25-29	21948	110%	0	95%
Kilosa DC	30-34	20366	100%	0	95%
Kilosa DC	35-39	18371	93%	38	95%
Kilosa DC	40-44	16439	86%	158	95%
Kilosa DC	45-49	12577	91%	52	95%
Kilosa DC	50-54	10061	0%	1010	95%
Kilosa DC	55-59	7248	0%	728	95%
Kilosa DC	60-64	5289	0%	531	95%
Kilosa DC	65+	8246	0%	828	95%
Morogoro DC	15-19	19157	105%	0	95%
Morogoro DC	20-24	14672	119%	0	95%
Morogoro DC	25-29	13117	113%	0	95%
Morogoro DC	30-34	11358	110%	0	95%
Morogoro DC	35-39	10269	102%	0	95%
Morogoro DC	40-44	9052	96%	0	95%
Morogoro DC	45-49	8214	85%	83	95%
Morogoro DC	50-54	6497	0%	652	95%
Morogoro DC	55-59	4836	0%	486	95%
Morogoro DC	60-64	3720	0%	374	95%
Morogoro DC	65+	6998	0%	703	95%
Mvomero DC	15-19	22021	121%	0	95%
Mvomero DC	20-24	18697	120%	0	95%
Mvomero DC	25-29	14890	121%	0	95%
Mvomero DC	30-34	13274	112%	0	95%
Mvomero DC	35-39	12166	102%	0	95%
Mvomero DC	40-44	11051	92%	33	95%
Mvomero DC	45-49	8683	95%	1	95%
Mvomero DC	50-54	6992	0%	702	95%
Mvomero DC	55-59	5316	0%	534	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mvomero DC	60-64	3779	0%	379	95%
Mvomero DC	65+	5653	0%	568	95%
Ulanga DC	15-19	11471	115%	0	95%
Ulanga DC	20-24	8808	126%	0	95%
Ulanga DC	25-29	7864	113%	0	95%
Ulanga DC	30-34	6649	110%	0	95%
Ulanga DC	35-39	6179	98%	0	95%
Ulanga DC	40-44	5505	89%	32	95%
Ulanga DC	45-49	4239	93%	10	95%
Ulanga DC	50-54	3321	0%	333	95%
Ulanga DC	55-59	2383	0%	239	95%
Ulanga DC	60-64	1821	0%	183	95%
Ulanga DC	65+	2495	0%	251	95%
Masasi DC	15-19	18540	103%	0	95%
Masasi DC	20-24	15954	103%	0	95%
Masasi DC	25-29	11319	123%	0	95%
Masasi DC	30-34	10506	112%	0	95%
Masasi DC	35-39	9459	105%	0	95%
Masasi DC	40-44	8798	93%	0	95%
Masasi DC	45-49	7417	89%	0	95%
Masasi DC	50-54	5667	0%	0	95%
Masasi DC	55-59	4531	0%	0	95%
Masasi DC	60-64	3852	0%	0	95%
Masasi DC	65+	6708	0%	0	95%
Buchosa DC	15-19	24858	94%	42	95%
Buchosa DC	20-24	18807	92%	111	95%
Buchosa DC	25-29	17959	76%	762	95%
Buchosa DC	30-34	15736	74%	762	95%
Buchosa DC	35-39	13076	75%	603	95%
Buchosa DC	40-44	10119	79%	373	95%
Buchosa DC	45-49	8818	73%	438	95%
Buchosa DC	50-54	5812	0%	1253	95%
Buchosa DC	55-59	4336	0%	935	95%
Buchosa DC	60-64	2908	0%	627	95%
Buchosa DC	65+	4477	0%	965	95%
Kwimba DC	15-19	31941	96%	0	95%
Kwimba DC	20-24	23429	105%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kwimba DC	25-29	18160	101%	0	95%
Kwimba DC	30-34	14300	82%	432	95%
Kwimba DC	35-39	12245	63%	880	95%
Kwimba DC	40-44	10443	54%	977	95%
Kwimba DC	45-49	9401	45%	1062	95%
Kwimba DC	50-54	6711	0%	1447	95%
Kwimba DC	55-59	4824	0%	1040	95%
Kwimba DC	60-64	3609	0%	778	95%
Kwimba DC	65+	5774	0%	1245	95%
Magu DC	15-19	23698	135%	0	95%
Magu DC	20-24	17170	152%	0	95%
Magu DC	25-29	14342	137%	0	95%
Magu DC	30-34	11868	112%	0	95%
Magu DC	35-39	9991	91%	89	95%
Magu DC	40-44	8013	82%	229	95%
Magu DC	45-49	7282	69%	432	95%
Magu DC	50-54	5140	0%	1108	95%
Magu DC	55-59	3940	0%	850	95%
Magu DC	60-64	2756	0%	594	95%
Magu DC	65+	4207	0%	907	95%
Misungwi DC	15-19	27809	99%	0	95%
Misungwi DC	20-24	20191	111%	0	95%
Misungwi DC	25-29	16709	96%	0	95%
Misungwi DC	30-34	13332	82%	394	95%
Misungwi DC	35-39	11277	68%	690	95%
Misungwi DC	40-44	9454	61%	733	95%
Misungwi DC	45-49	8154	55%	739	95%
Misungwi DC	50-54	5949	0%	1283	95%
Misungwi DC	55-59	4886	0%	1054	95%
Misungwi DC	60-64	3408	0%	735	95%
Misungwi DC	65+	5068	0%	1093	95%
Sengerema DC	15-19	28171	136%	0	95%
Sengerema DC	20-24	20034	167%	0	95%
Sengerema DC	25-29	16966	144%	0	95%
Sengerema DC	30-34	13124	126%	0	95%
Sengerema DC	35-39	11132	102%	0	95%
Sengerema DC	40-44	8948	92%	52	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Sengerema DC	45-49	7752	82%	236	95%
Sengerema DC	50-54	5406	0%	1166	95%
Sengerema DC	55-59	4351	0%	938	95%
Sengerema DC	60-64	2945	0%	635	95%
Sengerema DC	65+	4695	0%	1012	95%
Ukerewe DC	15-19	26360	128%	0	95%
Ukerewe DC	20-24	19842	140%	0	95%
Ukerewe DC	25-29	17755	125%	0	95%
Ukerewe DC	30-34	16546	107%	0	95%
Ukerewe DC	35-39	13197	108%	0	95%
Ukerewe DC	40-44	10730	108%	0	95%
Ukerewe DC	45-49	9025	104%	0	95%
Ukerewe DC	50-54	6490	0%	1400	95%
Ukerewe DC	55-59	5035	0%	1086	95%
Ukerewe DC	60-64	3256	0%	702	95%
Ukerewe DC	65+	4963	0%	1070	95%
Ludewa DC	15-19	10127	143%	0	95%
Ludewa DC	20-24	8791	150%	0	95%
Ludewa DC	25-29	6150	167%	0	95%
Ludewa DC	30-34	5532	132%	0	95%
Ludewa DC	35-39	4651	109%	0	95%
Ludewa DC	40-44	4183	84%	50	95%
Ludewa DC	45-49	3369	74%	76	95%
Ludewa DC	50-54	2797	0%	281	95%
Ludewa DC	55-59	2062	0%	207	95%
Ludewa DC	60-64	1558	0%	156	95%
Ludewa DC	65+	2486	0%	250	95%
Makambako TC	15-19	7424	133%	0	95%
Makambako TC	20-24	7270	106%	0	95%
Makambako TC	25-29	5939	87%	52	95%
Makambako TC	30-34	4954	73%	116	95%
Makambako TC	35-39	3868	71%	99	95%
Makambako TC	40-44	2798	74%	61	95%
Makambako TC	45-49	1849	86%	18	95%
Makambako TC	50-54	1290	0%	130	95%
Makambako TC	55-59	975	0%	98	95%
Makambako TC	60-64	636	0%	64	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Makambako TC	65+	904	0%	91	95%
Makete DC	15-19	7064	135%	0	95%
Makete DC	20-24	6655	132%	0	95%
Makete DC	25-29	4785	141%	0	95%
Makete DC	30-34	3948	120%	0	95%
Makete DC	35-39	3512	92%	12	95%
Makete DC	40-44	3075	73%	72	95%
Makete DC	45-49	2555	63%	87	95%
Makete DC	50-54	2038	0%	205	95%
Makete DC	55-59	1497	0%	150	95%
Makete DC	60-64	1062	0%	107	95%
Makete DC	65+	2180	0%	219	95%
Njombe DC	15-19	6237	202%	0	95%
Njombe DC	20-24	5704	254%	0	95%
Njombe DC	25-29	4353	273%	0	95%
Njombe DC	30-34	3240	250%	0	95%
Njombe DC	35-39	3060	164%	0	95%
Njombe DC	40-44	2536	120%	0	95%
Njombe DC	45-49	1892	100%	0	95%
Njombe DC	50-54	1498	0%	150	95%
Njombe DC	55-59	1105	0%	111	95%
Njombe DC	60-64	816	0%	82	95%
Njombe DC	65+	1362	0%	137	95%
Wanging'ombe DC	15-19	11906	123%	0	95%
Wanging'ombe DC	20-24	9966	122%	0	95%
Wanging'ombe DC	25-29	7716	109%	0	95%
Wanging'ombe DC	30-34	6679	84%	75	95%
Wanging'ombe DC	35-39	5679	71%	144	95%
Wanging'ombe DC	40-44	5104	58%	197	95%
Wanging'ombe DC	45-49	3845	58%	151	95%
Wanging'ombe DC	50-54	3087	0%	310	95%
Wanging'ombe DC	55-59	2361	0%	237	95%
Wanging'ombe DC	60-64	1840	0%	185	95%
Wanging'ombe DC	65+	2795	0%	281	95%
Chalinze DC	15-19	14334	112%	0	95%
Chalinze DC	20-24	12570	110%	0	95%
Chalinze DC	25-29	11018	107%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Chalinze DC	30-34	9319	107%	0	95%
Chalinze DC	35-39	8619	97%	0	95%
Chalinze DC	40-44	7441	92%	0	95%
Chalinze DC	45-49	6188	90%	0	95%
Chalinze DC	50-54	4560	0%	0	95%
Chalinze DC	55-59	3611	0%	0	95%
Chalinze DC	60-64	2788	0%	0	95%
Chalinze DC	65+	4466	0%	0	95%
Kibaha TC	15-19	10112	115%	0	95%
Kibaha TC	20-24	10627	94%	0	95%
Kibaha TC	25-29	8658	99%	0	95%
Kibaha TC	30-34	7175	101%	0	95%
Kibaha TC	35-39	5834	104%	0	95%
Kibaha TC	40-44	5149	97%	0	95%
Kibaha TC	45-49	3829	106%	0	95%
Kibaha TC	50-54	3101	0%	0	95%
Kibaha TC	55-59	2272	0%	0	95%
Kibaha TC	60-64	1549	0%	0	95%
Kibaha TC	65+	2144	0%	0	95%
Mkuranga DC	15-19	17786	86%	0	95%
Mkuranga DC	20-24	10478	126%	0	95%
Mkuranga DC	25-29	8575	130%	0	95%
Mkuranga DC	30-34	8162	116%	0	95%
Mkuranga DC	35-39	7486	106%	0	95%
Mkuranga DC	40-44	7073	93%	0	95%
Mkuranga DC	45-49	5533	96%	0	95%
Mkuranga DC	50-54	4601	0%	0	95%
Mkuranga DC	55-59	3400	0%	0	95%
Mkuranga DC	60-64	2604	0%	0	95%
Mkuranga DC	65+	4796	0%	0	95%
Kalambo DC	15-19	17047	120%	0	95%
Kalambo DC	20-24	12181	143%	0	95%
Kalambo DC	25-29	9499	123%	0	95%
Kalambo DC	30-34	8261	82%	427	95%
Kalambo DC	35-39	7031	54%	1136	95%
Kalambo DC	40-44	5680	42%	0	95%
Kalambo DC	45-49	4520	38%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Kalambo DC	50-54	3100	0%	0	95%
Kalambo DC	55-59	2407	0%	0	95%
Kalambo DC	60-64	1601	0%	0	95%
Kalambo DC	65+	2753	0%	0	95%
Nkasi DC	15-19	23734	110%	0	95%
Nkasi DC	20-24	17020	133%	0	95%
Nkasi DC	25-29	13388	121%	0	95%
Nkasi DC	30-34	12396	85%	474	95%
Nkasi DC	35-39	10888	63%	1356	95%
Nkasi DC	40-44	8855	53%	0	95%
Nkasi DC	45-49	6256	55%	0	95%
Nkasi DC	50-54	4218	0%	0	95%
Nkasi DC	55-59	3252	0%	0	95%
Nkasi DC	60-64	2483	0%	0	95%
Nkasi DC	65+	3484	0%	0	95%
Sumbawanga DC	15-19	24746	133%	0	95%
Sumbawanga DC	20-24	18459	169%	0	95%
Sumbawanga DC	25-29	15108	151%	0	95%
Sumbawanga DC	30-34	13073	106%	0	95%
Sumbawanga DC	35-39	11449	69%	1162	95%
Sumbawanga DC	40-44	8240	56%	1253	95%
Sumbawanga DC	45-49	6282	48%	0	95%
Sumbawanga DC	50-54	4469	0%	0	95%
Sumbawanga DC	55-59	3176	0%	0	95%
Sumbawanga DC	60-64	2297	0%	0	95%
Sumbawanga DC	65+	3550	0%	0	95%
Sumbawanga MC	15-19	21530	101%	0	95%
Sumbawanga MC	20-24	16931	114%	0	95%
Sumbawanga MC	25-29	11277	123%	0	95%
Sumbawanga MC	30-34	9823	91%	159	95%
Sumbawanga MC	35-39	8297	68%	869	95%
Sumbawanga MC	40-44	6382	58%	930	95%
Sumbawanga MC	45-49	4528	56%	680	95%
Sumbawanga MC	50-54	3138	0%	1163	95%
Sumbawanga MC	55-59	2330	0%	863	95%
Sumbawanga MC	60-64	1605	0%	595	95%
Sumbawanga MC	65+	2410	0%	893	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mbinga DC	15-19	16625	87%	393	95%
Mbinga DC	20-24	16183	78%	835	95%
Mbinga DC	25-29	11240	88%	232	95%
Mbinga DC	30-34	10313	78%	516	95%
Mbinga DC	35-39	8190	78%	416	95%
Mbinga DC	40-44	7480	68%	615	95%
Mbinga DC	45-49	6344	65%	573	95%
Mbinga DC	50-54	4575	0%	869	95%
Mbinga DC	55-59	3768	0%	895	95%
Mbinga DC	60-64	2216	0%	632	95%
Mbinga DC	65+	3337	0%	951	95%
Mbinga TC	15-19	9676	88%	284	95%
Mbinga TC	20-24	10048	74%	880	95%
Mbinga TC	25-29	6790	86%	254	95%
Mbinga TC	30-34	5970	81%	333	95%
Mbinga TC	35-39	4779	82%	257	95%
Mbinga TC	40-44	4254	73%	391	95%
Mbinga TC	45-49	3378	74%	289	95%
Mbinga TC	50-54	2530	0%	986	95%
Mbinga TC	55-59	1975	0%	769	95%
Mbinga TC	60-64	1075	0%	419	95%
Mbinga TC	65+	1607	0%	626	95%
Namtumbo DC	15-19	14383	149%	0	95%
Namtumbo DC	20-24	11510	188%	0	95%
Namtumbo DC	25-29	9049	203%	0	95%
Namtumbo DC	30-34	8719	159%	0	95%
Namtumbo DC	35-39	7715	126%	0	95%
Namtumbo DC	40-44	6634	108%	0	95%
Namtumbo DC	45-49	5016	116%	0	95%
Namtumbo DC	50-54	3813	0%	1485	95%
Namtumbo DC	55-59	3296	0%	1284	95%
Namtumbo DC	60-64	2233	0%	870	95%
Namtumbo DC	65+	3486	0%	1358	95%
Songea DC	15-19	8718	131%	0	95%
Songea DC	20-24	9185	114%	0	95%
Songea DC	25-29	6038	148%	0	95%
Songea DC	30-34	5892	122%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Songea DC	35-39	5119	108%	0	95%
Songea DC	40-44	4602	91%	83	95%
Songea DC	45-49	3668	92%	41	95%
Songea DC	50-54	2870	0%	1118	95%
Songea DC	55-59	2481	0%	966	95%
Songea DC	60-64	1716	0%	668	95%
Songea DC	65+	2705	0%	1054	95%
Tunduru DC	15-19	20030	151%	0	95%
Tunduru DC	20-24	17004	163%	0	95%
Tunduru DC	25-29	13907	163%	0	95%
Tunduru DC	30-34	12982	133%	0	95%
Tunduru DC	35-39	11664	108%	0	95%
Tunduru DC	40-44	9252	104%	0	95%
Tunduru DC	45-49	7323	106%	0	95%
Tunduru DC	50-54	5884	0%	1230	95%
Tunduru DC	55-59	4933	0%	984	95%
Tunduru DC	60-64	3455	0%	591	95%
Tunduru DC	65+	5884	0%	574	95%
Kishapu DC	15-19	22228	98%	0	95%
Kishapu DC	20-24	17461	117%	0	95%
Kishapu DC	25-29	13955	118%	0	95%
Kishapu DC	30-34	11974	99%	0	95%
Kishapu DC	35-39	9626	83%	259	95%
Kishapu DC	40-44	7932	69%	470	95%
Kishapu DC	45-49	6847	55%	623	95%
Kishapu DC	50-54	4789	0%	1033	95%
Kishapu DC	55-59	3792	0%	818	95%
Kishapu DC	60-64	2686	0%	579	95%
Kishapu DC	65+	4080	0%	880	95%
Msalala DC	15-19	19634	176%	0	95%
Msalala DC	20-24	14544	228%	0	95%
Msalala DC	25-29	12822	211%	0	95%
Msalala DC	30-34	10604	170%	0	95%
Msalala DC	35-39	8689	126%	0	95%
Msalala DC	40-44	6123	105%	0	95%
Msalala DC	45-49	5229	76%	228	95%
Msalala DC	50-54	3801	0%	820	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Msalala DC	55-59	2872	0%	619	95%
Msalala DC	60-64	1747	0%	377	95%
Msalala DC	65+	2667	0%	575	95%
Shinyanga DC	15-19	26699	113%	0	95%
Shinyanga DC	20-24	19756	134%	0	95%
Shinyanga DC	25-29	15972	129%	0	95%
Shinyanga DC	30-34	13115	106%	0	95%
Shinyanga DC	35-39	11028	81%	363	95%
Shinyanga DC	40-44	8572	68%	519	95%
Shinyanga DC	45-49	7488	53%	713	95%
Shinyanga DC	50-54	5067	0%	1093	95%
Shinyanga DC	55-59	4310	0%	930	95%
Shinyanga DC	60-64	2836	0%	612	95%
Shinyanga DC	65+	4619	0%	996	95%
Shinyanga MC	15-19	14195	120%	0	95%
Shinyanga MC	20-24	13185	127%	0	95%
Shinyanga MC	25-29	10971	125%	0	95%
Shinyanga MC	30-34	8752	112%	0	95%
Shinyanga MC	35-39	6987	93%	27	95%
Shinyanga MC	40-44	5336	80%	178	95%
Shinyanga MC	45-49	4600	65%	318	95%
Shinyanga MC	50-54	3367	0%	726	95%
Shinyanga MC	55-59	2881	0%	621	95%
Shinyanga MC	60-64	1646	0%	355	95%
Shinyanga MC	65+	2245	0%	484	95%
Ushetu DC	15-19	22668	165%	0	95%
Ushetu DC	20-24	16413	206%	0	95%
Ushetu DC	25-29	13999	192%	0	95%
Ushetu DC	30-34	10581	167%	0	95%
Ushetu DC	35-39	8981	118%	0	95%
Ushetu DC	40-44	6534	99%	0	95%
Ushetu DC	45-49	5693	75%	253	95%
Ushetu DC	50-54	4051	0%	873	95%
Ushetu DC	55-59	3251	0%	701	95%
Ushetu DC	60-64	2281	0%	492	95%
Ushetu DC	65+	3404	0%	734	95%
Busega DC	15-19	18827	130%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Busega DC	20-24	13919	157%	0	95%
Busega DC	25-29	10844	152%	0	95%
Busega DC	30-34	8505	134%	0	95%
Busega DC	35-39	6540	119%	0	95%
Busega DC	40-44	4590	118%	0	95%
Busega DC	45-49	4245	90%	44	95%
Busega DC	50-54	3403	0%	734	95%
Busega DC	55-59	2710	0%	585	95%
Busega DC	60-64	1745	0%	376	95%
Busega DC	65+	3041	0%	656	95%
Itilima DC	15-19	26654	107%	0	95%
Itilima DC	20-24	18438	139%	0	95%
Itilima DC	25-29	14870	133%	0	95%
Itilima DC	30-34	10014	127%	0	95%
Itilima DC	35-39	7991	96%	0	95%
Itilima DC	40-44	6232	81%	202	95%
Itilima DC	45-49	5603	62%	414	95%
Itilima DC	50-54	4032	0%	869	95%
Itilima DC	55-59	3434	0%	740	95%
Itilima DC	60-64	2320	0%	500	95%
Itilima DC	65+	3624	0%	782	95%
Maswa DC	15-19	32051	90%	386	95%
Maswa DC	20-24	25688	113%	0	95%
Maswa DC	25-29	18927	127%	0	95%
Maswa DC	30-34	14489	120%	0	95%
Maswa DC	35-39	11292	105%	0	95%
Maswa DC	40-44	8307	97%	0	95%
Maswa DC	45-49	7879	67%	499	95%
Maswa DC	50-54	5139	0%	1108	95%
Maswa DC	55-59	4563	0%	984	95%
Maswa DC	60-64	2947	0%	636	95%
Maswa DC	65+	4835	0%	1043	95%
Meatu DC	15-19	26243	99%	0	95%
Meatu DC	20-24	20627	124%	0	95%
Meatu DC	25-29	16759	130%	0	95%
Meatu DC	30-34	12055	123%	0	95%
Meatu DC	35-39	9129	97%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Meatu DC	40-44	6705	84%	164	95%
Meatu DC	45-49	6021	64%	422	95%
Meatu DC	50-54	4141	0%	893	95%
Meatu DC	55-59	3563	0%	768	95%
Meatu DC	60-64	2451	0%	528	95%
Meatu DC	65+	3440	0%	742	95%
Iramba DC	15-19	19283	91%	73	95%
Iramba DC	20-24	14929	102%	0	95%
Iramba DC	25-29	11744	105%	0	95%
Iramba DC	30-34	9789	105%	0	95%
Iramba DC	35-39	8005	107%	0	95%
Iramba DC	40-44	6474	106%	0	95%
Iramba DC	45-49	5421	103%	0	95%
Iramba DC	50-54	4104	0%	412	95%
Iramba DC	55-59	3194	0%	321	95%
Iramba DC	60-64	2528	0%	254	95%
Iramba DC	65+	4177	0%	419	95%
Ileje DC	15-19	10749	77%	485	95%
Ileje DC	20-24	7263	103%	0	95%
Ileje DC	25-29	4918	102%	0	95%
Ileje DC	30-34	4801	66%	345	95%
Ileje DC	35-39	4510	47%	543	95%
Ileje DC	40-44	4319	32%	0	95%
Ileje DC	45-49	3651	28%	0	95%
Ileje DC	50-54	2649	0%	0	95%
Ileje DC	55-59	2139	0%	0	95%
Ileje DC	60-64	1557	0%	0	95%
Ileje DC	65+	2780	0%	0	95%
Mbozi DC	15-19	38501	51%	4252	95%
Mbozi DC	20-24	30948	51%	3407	95%
Mbozi DC	25-29	20679	55%	2078	95%
Mbozi DC	30-34	19035	46%	2334	95%
Mbozi DC	35-39	16803	41%	2256	95%
Mbozi DC	40-44	13878	38%	0	95%
Mbozi DC	45-49	10479	38%	0	95%
Mbozi DC	50-54	7686	0%	1826	95%
Mbozi DC	55-59	5707	0%	1356	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Mbozi DC	60-64	3957	0%	940	95%
Mbozi DC	65+	6220	0%	1477	95%
Momba DC	15-19	10553	73%	568	95%
Momba DC	20-24	8780	69%	563	95%
Momba DC	25-29	7784	52%	840	95%
Momba DC	30-34	6572	44%	841	95%
Momba DC	35-39	5754	38%	815	95%
Momba DC	40-44	4750	35%	718	95%
Momba DC	45-49	3604	35%	0	95%
Momba DC	50-54	2729	0%	0	95%
Momba DC	55-59	2041	0%	0	95%
Momba DC	60-64	1446	0%	0	95%
Momba DC	65+	2164	0%	0	95%
Songwe DC	15-19	10131	96%	0	95%
Songwe DC	20-24	8421	92%	65	95%
Songwe DC	25-29	6735	78%	291	95%
Songwe DC	30-34	6203	62%	513	95%
Songwe DC	35-39	5241	55%	526	95%
Songwe DC	40-44	4404	49%	504	95%
Songwe DC	45-49	3186	53%	333	95%
Songwe DC	50-54	2431	0%	577	95%
Songwe DC	55-59	1863	0%	443	95%
Songwe DC	60-64	1331	0%	316	95%
Songwe DC	65+	1809	0%	430	95%
Tunduma TC	15-19	9010	65%	668	95%
Tunduma TC	20-24	10007	51%	1105	95%
Tunduma TC	25-29	9787	41%	1317	95%
Tunduma TC	30-34	8450	35%	1263	95%
Tunduma TC	35-39	5727	36%	838	95%
Tunduma TC	40-44	3972	37%	0	95%
Tunduma TC	45-49	2397	45%	0	95%
Tunduma TC	50-54	1286	0%	0	95%
Tunduma TC	55-59	874	0%	0	95%
Tunduma TC	60-64	508	0%	0	95%
Tunduma TC	65+	721	0%	0	95%
Igunga DC	15-19	32416	102%	0	95%
Igunga DC	20-24	25510	125%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Igunga DC	25-29	20815	113%	0	95%
Igunga DC	30-34	17190	93%	30	95%
Igunga DC	35-39	14239	78%	256	95%
Igunga DC	40-44	11142	70%	296	95%
Igunga DC	45-49	9223	60%	341	95%
Igunga DC	50-54	6174	0%	620	95%
Igunga DC	55-59	4821	0%	484	95%
Igunga DC	60-64	3517	0%	353	95%
Igunga DC	65+	5406	0%	543	95%
Kaliua DC	15-19	33365	104%	0	95%
Kaliua DC	20-24	25404	115%	0	95%
Kaliua DC	25-29	21477	98%	0	95%
Kaliua DC	30-34	17395	90%	97	95%
Kaliua DC	35-39	14258	86%	142	95%
Kaliua DC	40-44	10090	91%	39	95%
Kaliua DC	45-49	7827	86%	72	95%
Kaliua DC	50-54	5468	0%	549	95%
Kaliua DC	55-59	4252	0%	427	95%
Kaliua DC	60-64	2916	0%	293	95%
Kaliua DC	65+	4428	0%	445	95%
Nzega DC	15-19	36020	90%	172	95%
Nzega DC	20-24	26848	113%	0	95%
Nzega DC	25-29	22582	104%	0	95%
Nzega DC	30-34	17679	100%	0	95%
Nzega DC	35-39	14652	89%	87	95%
Nzega DC	40-44	10841	84%	124	95%
Nzega DC	45-49	9718	66%	302	95%
Nzega DC	50-54	7037	0%	707	95%
Nzega DC	55-59	5631	0%	565	95%
Nzega DC	60-64	3729	0%	374	95%
Nzega DC	65+	6422	0%	645	95%
Urambo DC	15-19	17071	118%	0	95%
Urambo DC	20-24	12948	154%	0	95%
Urambo DC	25-29	10753	151%	0	95%
Urambo DC	30-34	8409	141%	0	95%
Urambo DC	35-39	7226	119%	0	95%
Urambo DC	40-44	5194	122%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Urambo DC	45-49	4222	111%	0	95%
Urambo DC	50-54	2879	0%	289	95%
Urambo DC	55-59	2363	0%	237	95%
Urambo DC	60-64	1664	0%	167	95%
Urambo DC	65+	2609	0%	262	95%
Uyui DC	15-19	32977	112%	0	95%
Uyui DC	20-24	23681	135%	0	95%
Uyui DC	25-29	20148	119%	0	95%
Uyui DC	30-34	16203	108%	0	95%
Uyui DC	35-39	13396	98%	0	95%
Uyui DC	40-44	9567	104%	0	95%
Uyui DC	45-49	8188	91%	35	95%
Uyui DC	50-54	5693	0%	572	95%
Uyui DC	55-59	4659	0%	468	95%
Uyui DC	60-64	3229	0%	324	95%
Uyui DC	65+	5190	0%	521	95%
Korogwe DC	15-19	19578	90%	0	95%
Korogwe DC	20-24	14441	104%	0	95%
Korogwe DC	25-29	11397	113%	0	95%
Korogwe DC	30-34	8840	123%	0	95%
Korogwe DC	35-39	8569	106%	0	95%
Korogwe DC	40-44	7422	101%	0	95%
Korogwe DC	45-49	6768	90%	0	95%
Korogwe DC	50-54	5571	0%	0	95%
Korogwe DC	55-59	4321	0%	0	95%
Korogwe DC	60-64	3256	0%	0	95%
Korogwe DC	65+	5958	0%	0	95%
Lushoto DC	15-19	24829	83%	0	95%
Lushoto DC	20-24	16573	107%	0	95%
Lushoto DC	25-29	13069	115%	0	95%
Lushoto DC	30-34	9603	132%	0	95%
Lushoto DC	35-39	9078	117%	0	95%
Lushoto DC	40-44	8214	107%	0	95%
Lushoto DC	45-49	7458	96%	0	95%
Lushoto DC	50-54	5720	0%	0	95%
Lushoto DC	55-59	4998	0%	0	95%
Lushoto DC	60-64	3379	0%	0	95%

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (FY22)**	**VMMC_CIRC (in FY23)**	**Expected Coverage (in FY23)**
Lushoto DC	65+	5982	0%	0	95%
Muheza DC	15-19	16837	99%	0	95%
Muheza DC	20-24	14228	101%	0	95%
Muheza DC	25-29	11199	109%	0	95%
Muheza DC	30-34	8825	117%	0	95%
Muheza DC	35-39	8867	98%	0	95%
Muheza DC	40-44	7286	98%	0	95%
Muheza DC	45-49	6370	91%	0	95%
Muheza DC	50-54	4791	0%	0	95%
Muheza DC	55-59	4092	0%	0	95%
Muheza DC	60-64	3083	0%	0	95%
Muheza DC	65+	5470	0%	0	95%
Tanga CC	15-19	24620	102%	0	95%
Tanga CC	20-24	25784	84%	0	95%
Tanga CC	25-29	18216	101%	0	95%
Tanga CC	30-34	13303	117%	0	95%
Tanga CC	35-39	11082	117%	0	95%
Tanga CC	40-44	9298	116%	0	95%
Tanga CC	45-49	7490	116%	0	95%
Tanga CC	50-54	6402	0%	0	95%
Tanga CC	55-59	5442	0%	0	95%
Tanga CC	60-64	3599	0%	0	95%
Tanga CC	65+	4618	0%	0	95%

Standard Table 4.8.3

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
	Population Size Estimate* (SNUs)	**Disease Burden***	**FY23 Target**
PP_PREV	**374,095**	**AGYW (15-19): 1.08 % AGYW (20-24): 2.80%**	**428,709**
KP_PREV	**191,033**	**KP (FSW 26%; MSM 25%; PWID 36%)**	**180,549**
KP_MAT	**9,974**	**36%**	**5,975**
TOTAL	**428,709**		**610,262**

***Disease Burden Refers to HIV Prevalence for specified population (Sources: UNAIDS Spectrum Estimates File, 2021 December 2021 point estimate: Consensus Estimates on Key Populations Size and HIV Prevalence in Tanzania , July 2014)**

Standard Table 4.8.4

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target) OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target) OVC_SERV Preventative**	**Target # of active OVC (FY23 Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)**
Military Tanzania		1,047	-	-	1,047
Arusha CC	3,744	5,447	-	-	3,744
Bagamoyo DC	1,127	1,640	-	-	1,127
Bariadi DC	1,530	2,226	-	-	1,530
Bariadi TC	1,594	2,319	-	-	1,594
Biharamulo DC	2,167	3,153	-	-	2,167
Buchosa DC	3,489	5,076	-	-	3,489
Bukoba DC	3,860	5,616	-	-	3,860
Bukoba MC	2,259	3,286	-	-	2,259
Bukombe DC	3,193	4,645	-	-	3,193
Bunda DC	1,535	2,233	-	-	1,535
Bunda TC	1,507	2,193	-	-	1,507
Busega DC	2,518	3,663	-	-	2,518
Busokelo DC	1,680	2,444	-	-	1,680
Chalinze DC	1,646	2,395	-	-	1,646
Chamwino DC	1,411	2,053	-	-	1,411
Chato DC	4,461	6,490	-	-	4,461
Chunya DC	3,643	5,300	-	-	3,643
Dodoma MC	3,919	5,702	-	-	3,919
Geita DC	6,991	10,171	-	-	6,991
Geita TC	2,664	3,876	-	-	2,664
Ifakara TC	1,569	2,283	-	-	1,569
Igunga DC	4,340	6,314	-	-	4,340
Ikungi DC	1,095	1,593	-	-	1,095
Ilala MC	10,586	15,398	-	-	10,586

Ilemela MC	3,205	4,663	-	-	3,205
Iramba DC	1,441	2,096	-	-	1,441
Iringa DC	3,378	4,914	-	-	3,378
Iringa MC	4,073	5,925	-	-	4,073
Itilima DC	1,495	2,175	-	-	1,495
Kahama TC	4,302	6,259	12,292	15,716	4,302
Kaliua DC	3,517	5,116	-	-	3,517
Karagwe DC	2,451	3,566	-	-	2,451
Kibaha TC	1,562	2,272	-	-	1,562
Kibiti DC	1,001	1,456	-	-	1,001
Kigamboni MC	1,522	2,214	-	-	1,522
Kigoma Ujiji MC	1,204	1,751	-	-	1,204
Kilolo DC	2,639	3,839	-	-	2,639
Kilombero DC	2,414	3,512	-	-	2,414
Kilosa DC	2,963	4,311	-	-	2,963
Kinondoni MC	6,707	9,757	-	-	6,707
Kisarawe DC	991	1,442	-	-	991
Kishapu DC	2,382	3,466	-	-	2,382
Kiteto DC	1,031	1,500	-	-	1,031
Kongwa DC	1,594	2,319	-	-	1,594
Korogwe DC	1,082	1,574	-	-	1,082
Korogwe TC	1,080	1,571	-	-	1,080
Kwimba DC	4,386	6,381	-	-	4,386
Kyela DC	5,316	7,734	7,944	5,528	5,316
Kyerwa DC	2,313	3,365	-	-	2,313
Lindi DC	880	1,280	-	-	880
Ludewa DC	2,699	3,926	-	-	2,699
Lushoto DC	1,186	1,726	-	-	1,186
Mafinga TC	2,496	3,631	-	-	2,496
Magu DC	4,525	6,583	-	-	4,525

Makambako TC	2,634	3,832	-	-	2,634
Makete DC	2,209	3,214	-	-	2,209
Manyoni DC	1,223	1,779	-	-	1,223
Masasi DC	1,690	2,459	-	-	1,690
Maswa DC	2,432	3,538	-	-	2,432
Mbarali DC	6,534	9,506	10,727	8,107	6,534
Mbeya CC	9,166	13,335	12,775	9,302	9,166
Mbeya DC	3,408	4,958	-	-	3,408
Mbinga DC	1,663	2,419	-	-	1,663
Mbinga TC	1,730	2,517	-	-	1,730
Mbogwe DC	2,666	3,879	-	-	2,666
Mbozi DC	4,849	7,054	-	-	4,849
Meatu DC	1,915	2,786	-	-	1,915
Meru DC	1,179	1,715	-	-	1,179
Missenyi DC	2,931	4,264	-	-	2,931
Misungwi DC	4,167	6,062	-	-	4,167
Mjini	996	1,449	-	-	996
Mkuranga DC	1,703	2,477	-	-	1,703
Momba DC	1,416	2,060	-	-	1,416
Morogoro MC	2,946	4,286	-	-	2,946
Moshi DC	1,569	2,283	-	-	1,569
Moshi MC	2,375	3,455	-	-	2,375
Mpanda DC	1,265	1,840	-	-	1,265
Mpanda MC	2,155	3,135	-	-	2,155
Mpimbwe DC	1,535	2,233	-	-	1,535
Msalala DC	3,119	4,537	11,349	10,682	3,119
Mtwara MC	1,213	1,765	-	-	1,213
Mufindi DC	6,413	9,330	9,024	9,663	6,413
Muheza DC	2,071	3,013	-	-	2,071
Muleba DC	5,612	8,165	11,845	13,279	5,612

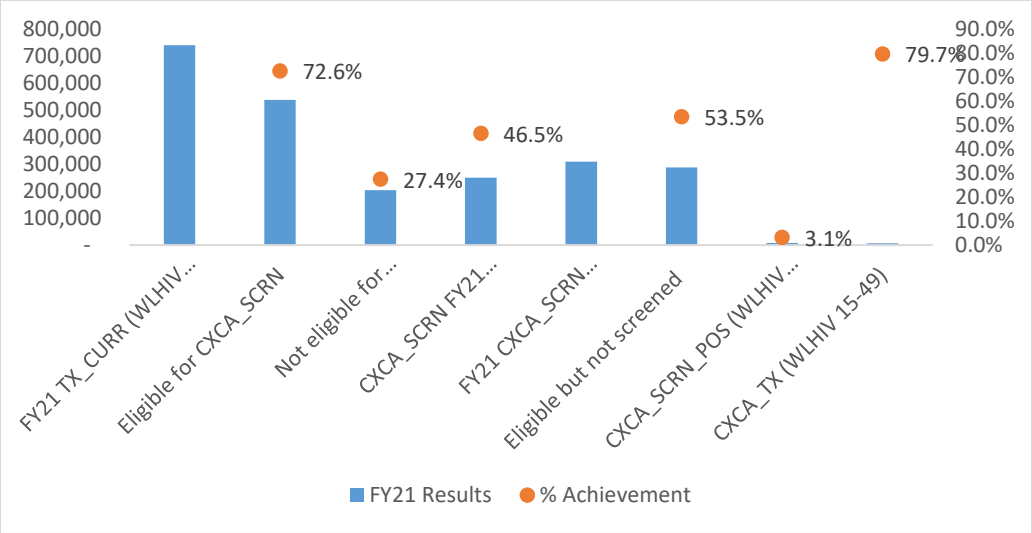
Musoma MC	2,051	2,984	-	-	2,051
Mvomero DC	1,520	2,211	-	-	1,520
Nachingwea DC	1,184	1,722	-	-	1,184
Ngara DC	1,500	2,182	-	-	1,500
Njombe DC	1,732	2,520	-	-	1,732
Njombe TC	3,880	5,645	-	-	3,880
Nkasi DC	2,049	2,981	-	-	2,049
Nsimbo DC	1,221	1,776	-	-	1,221
Nyamagana MC	6,658	9,686	17,421	15,624	6,658
Nyang'hwale DC	1,115	1,622	-	-	1,115
Nyasa DC	1,589	2,312	-	-	1,589
Nzega DC	4,863	7,075	-	-	4,863
Rombo DC	944	1,373	-	-	944
Rorya DC	4,703	6,842	-	-	4,703
Rungwe DC	2,943	4,282	-	-	2,943
Same DC	1,065	1,549	-	-	1,065
Sengerema DC	3,324	4,836	-	-	3,324
Serengeti DC	1,312	1,909	-	-	1,312
Shinyanga DC	3,042	4,426	13,918	13,976	3,042
Shinyanga MC	2,590	3,768	7,208	6,897	2,590
Sikonge DC	1,747	2,542	-	-	1,747
Simanjiro DC	1,110	1,615	-	-	1,110
Singida MC	1,063	1,546	-	-	1,063
Songea DC	1,204	1,751	-	-	1,204
Songea MC	3,247	4,724	-	-	3,247
Songwe DC	2,689	3,912	-	-	2,689
Sumbawanga DC	3,101	4,512	-	-	3,101
Sumbawanga MC	2,785	4,052	-	-	2,785
Tabora MC	2,026	2,948	-	-	2,026
Tanga CC	3,334	4,850	-	-	3,334

Temeke MC	9,018	13,119	-	-	9,018
Tunduma TC	1,989	2,894	-	-	1,989
Tunduru DC	1,671	2,431	-	-	1,671
Ubungo MC	4,221	6,141	-	-	4,221
Ukerewe DC	2,575	3,746	-	-	2,575
Urambo DC	1,374	1,999	-	-	1,374
Ushetu DC	3,761	5,472	13,428	10,937	3,761
Uvinza DC	1,774	2,581	-	-	1,774
Uyui DC	3,183	4,631	-	-	3,183
Wanging'ombe DC	2,486	3,617	-	-	2,486

4.9 Cervical cancer program

In FY21, 1180 PEPFAR sites offered cervical cancer screening using visual inspection with 5% acetic acid (VIA) and treatment using cryotherapy and thermocoagulation services. In FY21, a total of 537,812 WLHIV aged 15-49 were eligible for cervical cancer screening, and 250,084 received screening services (See Figure 4.8). Of those who screened positive for precancerous lesions 80% received treatment. PEPFAR, IPs, and GOT are committed to continuing to emphasize the single visit approach as a best practice and will continue to provide training support, mentorship, and supportive supervision to healthcare workers accordingly. Gradual transition from cryotherapy treatment to thermocoagulation will be on-going to reduce dependency on carbon dioxide cylinders which are difficult to transport during outreach services. IPs have been using a “screen and treat” approach, which will transition to a “screen, triage, and treat” approach in select sites in COP22 as HPV DNA testing becomes available. This is described in more detail below.

Figure 4.9.1: FY21 Cervical Cancer Screening Results for 15-49



In COP22, it is expected that 50% of eligible clients will be screened in facilities that contribute to 80% of PLHIV currently on treatment. WLHIV aged 25-49 years are the primary beneficiaries of the cervical cancer program supported by PEPFAR/T. To that effect, PEPFAR/T will reach 343,157 eligible WLHIV for cervical cancer screening, this is a 4% increase from COP21 targets.

In COP22 PEPFAR/T will transition to a “screen, triage, and treat” in line with 2021 WHO guidelines. In this new approach, HPV DNA testing will be used to screen eligible clients, and VIA will be used to triage WLHIV with a positive HPV test. This will be followed by immediate treatment of precancerous lesions. This high- performance approach will reduce both cervical cancer mortality and treatment-related morbidity resulting from cases that had been previously missed by VIA screening alone. To that effect, PEPFAR/ Tanzania will work with the GOT to adopt and operationalize a National HPV DNA Testing Roadmap that MOH recently drafted. Once adopted, procurement of HPV DNA test kits (which have been included in the Supply Plan Tool) will be ordered, clinical tools and registers will be reviewed and updated, and health care providers and laboratory staff will be trained. PEPFAR/T will utilize existing diagnostic platforms for processing the samples, and funds have been set aside for procuring reagents. In the future, these reagents will be integrated in the national commodity quantification exercise. PEPFAR/T plans to introduce this test through in phases, to allow for learning and adjustment to the local context. In COP22, PEPFAR/T will carry out HPV DNA testing to 10% (35,000) of the women targeted for cervical cancer screening.

COP22 funds will also support sample transportation systems and information, education, and communication efforts to raise awareness to potential clients, in collaboration with the Ministry of Health and PORALG. PEFFAR/T on the other hand, will work with IPs to prioritize their cervical cancer screening efforts to women living with HIV. Cervical cancer screening counseling efforts will focus on the importance of cervical cancer screening and its close association with HIV.

PEPFAR/T will utilize existing referral systems to refer women who screen positive for invasive cervical cancer to tertiary hospitals for advanced evaluation, biopsy, and further management. PEPFAR/T will strengthen electronic sample referral systems and facilitate quick biopsy result turnaround time to support women to reach the referral facilities. We will also support palliative treatment for WLHIV who have advanced cervical cancer.

PEPFAR/T will continue to implement quality assurance activities to ensure PEPFAR/T facilities provide highest quality care to WLHIV. We will ensure cervical cancer services are provided by trained health personnel in a well-established environment with improved infrastructure to allow for routine monitoring and auditing. PEPFAR/T will continue providing on job trainings and supervision to improve quality of services. HCWs will continue to use flash cards for quality assurance and quality improvement in diagnosis and accurate service provision at the point of care. CHWs will play an integral part in linking WLHIV to cervical cancer services and support successful referrals and feedback.

Following a 2-year pilot in Kilimanjaro region, in 2018, Tanzania introduced HPV vaccine nationally for girls aged 14 years old using routine immunization strategies at fixed posts in health facilities coupled with community outreach including in schools.[20] The vaccine is administered as a two-dose primary series. With strong social mobilization, Tanzania was able to achieve 78% HPV vaccination coverage for the first dose and 49% coverage for the second dose by the end of 2019. The COVID-19 pandemic disrupted national scale-up of HPV vaccination for eligible girls and intensified mobilization is required to increase full vaccination coverage for HPV. PEPFAR/T will work with GOT to facilitate HPV vaccination for eligible girls aged 14 years who are enrolled in HIV care and treatment services or benefiting from other PEPFAR/T supported HIV prevention programs.

4.10 Viral load and early infant diagnosis optimization

PEPFAR/T has continued to increase community VL suppression in FY21. Currently, there are 23 viral load and EID testing laboratories located in 15 regions and all are equipped with Roche and /or Abbott Platforms. Test platforms include C8800 (2), C6800 (2), C4800 (10), and Abbott m2000 (14). CAP/CTM (11) platforms currently being phased out and alternative platforms for EID testing are being explored in collaboration with the Ministry of Health. PEPFAR/T will be relying on the ongoing DNO exercise to inform any changes to the laboratory testing/platform landscape.

As noted earlier in the commodities section, PEPFAR/T is working with the GOT and stakeholders in the country to strengthen oversight and coordination for reliable supply chain systems to ensure uninterrupted testing. PEPFAR/T has made tremendous improvements in addressing the supply chain challenges that underlie the cycles of VL and EID testing backlogs, for example. Implementing the DNO exercise and continuing to advocate for Tanzania to sign on to the Global RFP will also be key components of these efforts. PEPFAR/T continues to support multiplexing strategies for VL, EID, TB, and COVID-19 testing in the country. Some conventional HVL testing platforms are already considered for EID testing as part of the CAP/CTM phase-out plan, and Abbott m2000 platforms are utilized for HVL and Covid-19 in some laboratories. Viral load POCT is used to strategically target special populations including PBFW and non-suppressed PLHIV in hard-to-reach areas. Multiplexing continues in POCT for TB, EID, and viral load. In FY22, 63 of the 268 GeneXpert platforms in country are used for VL/ EID and TB testing. Among the 268 GeneXpert platforms, 88% have GXAlert electronic system through which data is captured and reported centrally. Based on the results of the upcoming DNO, PEPFAR/T will work with the MOH and in-country stakeholders to optimize POCT platform utilization within the lab network as complementary to conventional testing for TB, EID & viral load. In collaboration with the MOH, PEPFAR/T continues to monitor data driven utilization of POCT for viral load, EID, and TB testing in hard-to-reach councils among priority populations.

[20] Li AJ, Manzi F, Kyesi F, Makame Y, Mwengee W, Fleming M, et al. Tanzania's human papillomavirus (HPV) vaccination program: Community awareness, feasibility, and acceptability of a national HPV vaccination program, 2019. Vaccine. 2022 Mar 31;40 Suppl 1:A38-A48

Specimen collection and transportation are done through an integrated hub and spoke sample transport system. PEPFAR/T aims to make the best use of U.S. taxpayer dollars by openly competing sample transportation services to a variety of providers including Tanzania Postal Corporation (TPC), and TPC is successfully providing services in some regions. Final mapping and referral pathways within the laboratory diagnostic network will be available after the upcoming DNO. All VL/EID testing laboratories are electronically reporting centrally in the Open Laboratory Data Repository (LDR) through LIS, except the two military laboratories. Technical integration of CTC3 with LIS and CTC3-LIS data flow was completed in FY21. Efforts are underway to finalize technical configurations in CTC3 to support LIS integration by FY22 to achieve full operation of CTC3/LIS for results tracking and clinic notification.

In COP22 PEPRAR/T will focus on person-centered services and utilize high-quality treatment literacy approaches to scale-up U=U messaging to support treatment adherence and vial suppression. PEPFAR program beneficiaries have been and will continue to be involved in message development. PEPFAR/T will ensure that clients with high viral load results receive enhanced adherence counseling, be offered a second viral load test, and follow other appropriate actions as per the national viral load testing algorithm.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

5.0 Critical systems investments for achieving key programmatic gaps

PEPFAR/T COP22 systems investments will build on prior investments and priorities. The main program shifts in COP20 and COP2021 were focused on ensuring rapid progress in finding PLHIV, effectively linking and retaining them on lifesaving ART, reducing HIV-related morbidity and mortality, and reducing new HIV infections breaking the chain of HIV transmission to achieve sustained epidemic control. To sustain the gains achieved requires consistent use of up-to-date and accurate data to measure progress and to guide real-time programmatic adjustments including at the site level. This ensures that the right strategies are implemented through effective health workforce utilization, and that these strategies are supported by training, mentorship, and provision of client-centered services to improve the quality of HIV services. Furthermore, proper use of data ensures that services and interventions are reaching the right people in the right places at the right time.

The SID 2021 assessments identified key systems barriers that prevent epidemic control and impede the long-term sustainability of the gains. In COP22, PEPFAR/T will prioritize its above site investments in priority areas to address these barriers. First, PEPFAR/T will continue investments in HMIS in addition to priority surveillance, research, and evaluation (SRE) efforts. The THIS 2022-2023 will be a high priority SRE activity that will inform the country's progress towards HIV epidemic control and other relevant health outcomes at the population level. To complement these efforts and to ensure accurate and up-to-date information on KP groups, PEPFAR/T will conduct an expanded BBS on the mainland and in Zanzibar. Moreover, a

PMTCT cascade evaluation will be conducted to identify and respond to gaps in maternal and pediatric HIV outcomes.

Beyond SRE activities, PEPFAR/T will also support laboratory systems investments to strengthen the laboratory accreditation processes, DNO, quality improvement, and assurance. Another priority includes continuing with investment in coordination and governance elements to scale up, monitor and maintain past investments in line with SID 2021 scores. PEPFAR/T will continue HRH investments built around the PEPFAR HRH strategy to ensure an adequate supply and quality of human resources to enable the expansion of HIV/AIDS services in PEPFAR supported moderate and high-volume program sites. And finally, PEPFAR/T will improve data use for program planning and ensure that above site investments support HIV person-centered care and health outcomes monitoring in real-time or near real-time. This includes investing in the NHCR, which plays a major role in generating unique patient identifiers nationally with interoperability in mind.

PEPFAR/T COP22 systems investments are strategically focused to support accelerated progress toward achieving epidemic control and build on the foundational building blocks of prior PEPFAR investments in Tanzania. The key investments highlighted focus on increasing impact, optimizing alignment of above-site activities, and partner management with site level implementation and strategic priorities. Through interagency country, PEPFAR/T has avoided duplication of above site technical assistance to maximum returns on investments and eliminate programmatic discordance among partners on-the-ground.

5.1 Information Systems and Data Use

Data and systems are core pillars of PEPFAR/T COP22 approach to support continuous quality improvement in reaching epidemic control and getting to the last mile in an equitable fashion. These tools enable PEPFAR/T to measure the impact of COP22 implementation, and its ability to achieve sustained epidemic control. Robust data and information systems are key to providing quality, client centered services that allow us to obtain equitable health outcomes among all PLHIV and subpopulations. Towards this goal, human, technological and infrastructure capacity are foundational to efficient and effective data and information systems.

For COP22, the key barriers preventing PEPFAR/T from achieving these goals are highlighted in the Table 5.1.

Table 5.1: Key barriers to providing quality care to more than 1.6 million PLHIV

Epidemic Control Barriers or System Gaps Identified: Gaps in surveillance and program data (i.e., data quality and completeness, health information systems) impede ability to analyse 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	
COP21 Status Update	**Key Activities and Benchmarks for COP22**
Patient-Level Health Record Systems	
CTC2/3	**CTC2/3**

• CTC2 database contains individual level clinical, lab, and pharmacy information and covers more than 3,100 (~95%) facilities. • Pharmacy, HTS, and lab modules are integrated into CTC2 but not implemented at all sites. • Within CTC2/3, there is no standardized method for capture or reporting of morbidity and mortality data • CTC2 to CTC3 data transfer occurs on a weekly basis, yet technical challenges prevent use for national-level, aggregate, and real-time monitoring. **GoTHOMIS** • GoTHOMIS has been implemented in 1,161 health facilities • HIV services (HTS, and CTC) modules implemented in GoTHOMIS, with TB and Leprosy module under development. • Biometric features not implemented in the current version. **AfyaCare** • Implementation in 15 regional and specialized hospitals with plans to support and additional 13 hospitals. HIV services module field tested but needs updating.	• Increase CTC2 (+pharmacy, testing, recency, and lab modules) database functionality to 95% of PEPFAR/T static facilities. • Include standardized morbidity and mortality data • CTC2 to CTC3 databases: Complete/accurate weekly file acceptance for 95% of static PEPFAR/T sites. **GoTHOMIS** • Incorporate standard treatment guidelines and integrate with diagnostic devices like Viral Load and other lab equipment • Include biometric features and linkage with product catalogue, client registry, etc. • Support deployment of GoTHOMIS to more facilities in collaboration with the GoT and other partners
Unique Identification	
• **The National Health Client Registry (NHCR)** has been linked to the two main national identification databases: NIDA and RITA, to validate a client's identification. Use case tests as part of initial trials with AfyaCare and GoTHOMIS have been successful, however full implementation has not occurred. • A **biometrics** module has been developed within the CTC2 database and successfully field tested in Zanzibar. A biometrics module has also been integrated within the AfyaCare system. Currently, the biometrics module is not integrated within HIV services in any PEPFAR/T supported facilities on the Mainland of Tanzania.	**NHCR** • Implement NHCR with patient-level record systems, including CTC2/3, GoTHOMIS, and AfyaCare for 95% of all installed instances. **Biometrics** • Activation of biometrics in the CTC2 database and inclusion within CTC3 has not been approved by GoT. PEPFAR/T will continue to advocate for the CTC2/3 data systems to support biometrics as a form of identification validation and support activation and implementation.
Lab Information Systems (LIS)	
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 in specimen tracking/results and patient-level monitoring.	Improve integrated and functional specimen tracking/results and patient-level monitoring for all PEPFAR/T supported sites.
Interoperability (CTC2/3, community systems, lab systems, DHIS2, etc.)	
Strengthened HIM. Initial ongoing integrations include exchange of client identifiers to validate unique identities, the development of SOPs, technical guidance and policies, and linkage of 17 applications within the HIM. Most systems integrated have been aggregate data systems and more patient-level systems need to be incorporated into the HIM.	Inclusion of patient-level data exchange (CTC2/3, GoTHOMIS, AfyaCare, lab system data, community level applications) and aggregated data exchange across multiple platforms (DHIS2, CTC2/3, OVC systems, etc.) to provide digital exchange of HIV-related service data to 50% or more of PEPFAR/T supported systems.

5.1.1 Scaling HIS to meet the needs of 1.6 million PLHIV in care in FY2023

Tanzania's information systems and data use investments have improved capabilities in service delivery as well as data quality and use at the facility and national levels. The focus of FY2023 will be to improve functionality of key systems (i.e., CTC2, CTC3, lab information systems, community systems) and interoperability to be able to support real-time, person-centered health services and program monitoring for more than 3,000 facilities and 1.6 million PLHIV that will be care in FY23. Strengthening of systems functionality and interoperability will drive improved data quality, continuous quality improvement, site-level patient monitoring, and programmatic and policy decision-making.

In the past two years, PEPFAR/T has supported the upgrading and adoption of technologies to improve data capture, storage, exchange, and quality for patient-level records (e.g., CTC2, GoTHOMIS, LIS, etc.) and aggregate-level program monitoring systems (e.g., CTC3, DHIS2, etc.). During COP22 PEPFAR/T will continue to support necessary upgrades to meet programmatic changes and improve system performance comprehensively. PEPFAR/T also plans to equip patient-level systems with the ability to uniquely identify clients. Additionally, PEPFAR/T plans to improve the availability of cause-of-death information to better understand the underlying drivers of mortality among PLHIV. PEPFAR/T will assess current mortality recording and reporting to inform the development of a standardized method for capturing mortality data in patient-level data systems.

In COP21, PEPFAR/T continued to reinforce the different independent systems to ensure interoperability and streamlining with the goal of strengthening broader HIS and the associated sub-systems to improve health data quality and use. Thus, various national internal and external systems have been interlinked. For instance, the HFR has been integrated with over nine systems through the HIM for improved health facility data consistency, accuracy, and validity across systems. The health commodities and logistics management systems (eLMIS & MSD Epicor). DHIS2 have been integrated via HIM for improved end to end data visibility and supply chain performance. Point of service systems have been linked with the Health Data Repository (HDR) for enhanced accessibility of individual level data from national level health facilities. CTC3 has been integrated with DHIS2 for improved HIV data accessibility for enhanced pandemic monitoring and control. The NHCR use cases were developed and linked through the HIM with the NIDA, which contains identification data for clients who are 16 years and above, and RITA systems, which contains identification for clients below 16 years, and tested with the AfyaCare EMR to support unique validation and identification of clients including PLHIV.

Community-based HIS are needed to monitor PEPFAR/Tanzania's efforts in HIV prevention and provide services to hard-to-reach populations towards the goal of reaching the last mile of epidemic control. Along with ensuring interoperability of systems, in COP21, PEPFAR/T supported enhancement of the OpenSRP community health platform, which had been adopted by the GOT as the national community health digital solution. The platform now includes the full range of community-based HIV services including HTS, index contact tracing, care and treatment, PMTCT, EID, and other modules. The system provides a holistic approach to community-based HIV services for improved patient experience.

In COP22, PEPFAR/T intends to further strengthen Tanzania's HIS interoperability platform by integrating more systems and demonstrate use cases such as OVC systems, AfyaCare / GoTHOMIS / CTC2 integration with the NHCR for unique PLHIV validation and identification. In addition, PEPFAR/T will implement data visualizations and dashboards to champion data use for evidence-based decisions and build the capacity of the GOT to sustain interoperable systems. The HDR will continue to be enhanced to receive de-identified individual level data from all-health EMRs through the HIM. This will provide program managers, decision makers and other stakeholders with secure access to specialized, programmatic information (HIV, TB, MCH, etc.) using de-identified, patient-level data with associated dashboards. Such data access and visualization will facilitate increased use of data to inform policies and decision making.

Finally, PEPFAR/T will continue to support the community platform (OpenSRP) to include additional community-based HIV interventions. The platform will be integrated with facility EMRs and CTC3 to link community level data with facilities to improve HIV services minimize ITT and missed appointment tracking. PEPFAR/T will also work to develop guidelines and standard operating procedures to streamline use of the community platform, and work to build capacity within the GOT and partners to use and sustain the community platform. In additional to supporting systems interoperability and the community platforms, during COP22 PEPFAR/T will also invest to improve accessibility of public health surveillance data. PEPFAR/T will help develop interfaces to support interoperability and data exchange to routinely monitor deaths in communities and health facilities.

5.2 Human Resources for Health

In COP22, PEPFAR/T HRH investments will be strategically focused on addressing HRH gaps and barriers to ensure that the health workforce is competent in delivering services that support high quality HIV prevention interventions and treatment services. PEPFAR/T will continue to support investments geared towards increasing the quantity and quality 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.

PEPFAR/Twill be focused on the following priorities:

1) Support efforts to fill health care professional staffing gaps, and ensure an adequate skill set among this workforce (through collaborative learning approaches including in-service training using digital health platforms services such as ECHO and e-learning models) to provide quality HIV services. PEPFAR/T will ensure the GOT commits to absorbing PEPFAR/T supported HCWs, as a part of the HRH sustainability approach and manages the online platforms for in-service training.
2) Support improved retention, deployment, and redistribution of health care workers (facility and community level), and ensure proper allocation of HCWs, including skill a mix determined by transitioning evidence-based HRH tools such as Workload Indicators

of Staffing Need (WISN), Prioritization and Optimization Allocation (POA), and Workforce Allocation Optimization (WAO) Tools to GOT systems and including both private and faith-based facilities.

3) Strengthen professional development through Continuous Professional Development (CPD) (considering individuals respective career paths and work with professional associations, 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 with supportive evidence (HRH data). Continue to engage governments to plan for employment/retention of PEPFAR-supported health workers and capture progress through the SID Index HRH element. Contribute to domestic resource mobilization efforts for increased financing for HRH, with monitoring triangulated through the PEPFAR Expenditure Reporting data process.
5) Increase the use of data for decision making (e.g., epidemiological pattern changes, THIS, KVP studies), demographic profile creation, policy shifts, infrastructure changes (increasing number of health facilities/new site providing HIV services), and allocation of HCWs. This will include reviewing the HRHIS to capture indictors that support the design of an HRH cascade.

For COP22, the key barriers identified that contribute towards gaps in Human Resources for Health are highlighted in Table 5.2.

Table 5.2: Key barriers related to Human Resources for Health (HRH)

Epidemic Control Barrier or Systems Gap Identified	2021 Results	selected activities and benchmarks for2022/3
Inadequate number of competent HRH to deliver quality team-based care services for differentiated service delivery modalities in facility and community sites.	Developed National Health Sector e-Continuing Professional Development (e-CPD) coordination framework. Developed Learning Management System (LMS) at CDE to host the intermediate in-service field epidemiology training course (cohort 5). Developed training modules for mid-level cadres to undertake task sharing roles. Trained nurses on nurse initiation and management of antiretroviral therapy (NIMART) and trained other HCWs per the task sharing policy. About 1,438 nurses, mentors, and Training of Trainers (ToTs) have been trained in 20 regions through the task sharing policy. Improved accessibility of ART services to PLHIV from 39% baseline (2017) to 84% (2021).	**Activities** Strengthen and expand social welfare workforce and monitor performance including transitioning workforce to Local Government Authorities (LGAs) in 84 councils. Build on previous HRH inventories to address the chronic HRH shortages for HIV service delivery. Continue to provide technical support to MOH on developing a retention plan to reduce vacancy rates. Continue to assist in increasing the number of residents and students graduating from Tanzania Field Epidemiology and Laboratory Training Program (TFELTP). Support and coordinate review of guidelines for updating eLearning materials to facilitate competences and productivity. Continue supporting development and review of e-learning curricula and materials and integrating them into CPD modules and e-learning platform including Task Sharing and nurse-initiated management of antiretroviral therapy (NIMART).

	For 2021, 29 new Field Epidemiologist graduated from a health training institute (14 for master's level course and 15 for the intermediate course) for the FELTP. 4 out of 9 HIV Lab ECHO modules have been designed into the eLearning format. 3 modules from Tanzania Midwife Association (TAMA) are also being converted into the eLearning format. Finalized the designing of curriculum for 2 Continuous Distance Education (CDE) modules.	Finalize the development of the CDE/Morogoro School of Health & Allied Sciences website and integrate curriculum with national e-learning platform. (http://elearning.moh.go.tz/) Update the Platforms and eLearning modules. Support the implementation of GOT merit-based recruitment to attract competent and skilled workforce for PEPFAR supported sites. **Benchmarks** 70% 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) by COP22. Have 45 high-volume sites implement an efficiency change and 60 HCWs self-report increased competence (from baseline) in key HIV areas. No less than 20% of PEPFAR supported HCWs contracted and transitioned to GoT. Convert CPD modules into eLearning format and upload onto the Platform. Convert and upload 30 CPD modules by the end of FY22 (seven modules per quarter). This target has been aligned with CDE 2020-2025 Strategic Plan. Train a total of 10,000 nurses, midwives, and other cadres over the next 3 - 4 years thorough the Task Sharing Policy. Mentor/train 35% of high burden sites on task sharing and SDM per policy and national M&E tools (in collaboration with USG clinical IPs and PORALG). Have 30 residents/students from the TFELTP graduate from a recognized training institute (HRH_PRE). Allow merit-based selection of HCWs so GOT can employ competent health care workers for improved health care delivery.
Inefficient system for HCW 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. Workforce Allocation Optimization (WAO) tool handed over to MOH for validation and expected use during next recruitment cycle.	**Activities** Transition support to GOT in institutionalization of WISN—POA-WAO in the public sector and support the methods in faith base and private health facilities. Support and facilitate digital dissemination of the developed retention toolkit across health facilities for effective implementation and integration into CHOP and CCHP.

	Developed National Health Sector HRH requirement and recruitment plan 2018-2023. The Health Sector Strategic Plan V has included WISN-POA as a National Priority and shift towards workload/performance and evidence-based allocation of staff.	Engage local partners and build their capacity to identify innovative and sustainable solutions to HRH recruitment, deployment, and transition to GOT public service. Further review and align HRH staffing to sustain service delivery, adaptations and capacity of local partners, host government and faith-based organizations to build HRH resiliency and sustainability. **Benchmark** At least 85% of approved permits are filled (recruited) in scale-up councils and disaggregated by cadre. 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. Implementation of WISN+POA methods to faith-based health facilities. Key HRH documents and toolkit disseminated to key stakeholders for quality HRH planning into CHOP and CCHP. 10% of PEPFAR contracted HCWs transitioned to GOT. Align HCWs performance with service delivery performance in PEPFAR supported health facilities.
Inadequate accessibility, availability, and timely utilization of HRH data for specific HIV intervention modeling for evidence-based decision making.	Currently 4 out of 13 NIMART indicators integrated in DHIS2/CTC database. HRHIS Assessment framework report available to assist in planning for interoperability and functionality of the HRHIS. Improvement of HRHIS is being finalized by MoH and PEPFAR/T and will provide technical assistance on pending issues that have remained. Agreement with MoH and key stakeholders on the integration process, key priorities, and timeline. Working sessions with MoH DAHRM, ICT (system developer), and DHRD are ongoing.	**Activities** Finalize support integration of Workforce Allocation Optimization (WAO) tool with other national databases and tools (WISN, POA, HRHIS, HCMIS). Support improvement of HRHIS to enhance HRH data quality and interoperability with other health data systems to facilitate demand creation at all levels. Support MOH and other USG and non-USG partners to ensure access to data and support analysis of HRH data. Support rollout/dissemination of the revised HRHIS at PHI and Present's Office, Regional Administration and Local Government (PORALG) including other collaborative stakeholders. Work with professional associations and GOT in strengthening the capability of National HRHIS for optimized and data driven workforce alignment to service delivery needs.

		Benchmark Integration with and utilization of WISN+POA+WOA in POPSM and HRHIS systems. Integrate all 13 NIMART indicators in the DHIS 2/CTC 3 database. Workforce Allocation Optimization (WAO) tool integrated with other national databases and tools (WISN, POA, HRHIS, HCMIS). 50% increase in use of data for critical HRH planning processes. Develop national HRH country profile. Provide a timely and accurate PEPFAR HRH_STAFF_NAT indicator. Functional HRHIS utilization for informed HRH decisions.

5.2.1 Human Resources for Health Achievements to date

According to the MOHH the Field Epidemiology and Laboratory Training Program (FELTP) Strategic Plan 2016 -2020, it is estimated that Tanzania requires 225 epidemiologists (1 per 200,000 people). However, most trained epidemiologists are located at the national level, leaving approximately 55% of the required positions vacant. This gap directly contributes to the nation's inability to effectively monitor and evaluate ongoing HIV/AIDS programs or detect other priority diseases, including the COVID-19 pandemic. As of December 2021, the FELTP program has trained 731 health care workers in Field Epidemiology and Laboratory Management, who are now deployed in multiple regions and districts throughout the country. They include a total of 152 graduates from the 2-year master's program and 67 from the intermediate 6-month program which directly receives support from PEPFAR/T. These individuals are directly influencing public health in Tanzania, responding to public health emergencies, and building and evaluating surveillance systems. For COP22, the FELTP graduates and residents will continue to assist with conducting/supporting monitoring and evaluation that move the program towards HIV epidemic control. This includes COVID-19 support 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 IPs and CDC staff. More importantly, it is a part of the mentorship model to assist in building the skills of residents and enabling the transfer of knowledge on current HIV related interventions. PEPFAR/T is supporting the process to develop the FELTP strategic plan 2021- 2025 that is expected to be approved by the MOH by March 2022. This plan will provide updated and innovative health methods that assist the program. In addition, PEPFAR/T is working with the GOT to ensure the FELTP program is sustainable. This is done by focusing on recognition of the graduates in the public service system, reviewing and updating the curriculum, and other activities that fall within in the draft national sustainability plan guided by the FELTP steering committee.

Through past investments, PEPFAR/T championed the use of data analytics to measure workload and apply it to identify staffing needs. PEPFAR/T added a prioritization and optimization tool on the WHO WISN tool and has supported its institutionalization in GOT systems. The host government has used the system to allocate HCWs across the country since July 2018. This approach has been adopted by GOT and in COP20, WISN + POA was institutionalized into GOT systems and policies i.e., Health Sector Strategic Plan V. POA has also been used for specific analytics to support PEPFAR allocation of contracted healthcare workers in Tanzania and other PEPFAR implementing countries. In COP22 PEPFAR/T 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 respond to specific HIV policy and program requirements, i.e., Test and Start, DSD, self-testing and surge needs as they are related to unique site level monitoring in scale-up councils to meet key targets.

5.2.2 Human Resources for Health Priorities and COP22 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 85% of HCW are retained for one year using the information available in the HRHIS to monitor progress (retention rates). This will be done through continued technical support to GOT (MOH & 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 COP22, 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 COP22,

During COP22 PEPFAR/T 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 continue to utilize the 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, ITT 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. Communication is underway with the MoH to commence evaluation of the task sharing policy of 2016 and its associated 5-year implementation plan, which is ending in FY22. In addition, PEPFAR/T continues to collaborate with the GOT, GFATM and other stakeholders in the acceleration of NIMART approach efforts, including monitoring of indicators and activities. This is guided by various national documents, including the PEPFAR/T supported costed implementation plan 2018-2023, and NIMART quality assessment tool.

In COP22, 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.

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 the Digital Health strategy 2019-2024. The strategic priorities within these documents and others are complementary, and they align with PEPFAR support areas.

In COP22, 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 FY22, 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 FY21 Q4, about 1,438 (14%) 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 F 22 and FY23.

In FY23, 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 FELTP. In COP22, 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 Human Resource for Heath Operating Unit Data Analytics dashboard of FY20, Comprehensive HRH Analytics & Monitoring Platform (CHAMPS) of FY21, 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 Public Health Laboratory (NPHL) four zonal referral laboratories, four specialized hospital laboratories, 29 regional level laboratories, 130 district level laboratories, and 583 laboratories in health centers. In all these laboratories, PEPFAR/T supports TB Diagnosis, scale-up of HIV viral load testing for routine monitoring for EID testing services that include access, uptake, documentation of final diagnosis/test result, sample transport and referral networks, and results return system using a spoke and hub model.

PEPFAR/T supports laboratory CQI activities including, EQA, PT, tester certification, and laboratory quality management systems to ensure accurate, timely and reliable test results. PEPFAR/T continues to support the DNO reassessment exercise to provide insights on testing demand, testing capacity and utilization, cost efficiency, and access to testing services to benefit and provide the highest quality of laboratory testing services to PEPFAR-supported clients.

5.3.1 Laboratory Systems priorities and COP22 activities

PEPFAR/T will focus on addressing identified gaps in COP22 to increase VL coverage and quality of testing. This will be done through (1) elimination of barriers that hinder scale-up of VLC and timely return of results for patient care, (2) integration and adoption of multiplex testing for HIV and TB, drug resistance, serum cryptococcal antigen (CrAg), HPV, COVID-19, and other HIV related diseases for optimal client-centered laboratory services, (3) accreditation and maintaining accreditation of viral load testing laboratories to international standards ISO 15189, (4) progressive improvements of Laboratory Information Systems, (5) optimization of data dashboard for viral load, EID, and TB, (6) continuous scale-up and quality improvement of HIV rapid testing, (7) support for biosafety training and the correct management and disposal of laboratory testing waste and (8) support for the certification of the HIV drug resistance testing laboratory.

In collaboration with MOH, PEPFAR/T will monitor data driven utilization of integrated POCT for viral load, EID, and TB testing in hard-to-reach councils and priority populations. The placement of POCT equipment will be informed by data driven recommendations from the DNO re-

assessment exercise. Currently, of the 334 GeneXpert platforms placed through the TB program nationwide, 101 conduct both VL/ EID and TB testing, leaving untapped capacity which can be utilized following data obtained from the upcoming PEPFAR-supported DNO reassessment exercise. Implementation and scale-up of the use of whole blood for EID POCT by the MOH will be supported by PEPFAR/T to ensure quality testing outcomes and to improve EID coverage. PEPFAR/T will continue to build on the progress made in previous COP cycles on improving sample quality, reducing sample rejection rates, and minimizing reagent and testing commodity wastage through supporting training and competency assessment of laboratorians. PEPFAR/T will continue to strengthen the laboratory/clinical interface across the entire testing cascade to improve testing services for all PLHIV in Tanzania.

As part of COP22, PEPFAR/T support will focus on improved utilization of high throughput viral load testing platforms within the existing laboratory diagnostic network to ensure efficiencies and uninterrupted laboratory testing services. PEPFAR/T will support transition from the Roche COBAS AmpliPrep/ COBAS TaqMan during its phase out by the manufacturer ensuring no disruptions to testing services and continuation of quality EID testing services. PEPFAR/T will continue to advocate for full adoption of the Global RFP to assist with minimizing of reagent and commodity stockouts and improved testing efficiencies.

Currently, there are 23 viral load and EID testing laboratories. Specimen collection and transportation are done through an integrated national hub and spoke sample transport referral system. In COP22, PEPFAR/T will continue working with the GOT to ensure smooth operation of sample transportation and adherence to sample quality, turnaround time, and cost efficiency. Furthermore, emphasis will be placed on updating the 2015 national viral load and EID testing guidelines to incorporate gains made in previous COP cycles and to build upon the data obtained from the DNO reassessment exercise to assist Tanzania in achieving and sustaining epidemic control. This will also enable the inclusion of the now available integration of multiplexed testing of HPV, COVID-19, among others, due to available updated testing technologies in the country.

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. Furthermore, multi-month dispensing has been scaled up with up to 90% of eligible clients are on 3MMD. The roll out of 6MMD started in Dar es Salaam region in February 2020 and 90% of eligible clients were receiving 6MMD by October 2021. Following the approval by MOH and stabilization of ARVs stocks, 6MMD implementation was rolled out to all the other regions and more than 600,000 clients were on 6MMD by December 2021. The expectation is to reach 60% of the TX_CURR by March 2022. The amended 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. DTG 10mg roll out is planned for April 2022.

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 ongoing in all PEPFAR 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 framework was approved in August 2021 and its scale up started in October 2021. Currently it is being implemented in all regions.

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, DSD, 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 COP22 guidance and the planning level letter as well as performance data's; the USG will on a quarterly basis engage with MOH leadership (including the Deputy Minister of Health and the Minister of Health) to identify any challenges for action. In COP22, PEPFAR/T will continue to support national and sub-national structures including the R/CHMTs in translating policy guidelines into annual operational plans and provide continuous monitoring support for effective implementation.

In COP22 PEPFAR/T will continue to provide technical support to NACP and other IPs to monitor and track efficiency of implementing various DSDs including, test and start, same day initiation, and six-month 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 levels.

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 HIVST such as use of automatic dispensers/vending machines in key hotspots and community locations.

For women, adolescent, and pediatric care, PEPFAR/T will continue to 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 implement the developed guidelines and standard operating procedures for the rollout of pediatric ARV optimization, including support to strengthen and monitor clinical services for CLHIV using CQI approaches and real-time data monitoring for programmatic action.

GOT policy around customs clearance and value added tax (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 COP22

In COP22 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 approved National PrEP implementation Strategic Framework. 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. Moreover, PEPFAR/T will strengthen demand creation activities to support PrEP services, improve data quality issues as well review the supply chain issues to ensure there is un-interrupted supply of PrEP commodities.

The other investments in COP22 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.

PEPFAR Tanzania will be implementing DNO activities for EID, viral load, TB, and other co-infections as well as ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups for 100%access to these services and promote the lab–clinical interface to support clients

In advancement of equity, reduction of stigma and discrimination as well as promotion of human rights to improve HIV prevention and treatment outcomes for key populations, AGYW and other vulnerable groups, PEPFAR Tanzania will collaborate with GOT to develop the National roadmap for reduction of Stigma and Discrimination in COP22 which in turn will be used to revise the training curricula for workplace, HCWs as well as religious institutions trainings. There will also be development of communications materials to be used at communities and incorporation of stigma and discrimination reviews for CQI.

Finally, the strategy will be to maintain and monitor the performance/ progression of other policies implemented in COP21 with the GOT on monthly and quarterly basis.

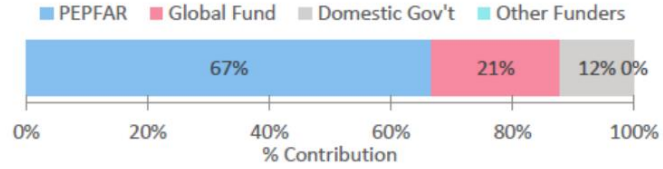
5.5 Financing

The goal of PEPFAR/T's systems investment in finance is for Tanzania to support sustainable financing for epidemic control. The most recent PEPFAR/T SID 4.0 (2021) reveals that the HIV program is largely donor dependent. The UNAIDS HIV investment case report (2019) indicated that PEPFAR and the GFATM accounted for 88% of financing in 2015 and 2016 and 90% in 2017, respectively. Several other donors and partners beyond PEPFAR and the GFATM have provided small amounts of financial support and technical assistance.

The graph below describes the resource allocation profile for the PEPFAR program in Tanzania (2022).

A1. Total Planned Budgets by Funder, 2022

Funder	Total Budget	% Contribution
PEPFAR	$437.6m	66.7%
Global Fund	$138.4m	21.1%
Domestic Gov't	$80.4m	12.2%
Other Funders		2022 n/a
Total	**$656.3 m**	



Note: Budgets and expenditures data for Global Fund for MDR-TB, TB Care and Prevention, and COVID-19 modules are excluded.

PEPFAR and the GFATM continue as the largest donor of Tanzania's HIV program, especially for the funding of core program priorities.

As highlighted in the COP22 Guidance; PEPFAR/T program supports sustainable financing efforts to improve efficient use of existing resources; private sector engagement and increasing the use of data- including resource tracking to inform increase in domestic revenue generation. As part of improving efficiencies, PEPFAR has supports national and local government systems for improved public financial management (PFM) - extending this support down to the lower planning levels and ensuring alignment with the GOT financing reform - DHFF. 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. Furthermore, the country's efforts on the Single National Health Insurance have now evolved and the new administration with a current focus on Universal Health Insurance (UHI). PEPFAR/T continues to support 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 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.

As with previous assessments, the SID 2021 revealed 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- 2022 Results)	Key selected activities and benchmarks (2022 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 National Health Insurance- which has now evolved to UHI (Universal Health Insurance). The DHFF 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 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 universal health insurance strategy Continue strengthening the Direct Facility Financing (DFF), to include contracting with the private sector, and extending output-based payments Strengthen LGA and service provider revenue collection and expenditure management as part of increased efficiencies in use of domestic resources. Provide 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 for the proposed Universal Health Insurance (UHI) Benchmarks Proportion of regions that implement improved insurance schemes to generate additional revenue for priority HIV services

		Proportion of councils and facilities that are using updated PlanRep and FFAR tools and demonstrate increased efficiency in the collection and use of financial resources to inform 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** Continue support for 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; and in alignment with core GoT systems like the MUSE 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 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, 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. In addition, PEPFAR/T has supported the DHFF management framework- which helps to support improved harmonization of fund flows to the facility.

PEPFAR/T's support for the redesign and launch of PlanRep and the 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 has resulted in a strategic purchasing agreement that shifted DFF for Health Basket Funds from input-based to output-based payments. As part of the DHFF implementation, PEPFAR support has included the automation of the disbursement formula of HBF funds to match with actual quarterly disbursements. 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 COP22

PEPFAR/T will continue to support and leverage the ongoing GOT financing reforms, including the DHFF management framework to increase use of public finance for the HIV 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 DHFF payments to the facilities and improve provider capacities to efficiently use these resources to deliver priority health and HIV services. Given the limited fiscal environment, PFM continues to be an area of focus for PEPFAR/T support to address barriers that hamper HIV service delivery and improve overall efficiencies at the local council and facility level. PEPFAR/T will provide support to ensure that the system allowing LGAs 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 recently completed ABC/M activity. The ABC/M established baseline cost estimates for HIV program activities in Tanzania. This will inform PEPFAR/T goals for financial and program sustainability by supporting informed resource allocation decisions and maximizing PEPFAR investments. Looking forward for COP22; PEPFAR TZ, will move into the Phase 2 of the ABC/M activity to build and develop host country capabilities for institutionalization of data collection and use of HIV cost and expenditure data to inform program decision making.

PEPFAR/T continues to provide support to the National Health Insurance Fund (NHIF) as a purchaser for national health insurance. The ongoing work on UHI will continue with extra support to NHIF. In addition, PEPFAR/T will continue support to the regions and districts to ensure effective administration and management – and insurance coverage, especially for PLHIV through the improved community health fund (iCHF). In addition, PEPFAR will also support actions that promote country dialogue and actions for functional and fiscal sustainability, including the new Sustainability TWG led by TACAIDS.

5.6 Private sector NEW for COP22

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

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. The Tanzania Medicines and Medical Devices Authority (TMDA) and TMDA has registered OraQuick, and INSTI- and BIOSURE HIVST kits are in the process of being registered.

The Total Market Approach (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.

Another core achievement is that 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) (2019-2021 Results)	Key selected activities and benchmarks (202 2 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 resulted in NACP, RCHS, and TACAID endorsing TMA for condom distribution. However, with arrival of free, branded condoms provided by GFATM, NACP is no longer adhering to published policy	**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 COP22 activities

SID 3.0 scoring does not represent the full picture of private sector investment and environment in Tanzania. First, the private sector was not reviewed comprehensively. The actual and potential contributions from commercial firms operating in agriculture, mining, and tourism, for instance, were not considered. The focus was almost exclusively on private health providers. Second, some epidemic control programs work at cross-purposes with the goal of building a sustainable HIV response through the private sector. While several GOT agencies made policy commitment and issued policy guidelines and training materials in support of TMA, the proposed massive distribution of free condoms threatens established commercial markets and modestly priced condom markets being nurtured by social enterprise. PEPFAR/T will redouble efforts in championing TMA. TMA advocacy for condoms will continue at the national level, but in COP22, 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. Third, TMA advocacy will be extended to the marketing of HIV self-test kits and PrEP through private sector entities such as community pharmacies.

Unfriendly business regulations have induced understandable caution in the private sector. PEPFAR/T interventions in COP22 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, such as the Private Nurses and Midwives Association of Tanzania members, who offer family-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 14,000 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 HIVST kit providers, businesses, and PEPFAR IPs.

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 GFATM, and other stakeholders,

Tanzania redesigned its supply chain system. 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 FY21 all the regions have transitioned except Kilimanjaro, Manyara and Arusha. National rollout will continue in collaboration with GFATM, MOH, and MSD.

In COP21, PEPFAR/T supported integration of Tanzania Health Supply Chain Portal (THSCP) to receive data from seven different systems through the HIM providing a one-stop centre for HIV supply chain data for monitoring of commodity expiry rates, tracking health commodities procurement, and provide high-level, end-to-end supply chain visibility.

Additionally, PEPFAR/T will also support incorporation of additional indicators (score cards) and systems in the THSCP, integration of eLMIS with health facility level systems (GoTHOMIS & AfyaCare) as they rollout, expansion of the re-designed eLMIS to cover all regions, and interoperability between MSD Epicor, Wambo and eLMIS to improve Information and data sharing regarding commodity procurement and deliveries. However, to further enhance supply chain performance, COP22 will also focus on the development of a bottom-up quantification module in eLMIS, support eLMIS upgrade to the latest version of OpenLMIS and use of standardized master data like health facility registry and product registry.

Furthermore, PEPFAR/T will continue to 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 will facilitate standardized information sharing and use across different data systems (CTC2, eLMIS, EMRs, etc.) through the HIM and support processes for product recalls through reverse logistics. To ensure sustainability of the supply chain systems, PEPFAR/T will continue to build the capacity of the MOH and continue to implement the transition plans to ensure full GOT ownership and support.

The IMPACT team approach initiative capacitates Regional and District Supply Chain Managers to review and analyse 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. PEPFAR will continue to support the IMPACT teams in FY22.

PEPFAR/T will also continue to support other vital areas to commodity security. Activities will include the implementation of the laboratory network optimization recommendations, expansion of eLMIS and upgrades to latest versions, improving the quantification methods through supporting GOT expansion of bottom-up Quantification to vertical programs and monitoring and support of new or scaled up products as they are integrated into the system.

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

Epidemic Control Barrier	Status (value from investment to date)	Key selected activities and benchmarks (2022 Plans)
Inefficient systems and resources for import, product registration, clearance, and Acceptable Remaining Shelf-life guidelines,	New program products, such as DTG 10 mg, quantified at a national level and registered with regulatory authority. For the remaining shelf life, the issue is still pending at the MoH level. PEPFAR is recommending the application WHO guidelines on the acceptable shelf life	**Activities** Build capacity of Tanzania Medicines and Medical Devices Authority on medicines evaluation and registration, formulation development, and stability testing. **Benchmarks** Number of days for product registration and import
Supply chain systems integrations (Wambo, eLMIS, DHIS2, Epicor 10)	Pending MoH Approval of the system interoperability work that is done by PEPFAR MIS team and stakeholders	**Activities** Facilitate access and interoperability between MSD E10, Wambo and eLMIS to improve Information and data sharing regarding commodity procurement and deliveries **Benchmarks** MSD E10, eLMIS &WAMBO systems interoperable
Commodity distribution stock on hand and consumption data reporting cycle/frequency	Expanding the Redesign Logistic system to more regions (Kilimanjaro, Manyara and Arusha)	**Activities** Rollout and Capacity building for the remaining regions
Country Adherence the Global RFP for Laboratory commodities	Ongoing negotiation with the GoT to accept terms of references of the Global RFP and benefits of prices that are negotiated	**Activities,** The use of the negotiated prices going forward and the data sharing with manufacturers

5.8 Surveillance, research, and evaluation (SRE)

In COP22, PEPFAR/T will undertake four SRE activities. DOD will continue to implement the African Cohort Study (AFRICOS) in Mbeya. CDC will conduct the THIS 2022-2023 nationally, an expanded BBS on the mainland and in Zanzibar, and PMTCT cascade evaluation in a representative sample of sites.

AFRICOS

AFRICOS is a large 15-year cohort study across multiple African sites (Kenya, Nigeria, Tanzania, and Uganda) that 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. This longitudinal assessment fosters an understanding of the impact of long-term comorbidities on HIV outcomes. Findings from AFRICOS have already contributed sound evidence including showing that:

1. Clients who transitioned to TLD had significantly lower rate of virologic failure compared to those that did not switch to TLD.
2. 6MMD clients are twice as likely to be virally suppressed compared to those on 3-5MMD.

3. Persistent low-level of viremia was associated with increased risk of virologic failure and non-communicable diseases and conditions such as hypertension, hypercholesterolemia, hyperglycemia, renal insufficiency.
4. In the context of TLD and MMD scale-up, viral suppression improved despite programmatic disruptions by the COVID-19 pandemic environment.

The study will be used to identify and address contributing factors to virologic failure. The AFRICOS data will provide important information for optimizing care models across different age groups to increase engagement in care, retention, adherence, and VLS—all of which are important for attaining HIV epidemic control. More broadly, AFRICOS will continue to serve as critical evaluation tool for PEPFAR program in Tanzania in assessing HIV pathogenesis, evaluating the impact of comorbidities/coinfections, and measuring long-term biomedical and biobehavioral outcomes in adults and adolescents. The AFRICOS platform is also used to strengthen local research and evaluation capacity through its longstanding collaborations with the National Institute of Medical Research-Mbeya Medical Research Center and Mbeya Zonal Referral Hospital and Regional Referral Hospital.

Expanded bio-behavioral survey (BBS)

Currently in FY2022, CDC is leading a BBS assessment in three mainland regions and covers FSW and PWID. In COP22, the BBS assessment will be expanded geographically to cover three additional regions on the mainland plus Zanzibar. The expanded BBS will include FSW, PWID, and MSM. CDC, PEPFAR/T, IPs, and NACP will continue to meaningfully engage KP constituencies to design the BBS expansion on the mainland and in Zanzibar. The BBS will be designed to determine HIV burden and identify behavioral risk factors that contribute to HIV infection among KP. It is also designed to quantify the size of sub-population groups. Conducting the expanded BBS is aligned with the COP22 guidelines instructing countries to utilize BBS studies to fill gaps in population-level surveillance data for KP populations and to inform targeted program implementation and equitable outcomes. Data from the COP21 BBS coupled with the expanded COP2022 BBS will provide comprehensive data on the clinical and behavioral outcomes among KP groups in Tanzania. It should be noted that the country is currently using outdated size estimations and HIV prevalence estimates for KP that were generated in 2012. In addition, the 2012 estimates were generated using outdated methods that are not in line with the current UNAIDS/WHO KP bio-behavioral guidelines for generation of population size estimates. Updated BBS data will allow PEPFAR/T to have evidence-based KP target-setting to ensure equitable resource allocation and coverage of services.

Tanzania HIV Impact Survey (THIS) 2022-2023

THIS 2016-2017 is now five years old. Use of the THIS 2016-2017 results transformed the HIV response in Tanzania; however, the utility of the THIS 2016-2017 has waned given the evolved state of the epidemic in the country. Therefore, in FY2023, Tanzania will conduct the THIS 2022-2023 using comparable methodologies as done in the last survey. The new survey will provide nationally representative prevalence estimates that can be extrapolated with the new 2022 census data to generate reliable estimates of the number of PLHIV in Tanzania. A key objective of the THIS 2022-2023 is to assess Tanzania's progress towards reaching the UNAIDS 95-95-95 targets and population viral load suppression. HIV incidence and other key

behavioral and social outcomes will be assessed in the survey to identify unmet needs and programmatic gaps. PEPFAR/T has and will continue to strongly engage GOT and other stakeholders in the planning and implementation of the survey. PEPFAR/T, GOT, and other key stakeholders are committed to accelerating the implementation of the THIS 2022-2023 to ensure that preliminary data insights from are available to inform COP 23 program planning. As with the 2016-2017 survey, it is anticipated that the pending THIS 2022-2023 will further transform the HIV epidemic response in Tanzania. PEPFAR/T stands ready to work closely with the GOT and key stakeholders to use the data swiftly to recalibrate investment strategies with an equity lens.

PMTCT Cascade Evaluation

A comprehensive picture of the PMTCT cascade is lacking in Tanzania in part because data capture systems in ANC / PMTCT clinics are not linked with data systems in the CTCs. The PMTCT cascade has upstream and downstream components. Upstream includes data captured from testing/re-testing pregnant women attending ANC to identify HIV positive women who need to be enrolled in HIV care and treatment services. Downstream includes data captured from testing HEI to identify CLHIV who need to be linked and retained in lifelong care. PEPFAR/T will conduct a comprehensive and focused PMTCT cascade evaluation by linking various patient level registers (paper-based and electronic) to reconstruct the cascade. The evaluation will identify specific areas in the reconstructed cascade where the biggest drop-offs are observed including from the ANC and delivery to the 2- and 12-month EID period. A representative sample of sites will be randomly selected to provide a national snapshot. PEPFAR/T will strongly engage the NACP and regional authorities in designing and implementing the evaluation.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR/T did a thorough assessment of the need for new or repurposed staff across the interagency team. Using staffing tools and extensive internal agency and interagency discussion, the team determined that the overall funding allocation by budget code and the budget code attribution by Full-Time Employees (FTE) were well-aligned.

There are currently 16 vacancies across all agencies: DOD (0), CDC (12), USAID (2), State (2), and Peace Corps (2). Most of these positions have reached the recruitment stage, and it is expected that offers of employment will be extended for all positions during the 2022 calendar year.

DOD is maintaining the same structure as in COP21. All 17 positions are filled. There are no vacant positions, and no new/additional positions are planned for COPP22. With the current staffing structure DOD is in a good position to implement SIMS, achieve program goals, and 95-95- 95-95 targets.

CDC is in the process of filling eleven vacant positions. Two positions have been filled and are waiting for the candidates to arrive in country (Deputy Associate Director for Programs, Clinical Surveillance Officer). Two positions are in the middle of on-boarding clearance (CoAg Specialist, Lab Liaison), and four positions are in the candidate selection process (Computer Management Specialist, Senior Implementation Science Advisor, Strategic Information Branch Chief, and Associate Director for Data and Science). Two positions are with RCC for reclassification (Program Specialist). CDC is working with the Embassy on reprogramming one position (IPC Specialist). There is also a key position that will be vacant in July, the Associate Director for Programs. This position has already been classified and gotten all the approvals and will be advertised the week on April 4th.

USAID has successfully recruited 10 positions in the last year, including Deputy Health Director, Project Management Specialist (HIV/AIDS and TB), Public Health Specialist – LG Health System Strengthening, Evaluation Learning Advisor, DREAMS Partnership Coordinator, Development and Assistance Specialist (SI), Sr. Supply Chain Management Advisor, Project Management Specialist (M & E), Project Management Specialist – HSS, and Program Management Specialist (Supply Chain Management). This restructuring of positions within USAID is to achieve program goals and 95-95- 95 targets. For COP22 USAID is planning to fill two vacant positions: the HIV & TB Treatment Advisor, and the Health Information Specialist.

State successfully filled the Deputy Coordinator position (hired through USAID) in August 2021 and added one locally employed staff as the Administrative Finance Assistant in December 2020. In the past, State has relied on the Expanded Professional Associates Program (EPAP) for one position within the PEPFAR Coordination Office. For the last two EPAP cycles, State has declined to allow post to fill this position. The PEPFAR Coordination Office will be transitioning this position to an LES position to fill critical SI staffing support needs. The PEPFAR Coordination Office has one additional vacancy – the Strategic Information Advisor – and efforts are underway to fill this position, which is a USAID personal services contract.

Peace Corps assessed staffing during the COP21 fiscal year and repurposed two positions. Therefore, Peace Corps Tanzania will maintain 10 PEPFAR-funded positions in COP22. Two of the 10 will be filled by end of Q4 2022. An offer has been extended for one technical position. In addition, the COP21 HIV Coordinator position has been repurposed and is now the M&E Analyst position. By maintaining these 10 positions, post has the technical and operational coverage for a successful volunteer re-entry as well as enhanced training, program implementation, monitoring/oversight, and reporting in the targeted SNUs.

Each implementing agency in PEPFAR/T conducted an internal staffing review to ensure that staff time was aligned with core programmatic, population, and geographic priorities, as well as business process coverage. Agencies continuously assessed the most important needs when vacancies occurred and repurposed appropriately. USAID, CDC, WRAIR/DOD, Peace Corps, and State have increased the cost of doing business (CODB) by 4% in COP22, with slight increases across each agency. This small increase it to allow adequate resources for the resumption of activities after the major pause in programming and restrictions during the COVID-19 pandemic, and to allow for proper on-boarding of new hires.

PEPFAR/T has continued to structure itself in goal-oriented working groups that focus on time-bound deliverables that respond to current priorities. 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. These “Goal Teams” focus on the four pillars of action: (1) generate data to drive performance, (2) ensure all sites are performing, (3) ensure implementation of effective policies, and (4) develop activities and tools to support effective implementation and continuous quality improvement. The Goal Teams develop 30-60-90-day plans to address these action pillars and report their progress at weekly PEPFAR Steering Committee meetings. In addition to Goals Teams, cross-cutting Core Groups focus on HIS/data systems, supply chain and commodities, HRH and health financing, and reporting. These Core Groups provide support to the Goal Teams to ensure they achieve their objectives. This new structure is being Beta tested in COP21 and will be refined, based on experience, in COP22.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

COP 22 ART COVERAGE

Region	PSNU	Prioritization	96%	104%	96%	26%	85%	101%	118%	100%	97%	94%	94%	92%	95%	95%	226%	4348%	239%	128%	26%	88%	109%	121%	97%	100%	100%	99%	95%	95%	93%	92%	114%	86%	71%
			All	All	All	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
			Total	<15	15+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Military Tanzania	Military Tanzania	MI	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Arusha	Arusha CC	Scale-up: Saturation	103%	114%	102%	9%	98%	90%	134%	130%	113%	87%	87%	76%	83%	104%	126%	155%	119%	87%	10%	94%	98%	178%	111%	96%	99%	89%	94%	98%	100%	126%	188%	141%	106%
Arusha	Arusha DC	Scale-up: Saturation	90%	94%	89%	33%	95%	93%	96%	92%	89%	89%	87%	88%	82%	87%	101%	120%	81%	77%	33%	100%	93%	100%	95%	88%	87%	94%	94%	92%	67%	97%	100%	96%	75%
Arusha	Karatu DC	Sustained	84%	73%	85%	0%	53%	81%	74%	90%	99%	87%	86%	87%	87%	76%	80%	99%	78%	79%	0%	69%	77%	82%	94%	98%	92%	93%	87%	80%	76%	73%	106%	79%	55%
Arusha	Longido DC	Sustained	84%	86%	84%	100%	82%	81%	86%	97%	90%	88%	87%	87%	73%	79%	79%	100%	67%	79%	100%	109%	86%	81%	92%	87%	86%	86%	86%	86%	78%	75%	77%	110%	88%	70%
Arusha	Meru DC	Sustained	83%	81%	83%	0%	97%	79%	85%	105%	87%	87%	90%	87%	80%	74%	85%	96%	75%	82%	0%	85%	75%	83%	91%	87%	87%	87%	87%	79%	72%	77%	94%	73%	61%
Arusha	Monduli DC	Sustained	107%	106%	107%	0%	75%	100%	142%	133%	89%	100%	91%	103%	83%	120%	139%	167%	117%	76%	0%	109%	89%	121%	95%	91%	91%	91%	89%	124%	81%	138%	195%	135%	86%
Arusha	Ngorongoro DC	Sustained	95%	102%	95%	0%	200%	120%	64%	100%	93%	95%	121%	125%	81%	61%	100%	128%	82%	73%	0%	200%	80%	73%	94%	130%	98%	92%	89%	64%	72%	107%	158%	123%	77%
Dar es Salaam	Ilala MC	Scale-up: Saturation	99%	41%	101%	17%	72%	9%	25%	114%	112%	87%	74%	69%	86%	102%	120%	163%	122%	90%	18%	72%	69%	25%	101%	98%	101%	91%	91%	89%	124%	81%	138%	195%	135%	86%
Dar es Salaam	Kigamboni MC	Scale-up: Saturation	104%	94%	105%	0%	70%	88%	114%	88%	74%	73%	118%	99%	116%	116%	107%	151%	70%	71%	0%	71%	107%	113%	89%	99%	100%	111%	107%	103%	108%	97%	141%	70%	70%
Dar es Salaam	Kinondoni MC	Scale-up: Saturation	90%	63%	91%	43%	72%	70%	59%	117%	92%	72%	71%	69%	87%	99%	104%	143%	107%	76%	45%	72%	84%	20%	86%	86%	88%	78%	88%	100%	101%	87%	127%	104%	78%
Dar es Salaam	Temeke MC	Scale-up: Saturation	82%	73%	82%	8%	71%	69%	84%	95%	86%	71%	70%	69%	74%	83%	89%	120%	93%	70%	8%	72%	69%	84%	86%	73%	89%	100%	71%	82%	82%	70%	105%	92%	70%
Dar es Salaam	Ubungo MC	Scale-up: Saturation	71%	69%	71%	0%	72%	69%	78%	86%	86%	87%	71%	69%	71%	70%	70%	90%	74%	70%	0%	71%	69%	73%	86%	87%	71%	69%	68%	68%	68%	68%	70%	70%	70%
Dodoma	Bahi DC	Sustained	85%	94%	85%	0%	97%	90%	96%	96%	92%	86%	88%	88%	80%	82%	79%	83%	85%	93%	0%	90%	90%	118%	95%	94%	85%	86%	87%	82%	78%	78%	102%	79%	68%
Dodoma	Chamwino DC	Sustained	111%	123%	110%	50%	113%	151%	104%	97%	103%	85%	91%	90%	126%	108%	135%	158%	97%	84%	50%	163%	111%	118%	111%	113%	100%	119%	95%	107%	92%	133%	184%	120%	70%
Dodoma	Chemba DC	Sustained	86%	87%	86%	0%	82%	84%	95%	87%	91%	86%	89%	90%	82%	102%	80%	79%	92%	68%	0%	82%	100%	83%	103%	90%	93%	87%	88%	91%	65%	95%	75%	65%	77%
Dodoma	Dodoma MC	Attained	90%	95%	89%	57%	86%	84%	115%	101%	92%	85%	85%	86%	79%	82%	99%	112%	74%	64%	62%	89%	91%	109%	90%	90%	85%	85%	85%	94%	91%	97%	129%	88%	63%
Dodoma	Kondoa DC	Scale-up: Saturation	97%	122%	96%	0%	40%	122%	167%	113%	103%	100%	106%	90%	83%	84%	106%	115%	82%	89%	0%	120%	129%	129%	108%	113%	110%	105%	96%	90%	76%	93%	116%	80%	71%
Dodoma	Kondoa TC	Scale-up: Saturation	125%	185%	122%	0%	88%	150%	164%	131%	100%	91%	90%	93%	138%	86%	144%	149%	89%	100%	0%	143%	223%	315%	119%	101%	90%	101%	122%	152%	116%	181%	221%	117%	67%
Dodoma	Kongwa DC	Scale-up: Saturation	83%	87%	83%	13%	92%	80%	95%	90%	91%	85%	86%	85%	76%	75%	76%	82%	83%	69%	14%	71%	80%	116%	98%	96%	90%	85%	86%	79%	72%	70%	89%	96%	68%
Dodoma	Mpwapwa DC	Sustained	87%	88%	87%	0%	100%	80%	79%	98%	97%	88%	90%	85%	79%	76%	78%	93%	80%	66%	0%	90%	97%	103%	96%	132%	88%	89%	89%	67%	85%	85%	118%	74%	65%
Geita	Bukombe DC	Scale-up: Saturation	104%	136%	102%	200%	90%	142%	143%	91%	90%	93%	110%	102%	109%	99%	105%	132%	99%	66%	200%	91%	150%	174%	89%	100%	118%	118%	101%	103%	97%	81%	117%	102%	66%
Geita	Chato DC	Scale-up: Saturation	118%	159%	116%	0%	88%	180%	163%	90%	93%	119%	150%	132%	115%	92%	98%	99%	77%	72%	0%	109%	195%	215%	90%	136%	160%	158%	133%	109%	86%	84%	97%	82%	67%
Geita	Geita DC	Scale-up: Saturation	87%	104%	86%	42%	92%	112%	94%	90%	90%	95%	99%	92%	90%	77%	82%	93%	77%	61%	42%	91%	122%	111%	90%	93%	103%	103%	87%	80%	69%	64%	85%	56%	57%
Geita	Geita TC	Scale-up: Saturation	98%	116%	97%	11%	75%	118%	155%	90%	90%	90%	91%	91%	92%	87%	97%	121%	82%	58%	13%	91%	124%	147%	91%	94%	105%	101%	101%	101%	102%	97%	116%	96%	67%
Geita	Mbogwe DC	Scale-up: Saturation	102%	138%	100%	25%	73%	159%	164%	90%	89%	107%	110%	122%	99%	103%	98%	100%	70%	69%	29%	95%	143%	183%	91%	99%	114%	121%	109%	98%	90%	73%	102%	90%	61%
Geita	Nyang'hwale DC	Sustained	87%	121%	85%	25%	97%	110%	142%	94%	94%	93%	84%	84%	86%	93%	86%	85%	68%	62%	25%	100%	120%	167%	93%	94%	94%	91%	89%	79%	78%	64%	84%	90%	58%
Iringa	Iringa DC	Scale-up: Saturation	83%	86%	83%	60%	103%	71%	130%	90%	90%	90%	94%	93%	89%	75%	76%	83%	59%	68%	60%	99%	99%	31%	90%	104%	105%	87%	92%	82%	79%	71%	87%	58%	48%
Iringa	Iringa MC	Attained	111%	111%	111%	78%	110%	93%	188%	110%	103%	101%	105%	122%	131%	128%	124%	140%	74%	62%	88%	109%	127%	46%	90%	104%	100%	99%	124%	99%	138%	123%	151%	79%	49%
Iringa	Kilolo DC	Scale-up: Saturation	87%	115%	86%	63%	97%	97%	142%	90%	102%	101%	85%	94%	95%	79%	78%	86%	60%	69%	63%	100%	110%	138%	91%	103%	100%	99%	97%	80%	81%	71%	92%	57%	48%
Iringa	Mufindi TC	Scale-up: Saturation	106%	134%	105%	120%	128%	107%	169%	119%	91%	101%	108%	94%	107%	109%	102%	112%	93%	53%	120%	61%	121%	198%	99%	117%	133%	124%	117%	109%	86%	73%	95%	65%	49%
Iringa	Mufindi DC	Scale-up: Saturation	90%	88%	90%	56%	79%	106%	116%	93%	101%	101%	99%	103%	99%	98%	81%	96%	55%	109%	56%	82%	119%	20%	94%	102%	101%	100%	94%	79%	76%	65%	86%	58%	110%
Kagera	Biharamulo DC	Scale-up: Saturation	108%	114%	108%	0%	107%	117%	109%	101%	123%	105%	123%	94%	101%	87%	99%	108%	102%	97%	0%	102%	137%	125%	125%	111%	134%	129%	92%	102%	106%	108%	98%	109%	115%
Kagera	Bukoba DC	Scale-up: Saturation	101%	116%	100%	40%	89%	127%	133%	98%	109%	116%	146%	121%	98%	77%	79%	85%	83%	90%	40%	91%	145%	101%	124%	127%	140%	120%	99%	86%	77%	78%	85%	82%	91%
Kagera	Bukoba MC	Attained	95%	106%	94%	25%	98%	110%	131%	96%	103%	90%	92%	95%	85%	82%	76%	96%	77%	84%	25%	89%	121%	94%	119%	111%	96%	101%	87%	99%	92%	88%	124%	89%	98%
Kagera	Karagwe DC	Scale-up: Saturation	93%	118%	92%	0%	62%	128%	135%	98%	132%	94%	105%	92%	85%	95%	85%	100%	87%	86%	0%	93%	137%	145%	102%	97%	102%	100%	86%	82%	80%	82%	87%	84%	81%
Kagera	Kyerwa DC	Scale-up: Saturation	91%	101%	90%	0%	101%	104%	109%	103%	103%	100%	92%	96%	87%	78%	76%	96%	78%	87%	0%	91%	105%	107%	110%	95%	106%	93%	91%	77%	81%	78%	98%	97%	102%
Kagera	Missenyi DC	Scale-up: Saturation	117%	148%	115%	29%	104%	164%	152%	110%	105%	119%	151%	124%	123%	106%	89%	105%	95%	91%	29%	96%	172%	186%	121%	129%	163%	139%	119%	110%	92%	93%	100%	97%	108%
Kagera	Muleba DC	Scale-up: Saturation	92%	114%	91%	0%	108%	115%	143%	102%	115%	104%	116%	101%	92%	81%	76%	88%	80%	88%	0%	64%	125%	129%	103%	106%	102%	102%	91%	76%	76%	76%	99%	79%	88%
Kagera	Ngara DC	Scale-up: Saturation	102%	107%	102%	0%	64%	111%	162%	106%	96%	120%	121%	104%	100%	93%	91%	101%	95%	104%	0%	64%	119%	107%	125%	116%	123%	106%	94%	90%	93%	93%	98%	95%	100%
Kaskazini Pemba	Micheweni	Sustained	64%	70%	63%	-	0%	50%	100%	133%	100%	100%	80%	80%	67%	60%	75%	50%	33%	33%	-	100%	50%	100%	33%	40%	29%	71%	43%	57%	114%	40%	50%	50%	50%
Kaskazini Pemba	Wete	Sustained	114%	179%	109%	-	100%	167%	233%	140%	100%	43%	113%	122%	122%	180%	100%	100%	60%	40%	-	400%	167%	100%	100%	63%	50%	117%	164%	127%	138%	110%	113%	100%	67%
Kaskazini Unguja	Kaskazini A	Sustained	77%	144%	74%	-	100%	100%	233%	100%	86%	82%	100%	71%	73%	114%	75%	70%	17%	17%	-	100%	200%	100%	113%	106%	103%	6%	92%	138%	72%	37%	41%	20%	22%
Kaskazini Unguja	Kaskazini B	Sustained	37%	38%	37%	-	50%	33%	33%	100%	86%	83%	80%	75%	27%	29%	25%	30%	17%	17%	-	50%	33%	33%	43%	24%	90%	25%	19%	25%	18%	26%	24%	30%	33%

COP 22 ART COVERAGE

Region	PSNU	Prioritization	96%	104%	96%	26%	85%	101%	118%	100%	97%	94%	94%	92%	95%	95%	226%	4348%	239%	128%	26%	88%	109%	121%	97%	100%	100%	99%	95%	95%	93%	92%	114%	86%	71%
			All	All	All	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
			Total	<15	15+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Katavi	Mlele DC	Sustained	120%	132%	119%	0%	93%	142%	143%	103%	104%	112%	100%	128%	141%	126%	123%	152%	109%	91%	0%	113%	131%	173%	124%	103%	103%	109%	136%	120%	101%	119%	175%	121%	92%
Katavi	Mpanda DC	Scale-up: Saturation	88%	97%	87%	25%	85%	112%	98%	100%	94%	89%	90%	90%	84%	80%	80%	97%	76%	84%	25%	85%	112%	90%	110%	89%	94%	89%	90%	77%	82%	75%	104%	77%	84%
Katavi	Mpanda MC	Scale-up: Saturation	117%	159%	117%	50%	100%	95%	146%	108%	107%	104%	106%	97%	126%	101%	137%	179%	120%	88%	50%	84%	135%	149%	110%	113%	108%	118%	116%	122%	123%	121%	162%	107%	94%
Katavi	Mpimbwe DC	Sustained	159%	246%	153%	0%	142%	252%	319%	111%	107%	119%	156%	185%	160%	140%	146%	187%	136%	85%	0%	184%	297%	262%	123%	135%	157%	185%	153%	150%	144%	169%	241%	179%	97%
Katavi	Nsimbo DC	Sustained	86%	95%	85%	17%	91%	104%	93%	95%	95%	89%	91%	90%	74%	76%	76%	73%	82%	90%	17%	89%	110%	92%	106%	90%	89%	90%	90%	82%	84%	79%	73%	83%	85%
Kigoma	Buhigwe DC	Scale-up: Saturation	83%	146%	80%	0%	83%	160%	200%	93%	111%	93%	80%	81%	89%	74%	75%	87%	75%	44%	0%	100%	120%	178%	85%	88%	90%	73%	81%	59%	87%	87%	81%	80%	43%
Kigoma	Kakonko DC	Scale-up: Saturation	83%	116%	81%	0%	67%	131%	165%	103%	90%	90%	96%	90%	81%	74%	77%	92%	76%	48%	0%	47%	96%	160%	90%	90%	91%	83%	83%	75%	65%	77%	76%	75%	47%
Kigoma	Kasulu DC	Sustained	90%	98%	89%	0%	111%	94%	76%	91%	90%	90%	121%	96%	100%	77%	98%	110%	71%	46%	0%	94%	94%	134%	90%	98%	97%	95%	92%	85%	70%	83%	89%	82%	56%
Kigoma	Kasulu TC	Sustained	97%	105%	96%	50%	38%	80%	117%	100%	93%	88%	81%	82%	83%	86%	125%	151%	100%	57%	50%	108%	105%	178%	120%	90%	98%	92%	96%	116%	90%	90%	130%	87%	56%
Kigoma	Kibondo DC	Sustained	82%	89%	82%	0%	56%	86%	75%	90%	116%	90%	82%	84%	79%	72%	90%	109%	77%	51%	0%	100%	88%	130%	90%	90%	90%	84%	88%	78%	70%	69%	83%	72%	45%
Kigoma	Kigoma DC	Sustained	86%	97%	85%	0%	29%	109%	127%	88%	100%	92%	115%	151%	119%	77%	71%	75%	48%	48%	0%	86%	130%	90%	89%	85%	91%	100%	95%	64%	73%	72%	68%	42%	56%
Kigoma	Kigoma Ujiji MC	Scale-up: Saturation	95%	97%	95%	25%	79%	96%	119%	94%	90%	90%	82%	83%	99%	90%	99%	155%	101%	80%	25%	68%	85%	125%	89%	90%	90%	100%	99%	99%	94%	94%	98%	93%	64%
Kigoma	Uvinza DC	Sustained	85%	105%	84%	0%	102%	130%	105%	90%	102%	102%	110%	78%	79%	81%	78%	77%	64%	47%	0%	93%	117%	91%	91%	102%	102%	100%	83%	78%	74%	65%	78%	64%	48%
Kilimanjaro	Hai DC	Sustained	81%	82%	81%	33%	60%	71%	85%	88%	86%	79%	64%	73%	76%	87%	97%	104%	68%	55%	33%	100%	83%	98%	83%	83%	83%	72%	78%	82%	82%	87%	105%	74%	55%
Kilimanjaro	Moshi DC	Scale-up: Saturation	62%	55%	63%	0%	43%	43%	60%	87%	84%	77%	59%	59%	57%	61%	71%	78%	55%	55%	0%	35%	45%	94%	82%	79%	81%	57%	57%	54%	54%	55%	68%	54%	55%
Kilimanjaro	Moshi MC	Scale-up: Saturation	157%	157%	157%	80%	106%	104%	238%	201%	120%	89%	86%	100%	141%	164%	211%	245%	199%	159%	100%	103%	118%	263%	140%	92%	89%	115%	132%	191%	205%	269%	371%	263%	186%
Kilimanjaro	Mwanga DC	Sustained	100%	103%	100%	0%	107%	69%	139%	91%	88%	83%	83%	86%	103%	108%	145%	165%	75%	70%	0%	108%	89%	123%	85%	80%	81%	77%	90%	108%	113%	122%	154%	74%	68%
Kilimanjaro	Rombo DC	Sustained	94%	88%	95%	0%	76%	55%	135%	87%	86%	79%	83%	94%	105%	105%	120%	125%	67%	54%	0%	80%	65%	106%	88%	84%	88%	88%	90%	117%	94%	99%	123%	83%	54%
Kilimanjaro	Same DC	Sustained	95%	68%	98%	0%	92%	41%	82%	79%	78%	102%	71%	70%	99%	97%	119%	136%	75%	69%	0%	92%	47%	84%	79%	84%	83%	83%	100%	103%	99%	105%	128%	150%	116%	68%
Kilimanjaro	Siha DC	Sustained	109%	111%	109%	0%	107%	146%	115%	93%	85%	84%	101%	84%	96%	115%	144%	178%	86%	71%	0%	121%	93%	104%	95%	105%	102%	94%	102%	122%	114%	134%	176%	92%	69%
Kusini Pemba	Chake Chake	Sustained	89%	100%	88%	-	100%	100%	200%	86%	89%	92%	93%	88%	29%	100%	100%	92%	63%	63%	-	100%	20%	80%	89%	100%	91%	87%	100%	91%	95%	100%	100%	83%	67%
Kusini Pemba	Mkoani	Sustained	93%	133%	91%	-	0%	200%	100%	150%	100%	50%	60%	100%	150%	67%	140%	120%	67%	67%	-	0%	200%	300%	67%	80%	43%	57%	86%	86%	117%	60%	67%	50%	50%
Lindi	Kilwa DC	Sustained	94%	82%	95%	0%	90%	61%	88%	105%	90%	92%	85%	103%	90%	94%	106%	122%	83%	49%	0%	100%	83%	98%	91%	91%	91%	104%	91%	92%	104%	91%	105%	98%	61%
Lindi	Lindi DC	Sustained	89%	98%	88%	0%	64%	106%	102%	103%	106%	103%	91%	88%	82%	88%	88%	99%	91%	61%	0%	96%	89%	135%	103%	105%	98%	91%	88%	92%	85%	84%	84%	98%	54%
Lindi	Lindi MC	Sustained	110%	99%	111%	0%	65%	97%	103%	127%	90%	91%	87%	89%	96%	106%	142%	147%	95%	60%	0%	100%	97%	132%	90%	91%	93%	110%	127%	131%	123%	131%	125%	98%	56%
Lindi	Liwale DC	Sustained	87%	85%	88%	0%	55%	91%	83%	105%	93%	89%	87%	90%	110%	99%	103%	98%	69%	55%	0%	82%	90%	100%	91%	91%	91%	88%	94%	94%	70%	72%	86%	80%	49%
Lindi	Nachingwea DC	Sustained	103%	108%	103%	0%	93%	96%	100%	101%	85%	106%	103%	89%	118%	99%	130%	145%	87%	50%	0%	92%	125%	135%	94%	96%	114%	107%	104%	100%	110%	102%	109%	98%	59%
Lindi	Ruangwa DC	Sustained	90%	96%	89%	0%	96%	93%	96%	104%	90%	90%	85%	90%	100%	92%	102%	118%	77%	53%	0%	96%	105%	102%	92%	90%	102%	102%	96%	99%	89%	75%	72%	58%	55%
Manyara	Babati DC	Sustained	88%	95%	87%	0%	100%	100%	106%	91%	96%	90%	85%	87%	85%	90%	92%	103%	80%	67%	0%	96%	91%	89%	119%	91%	91%	91%	87%	68%	85%	76%	89%	123%	88%	75%
Manyara	Babati TC	Sustained	91%	105%	90%	50%	93%	96%	131%	107%	95%	90%	95%	87%	81%	80%	82%	86%	87%	52%	50%	113%	104%	100%	92%	92%	91%	92%	93%	102%	98%	88%	98%	96%	57%
Manyara	Hanang DC	Sustained	82%	97%	80%	0%	100%	106%	100%	89%	90%	91%	87%	87%	73%	65%	64%	62%	84%	74%	0%	104%	105%	84%	91%	105%	91%	86%	87%	74%	70%	69%	64%	86%	73%
Manyara	Kiteto DC	Sustained	107%	106%	107%	33%	96%	105%	114%	104%	90%	91%	107%	93%	121%	101%	112%	119%	85%	56%	33%	85%	110%	127%	108%	126%	108%	94%	117%	111%	97%	115%	156%	118%	71%
Manyara	Mbulu DC	Sustained	97%	108%	97%	0%	73%	83%	156%	100%	92%	91%	96%	86%	83%	87%	114%	140%	92%	89%	0%	100%	94%	147%	118%	90%	112%	87%	87%	113%	94%	84%	113%	90%	79%
Manyara	Mbulu TC	Sustained	83%	94%	83%	0%	100%	111%	111%	100%	104%	94%	105%	88%	83%	53%	80%	78%	87%	47%	0%	100%	89%	78%	125%	94%	90%	90%	94%	96%	64%	58%	78%	106%	61%	55%
Manyara	Simanjiro DC	Sustained	90%	97%	89%	50%	116%	91%	93%	99%	90%	90%	94%	87%	100%	86%	101%	117%	81%	83%	50%	100%	107%	91%	111%	121%	91%	87%	86%	78%	86%	78%	75%	76%	105%	75%	53%
Mara	Bunda DC	Scale-up: Saturation	91%	105%	90%	0%	89%	101%	106%	117%	116%	86%	109%	100%	88%	95%	86%	128%	65%	54%	0%	93%	109%	140%	88%	91%	96%	100%	100%	75%	74%	74%	81%	94%	75%	53%
Mara	Bunda TC	Scale-up: Saturation	101%	131%	99%	120%	89%	117%	124%	103%	88%	87%	83%	100%	109%	109%	99%	99%	98%	58%	120%	116%	128%	202%	88%	87%	107%	111%	103%	99%	112%	99%	98%	117%	63%
Mara	Butiama DC	Sustained	84%	92%	84%	20%	89%	93%	95%	86%	89%	86%	93%	108%	84%	105%	86%	84%	69%	56%	20%	89%	104%	95%	87%	102%	102%	82%	81%	72%	57%	89%	90%	78%	55%
Mara	Musoma DC	Scale-up: Saturation	87%	100%	86%	50%	114%	105%	94%	91%	108%	101%	89%	88%	87%	87%	83%	87%	68%	55%	50%	50%	109%	119%	90%	111%	104%	93%	94%	87%	72%	59%	86%	54%	57%
Mara	Musoma MC	Scale-up: Saturation	97%	106%	96%	0%	82%	104%	146%	105%	91%	90%	86%	87%	91%	94%	108%	123%	88%	57%	0%	55%	85%	170%	90%	90%	90%	87%	90%	103%	116%	108%	144%	95%	55%
Mara	Nyrya DC	Scale-up: Saturation	87%	106%	86%	35%	89%	100%	126%	87%	87%	87%	88%	85%	74%	77%	85%	85%	71%	55%	38%	94%	112%	120%	86%	102%	100%	98%	94%	94%	78%	78%	79%	100%	56%	54%
Mara	Serengeti DC	Scale-up: Saturation	93%	102%	92%	17%	100%	97%	129%	97%	87%	87%	96%	83%	86%	94%	109%	130%	89%	57%	20%	90%	89%	125%	88%	87%	87%	84%	84%	78%	89%	114%	163%	121%	71%
Mara	Tarime DC	Sustained	88%	96%	87%	0%	89%	91%	107%	105%	87%	86%	94%	88%	91%	92%	84%	95%	74%	52%	0%	103%	91%	116%	87%	101%	97%	85%	83%	70%	82%	89%	116%	96%	63%
Mara	Tarime TC	Scale-up: Saturation	103%	101%	103%	0%	85%	94%	141%	86%	87%	88%	81%	90%	101%	115%	104%	151%	100%	71%	0%	116%	97%	93%	85%	87%	109%	107%	97%	108%	101%	138%	108%	126%	82%

COP 22 ART COVERAGE

			96%	104%	96%	26%	85%	101%	118%	100%	97%	94%	94%	92%	95%	95%	226%	4348%	239%	128%	26%	88%	109%	121%	97%	100%	100%	99%	95%	95%	93%	92%	114%	86%	71%
Region	PSNU	Prioritization	All	All	All	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
			Total	<15	15+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Mbeya	Busokelo DC	Sustained	104%	159%	101%	0%	81%	170%	215%	92%	91%	91%	87%	106%	95%	102%	105%	113%	77%	57%	0%	107%	123%	225%	90%	94%	128%	129%	127%	99%	113%	100%	95%	84%	62%
Mbeya	Chunya DC	Sustained	134%	143%	133%	25%	82%	114%	180%	102%	96%	113%	120%	145%	150%	125%	131%	150%	93%	52%	25%	75%	158%	240%	124%	176%	152%	153%	158%	146%	99%	112%	142%	109%	59%
Mbeya	Kyela DC	Scale-up: Saturation	109%	139%	108%	93%	82%	138%	170%	118%	90%	90%	88%	94%	107%	141%	125%	153%	93%	55%	93%	78%	142%	185%	105%	90%	93%	99%	122%	120%	138%	110%	115%	84%	57%
Mbeya	Mbarali DC	Scale-up: Saturation	84%	88%	83%	26%	53%	96%	121%	90%	100%	90%	88%	87%	88%	85%	86%	101%	74%	48%	26%	84%	104%	65%	79%	86%	90%	89%	88%	82%	75%	73%	82%	72%	48%
Mbeya	Mbeya CC	Attained	93%	34%	96%	8%	104%	14%	16%	137%	97%	125%	85%	76%	88%	90%	97%	119%	91%	100%	8%	95%	14%	16%	112%	131%	90%	91%	90%	101%	94%	95%	88%	93%	52%
Mbeya	Mbeya DC	Scale-up: Saturation	75%	112%	74%	87%	86%	88%	139%	90%	107%	90%	74%	71%	73%	71%	76%	72%	71%	52%	87%	101%	105%	160%	90%	90%	90%	74%	70%	70%	64%	74%	67%	49%	53%
Mbeya	Rungwe DC	Scale-up: Saturation	107%	143%	105%	43%	61%	130%	200%	91%	103%	90%	90%	91%	111%	113%	122%	136%	76%	51%	43%	70%	138%	220%	104%	102%	110%	111%	115%	120%	118%	106%	104%	85%	58%
Mjini Magharibi	Magharibi A	Sustained	51%	91%	50%	0%	114%	67%	117%	89%	89%	90%	84%	89%	12%	13%	12%	11%	7%	9%	0%	114%	67%	117%	94%	90%	91%	87%	87%	12%	12%	12%	11%	6%	8%
Mjini Magharibi	Magharibi B	Scale-up: Saturation	51%	49%	51%	0%	33%	38%	120%	88%	83%	93%	88%	88%	33%	21%	10%	8%	8%	10%	0%	33%	43%	60%	94%	98%	95%	88%	88%	9%	11%	10%	12%	12%	7%
Mjini Magharibi	Mjini	Scale-up: Saturation	117%	197%	114%	0%	65%	158%	447%	284%	138%	97%	82%	86%	119%	149%	127%	138%	46%	11%	0%	95%	204%	324%	159%	114%	128%	123%	146%	147%	98%	90%	102%	64%	30%
Morogoro	Gairo DC	Scale-up: Saturation	82%	77%	82%	0%	113%	84%	74%	90%	90%	89%	94%	82%	91%	59%	67%	67%	76%	57%	0%	100%	64%	67%	89%	97%	124%	99%	86%	64%	67%	66%	71%	80%	70%
Morogoro	Ifakara TC	Sustained	114%	119%	114%	0%	128%	104%	128%	101%	91%	91%	91%	89%	87%	107%	137%	159%	76%	58%	0%	121%	115%	133%	91%	94%	106%	100%	113%	151%	133%	152%	199%	108%	53%
Morogoro	Kilombero DC	Scale-up: Saturation	108%	124%	107%	14%	92%	116%	145%	94%	112%	90%	111%	98%	102%	100%	107%	126%	71%	59%	17%	74%	144%	158%	97%	138%	144%	118%	105%	103%	110%	105%	141%	81%	58%
Morogoro	Kilosa DC	Scale-up: Saturation	97%	93%	97%	0%	56%	86%	112%	91%	90%	90%	106%	106%	125%	96%	109%	125%	76%	56%	0%	60%	98%	126%	90%	90%	94%	110%	99%	98%	80%	88%	119%	72%	60%
Morogoro	Malinyi DC	Sustained	105%	136%	104%	0%	114%	146%	150%	111%	88%	102%	87%	86%	89%	95%	98%	118%	61%	67%	0%	86%	129%	187%	102%	134%	131%	119%	100%	107%	121%	111%	145%	57%	65%
Morogoro	Morogoro DC	Scale-up: Saturation	75%	80%	75%	0%	65%	98%	54%	93%	102%	96%	67%	96%	67%	78%	55%	57%	69%	64%	0%	65%	91%	102%	92%	99%	95%	93%	92%	55%	58%	58%	72%	63%	71%
Morogoro	Morogoro MC	Attained	91%	93%	91%	0%	88%	95%	117%	89%	94%	93%	91%	91%	79%	81%	100%	118%	69%	58%	0%	78%	74%	117%	93%	94%	94%	90%	90%	95%	88%	83%	152%	73%	68%
Morogoro	Mvomero DC	Scale-up: Saturation	88%	80%	89%	0%	58%	86%	108%	94%	93%	91%	94%	93%	78%	75%	133%	122%	58%	66%	0%	71%	68%	84%	93%	103%	107%	98%	91%	77%	72%	75%	115%	55%	63%
Morogoro	Ulanga DC	Scale-up: Saturation	80%	110%	78%	100%	108%	96%	93%	92%	102%	97%	79%	92%	82%	67%	60%	68%	65%	59%	100%	92%	120%	147%	89%	102%	101%	99%	88%	63%	66%	53%	68%	74%	59%
Mtwara	Masasi DC	Scale-up: Saturation	88%	89%	88%	29%	54%	85%	89%	101%	91%	90%	73%	69%	78%	86%	100%	119%	40%	50%	33%	84%	99%	114%	91%	90%	91%	86%	83%	90%	106%	96%	135%	87%	44%
Mtwara	Masasi TC	Sustained	110%	92%	111%	33%	92%	85%	98%	114%	91%	90%	120%	89%	101%	130%	136%	168%	48%	48%	33%	64%	85%	126%	91%	91%	91%	129%	112%	116%	125%	123%	171%	51%	56%
Mtwara	Mtwara DC	Sustained	82%	98%	81%	0%	120%	90%	103%	98%	106%	89%	84%	48%	41%	42%	48%	42%	86%	51%	0%	113%	86%	103%	93%	104%	108%	119%	79%	99%	107%	99%	40%	70%	56%
Mtwara	Mtwara MC	Sustained	109%	116%	109%	0%	50%	138%	146%	99%	94%	94%	104%	85%	125%	125%	126%	151%	45%	50%	0%	107%	117%	137%	90%	94%	94%	105%	113%	126%	131%	107%	160%	49%	56%
Mtwara	Nanyamba TC	Sustained	80%	104%	79%	0%	100%	90%	109%	106%	100%	116%	100%	82%	90%	84%	100%	98%	72%	59%	0%	120%	120%	109%	96%	95%	91%	90%	72%	49%	73%	67%	87%	60%	53%
Mtwara	Nanyumbu DC	Sustained	80%	89%	79%	33%	100%	89%	94%	94%	94%	94%	74%	42%	42%	45%	41%	44%	84%	56%	33%	96%	84%	90%	94%	108%	100%	132%	75%	84%	72%	88%	117%	50%	43%
Mtwara	Newala DC	Sustained	58%	82%	57%	0%	45%	100%	91%	100%	96%	95%	94%	51%	51%	49%	47%	52%	75%	58%	0%	40%	95%	90%	94%	93%	94%	54%	43%	44%	43%	40%	40%	73%	45%
Mtwara	Newala TC	Sustained	104%	91%	104%	50%	69%	113%	88%	99%	103%	95%	89%	47%	47%	145%	155%	87%	88%	50%	50%	100%	87%	89%	93%	95%	94%	127%	122%	124%	120%	124%	155%	46%	42%
Mtwara	Tandahimba DC	Sustained	109%	116%	109%	0%	94%	109%	152%	122%	105%	113%	85%	110%	104%	125%	125%	138%	51%	52%	0%	89%	119%	125%	90%	91%	90%	140%	130%	113%	131%	103%	135%	56%	51%
Mwanza	Buchosa DC	Scale-up: Saturation	85%	98%	84%	7%	90%	101%	96%	90%	49%	93%	86%	87%	87%	82%	84%	80%	90%	73%	7%	91%	103%	116%	90%	109%	110%	96%	86%	70%	64%	62%	88%	67%	73%
Mwanza	Ilemela MC	Attained	85%	96%	85%	21%	102%	89%	105%	90%	90%	90%	87%	90%	78%	76%	61%	77%	70%	76%	23%	54%	105%	132%	94%	109%	103%	95%	88%	70%	73%	75%	70%	82%	86%
Mwanza	Kwimba DC	Scale-up: Saturation	96%	129%	94%	12%	66%	128%	164%	90%	90%	90%	115%	118%	105%	88%	87%	100%	79%	72%	12%	93%	134%	189%	100%	102%	101%	96%	96%	97%	87%	76%	80%	77%	86%
Mwanza	Magu DC	Scale-up: Saturation	93%	117%	92%	6%	88%	120%	120%	102%	90%	90%	107%	96%	109%	83%	87%	101%	86%	73%	7%	91%	133%	149%	90%	102%	104%	105%	92%	81%	84%	83%	80%	86%	72%
Mwanza	Misungwi DC	Scale-up: Saturation	90%	105%	89%	0%	65%	101%	120%	91%	91%	103%	98%	93%	95%	81%	87%	98%	73%	73%	0%	94%	112%	135%	89%	114%	105%	96%	96%	87%	77%	63%	82%	59%	73%
Mwanza	Nyamagana MC	Attained	105%	96%	106%	0%	92%	87%	106%	95%	103%	97%	92%	88%	93%	98%	111%	144%	95%	90%	0%	93%	93%	118%	115%	113%	106%	98%	99%	117%	120%	115%	147%	109%	89%
Mwanza	Sengerema DC	Scale-up: Saturation	122%	129%	121%	60%	114%	125%	141%	89%	91%	107%	129%	125%	122%	124%	114%	133%	105%	76%	60%	96%	134%	164%	101%	145%	162%	148%	131%	119%	102%	100%	106%	101%	83%
Mwanza	Ukerewe DC	Scale-up: Saturation	96%	99%	96%	0%	90%	100%	104%	96%	124%	94%	107%	93%	98%	88%	89%	85%	79%	75%	0%	91%	99%	124%	98%	102%	121%	108%	99%	92%	85%	87%	87%	84%	73%
Njombe	Ludewa DC	Scale-up: Saturation	87%	120%	86%	217%	65%	114%	145%	91%	90%	91%	94%	89%	93%	83%	71%	77%	64%	47%	217%	94%	112%	132%	90%	90%	91%	101%	95%	95%	86%	79%	98%	61%	46%
Njombe	Makambako TC	Scale-up: Saturation	87%	113%	86%	43%	87%	101%	138%	90%	90%	91%	92%	92%	81%	87%	86%	98%	78%	61%	43%	102%	98%	152%	91%	91%	94%	92%	91%	74%	81%	70%	97%	53%	59%
Njombe	Makete DC	Scale-up: Saturation	109%	163%	107%	0%	54%	151%	228%	102%	91%	91%	95%	112%	121%	119%	122%	132%	85%	52%	0%	69%	152%	256%	90%	90%	105%	105%	99%	99%	134%	125%	157%	90%	52%
Njombe	Njombe DC	Scale-up: Saturation	96%	138%	94%	25%	45%	135%	188%	95%	113%	95%	100%	115%	99%	100%	79%	88%	83%	53%	25%	83%	127%	195%	93%	124%	113%	100%	102%	91%	80%	79%	89%	70%	49%
Njombe	Njombe TC	Attained	100%	103%	100%	0%	81%	106%	96%	107%	102%	94%	98%	99%	101%	97%	90%	107%	98%	184%	0%	76%	124%	119%	94%	109%	100%	99%	99%	99%	102%	87%	94%	98%	98%
Njombe	Wanging'ombe DC	Scale-up: Saturation	105%	153%	103%	0%	91%	133%	193%	90%	91%	91%	106%	110%	107%	98%	99%	107%	99%	98%	0%	91%	149%	224%	90%	110%	111%	111%	111%	101%	103%	99%	117%	76%	98%

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			96%	104%	96%	26%	85%	101%	118%	100%	97%	94%	94%	92%	95%	95%	226%	4348%	239%	128%	26%	88%	109%	121%	97%	100%	100%	99%	95%	95%	93%	92%	114%	86%	71%
Region	PSNU	Prioritization	All	All	All	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
			Total	<15	15+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Pwani	Bagamoyo DC	Sustained	96%	90%	97%	25%	90%	90%	86%	69%	102%	116%	108%	94%	93%	88%	97%	123%	83%	52%	25%	97%	88%	98%	69%	113%	106%	112%	89%	88%	88%	95%	143%	94%	55%
Pwani	Chalinze DC	Scale-up: Saturation	85%	86%	85%	0%	88%	75%	89%	90%	90%	90%	124%	87%	90%	77%	78%	95%	79%	41%	0%	88%	85%	102%	90%	90%	92%	110%	87%	80%	69%	74%	102%	79%	43%
Pwani	Kibaha DC	Sustained	98%	87%	99%	0%	45%	76%	86%	90%	89%	90%	99%	96%	108%	111%	114%	136%	89%	51%	0%	100%	97%	114%	104%	91%	90%	107%	107%	101%	88%	96%	126%	88%	46%
Pwani	Kibaha TC	Scale-up: Saturation	122%	105%	123%	0%	45%	100%	118%	111%	105%	90%	104%	93%	122%	123%	162%	190%	128%	80%	0%	100%	97%	153%	102%	107%	116%	124%	121%	142%	129%	130%	181%	113%	69%
Pwani	Kibiti DC	Sustained	123%	124%	123%	33%	71%	135%	148%	90%	89%	91%	138%	121%	150%	132%	152%	178%	116%	60%	33%	76%	119%	162%	93%	90%	111%	139%	126%	129%	121%	125%	177%	118%	56%
Pwani	Kisarawe DC	Sustained	114%	109%	114%	33%	48%	98%	141%	92%	90%	91%	86%	95%	111%	109%	163%	99%	109%	56%	33%	85%	113%	139%	99%	92%	91%	97%	110%	132%	147%	146%	197%	116%	57%
Pwani	Mafia DC	Sustained	91%	87%	91%	0%	100%	73%	100%	105%	91%	91%	85%	89%	95%	91%	95%	110%	82%	50%	0%	100%	42%	133%	92%	90%	90%	96%	94%	84%	103%	76%	108%	84%	62%
Pwani	Mkuranga DC	Scale-up: Saturation	109%	99%	109%	33%	98%	94%	114%	94%	94%	94%	110%	111%	99%	135%	165%	186%	126%	63%	33%	73%	87%	128%	101%	93%	94%	107%	120%	99%	98%	115%	155%	98%	53%
Pwani	Rufiji DC	Sustained	106%	110%	106%	0%	110%	88%	127%	108%	89%	90%	86%	86%	120%	124%	137%	159%	104%	58%	0%	95%	105%	142%	91%	88%	90%	114%	112%	104%	104%	114%	154%	99%	46%
Rukwa	Kalambo DC	Scale-up: Saturation	97%	113%	96%	0%	100%	159%	97%	109%	106%	100%	119%	90%	97%	99%	100%	121%	86%	81%	0%	100%	146%	90%	127%	101%	105%	91%	90%	90%	82%	90%	99%	90%	79%
Rukwa	Nkasi DC	Scale-up: Saturation	94%	129%	92%	0%	96%	144%	124%	94%	95%	103%	94%	92%	96%	98%	98%	99%	103%	86%	0%	93%	163%	154%	93%	89%	94%	94%	94%	82%	79%	106%	99%	93%	64%
Rukwa	Sumbawanga DC	Scale-up: Saturation	114%	149%	112%	0%	91%	182%	166%	104%	94%	101%	110%	131%	130%	132%	130%	157%	108%	93%	0%	92%	193%	159%	99%	92%	99%	99%	108%	115%	116%	108%	147%	98%	94%
Rukwa	Sumbawanga MC	Scale-up: Saturation	111%	144%	110%	200%	88%	160%	127%	114%	111%	97%	88%	100%	121%	110%	125%	157%	104%	90%	200%	96%	184%	163%	106%	97%	90%	113%	107%	126%	112%	111%	161%	108%	91%
Ruvuma	Madaba DC	Sustained	107%	149%	105%	0%	67%	163%	208%	98%	100%	103%	120%	99%	120%	110%	92%	97%	100%	79%	0%	86%	143%	188%	92%	100%	132%	133%	114%	101%	90%	88%	98%	103%	81%
Ruvuma	Mbinga DC	Scale-up: Saturation	97%	129%	96%	0%	76%	157%	145%	90%	90%	91%	94%	94%	114%	99%	94%	105%	66%	81%	0%	90%	153%	126%	90%	90%	90%	88%	106%	99%	88%	100%	129%	78%	78%
Ruvuma	Mbinga TC	Scale-up: Saturation	91%	110%	91%	0%	94%	116%	110%	91%	91%	91%	82%	90%	90%	89%	95%	103%	65%	66%	0%	94%	123%	120%	91%	90%	91%	101%	90%	98%	78%	91%	120%	72%	69%
Ruvuma	Namtumbo DC	Scale-up: Saturation	80%	68%	81%	0%	92%	66%	70%	93%	94%	94%	98%	97%	64%	70%	77%	84%	70%	68%	0%	100%	67%	57%	93%	94%	94%	95%	95%	67%	66%	65%	61%	70%	77%
Ruvuma	Nyasa DC	Sustained	112%	150%	111%	67%	84%	179%	170%	83%	122%	129%	153%	131%	100%	107%	102%	112%	74%	84%	67%	121%	150%	164%	86%	156%	134%	132%	108%	102%	93%	86%	113%	68%	86%
Ruvuma	Songea DC	Scale-up: Saturation	86%	97%	86%	33%	88%	106%	89%	91%	90%	91%	91%	94%	90%	87%	91%	94%	64%	74%	33%	96%	90%	114%	90%	94%	95%	89%	84%	81%	81%	80%	94%	47%	74%
Ruvuma	Songea MC	Attained	91%	98%	91%	50%	95%	91%	97%	90%	90%	91%	92%	91%	93%	87%	98%	102%	71%	80%	50%	100%	96%	117%	90%	90%	90%	96%	91%	96%	89%	82%	106%	84%	80%
Ruvuma	Tunduru DC	Scale-up: Saturation	87%	103%	86%	140%	95%	110%	89%	91%	91%	90%	93%	93%	75%	88%	85%	88%	64%	74%	140%	97%	131%	90%	91%	91%	90%	89%	93%	90%	85%	70%	87%	80%	74%
Shinyanga	Kahama TC	Attained	104%	133%	103%	33%	96%	144%	173%	91%	90%	91%	97%	96%	100%	103%	110%	137%	87%	77%	33%	73%	144%	158%	91%	97%	112%	115%	102%	113%	96%	96%	138%	82%	65%
Shinyanga	Kishapu DC	Scale-up: Saturation	80%	103%	78%	0%	96%	111%	99%	89%	90%	90%	88%	87%	75%	70%	87%	101%	62%	58%	0%	100%	103%	120%	90%	90%	90%	87%	87%	61%	53%	71%	96%	58%	54%
Shinyanga	Msalala DC	Scale-up: Saturation	89%	98%	88%	10%	63%	116%	104%	93%	94%	92%	107%	96%	95%	91%	95%	109%	67%	61%	10%	99%	115%	87%	93%	94%	99%	98%	86%	79%	73%	66%	93%	58%	61%
Shinyanga	Shinyanga DC	Scale-up: Saturation	98%	126%	96%	0%	90%	123%	164%	91%	91%	90%	89%	101%	95%	89%	95%	113%	67%	57%	0%	89%	149%	133%	90%	95%	108%	122%	104%	93%	84%	96%	131%	79%	55%
Shinyanga	Shinyanga MC	Scale-up: Saturation	107%	149%	105%	50%	111%	149%	186%	112%	90%	90%	88%	95%	120%	119%	141%	157%	93%	62%	50%	93%	131%	204%	90%	90%	95%	112%	99%	99%	112%	104%	157%	99%	61%
Shinyanga	Ushetu DC	Scale-up: Saturation	93%	124%	91%	0%	91%	145%	112%	90%	91%	90%	91%	107%	97%	94%	98%	113%	69%	57%	0%	98%	154%	141%	90%	90%	101%	98%	93%	86%	77%	78%	107%	63%	58%
Simiyu	Bariadi DC	Sustained	81%	130%	78%	120%	92%	135%	121%	90%	91%	90%	72%	85%	76%	79%	98%	78%	85%	62%	150%	91%	142%	179%	91%	90%	91%	70%	65%	70%	71%	74%	71%	58%	63%
Simiyu	Bariadi TC	Sustained	126%	152%	124%	0%	94%	131%	185%	97%	90%	91%	126%	112%	145%	146%	145%	166%	101%	84%	0%	106%	171%	233%	91%	102%	125%	137%	140%	128%	121%	117%	159%	95%	96%
Simiyu	Busega DC	Scale-up: Saturation	97%	121%	96%	0%	97%	131%	135%	91%	90%	90%	89%	98%	113%	91%	111%	116%	82%	86%	0%	89%	114%	162%	91%	90%	94%	112%	93%	108%	77%	85%	110%	76%	92%
Simiyu	Itilima DC	Scale-up: Saturation	91%	130%	89%	0%	94%	142%	155%	92%	90%	90%	104%	90%	90%	87%	91%	106%	95%	73%	0%	74%	125%	179%	95%	90%	90%	78%	80%	78%	92%	83%	118%	92%	72%
Simiyu	Maswa DC	Scale-up: Saturation	82%	108%	81%	0%	68%	114%	155%	90%	90%	90%	69%	67%	72%	74%	98%	117%	79%	77%	0%	64%	116%	139%	90%	90%	90%	72%	67%	70%	76%	88%	130%	80%	77%
Simiyu	Meatu DC	Scale-up: Saturation	103%	129%	102%	17%	100%	138%	139%	114%	90%	90%	94%	94%	110%	99%	139%	169%	80%	78%	20%	105%	151%	136%	91%	90%	90%	97%	98%	99%	98%	108%	160%	80%	81%
Singida	Ikungi DC	Sustained	87%	108%	86%	33%	143%	117%	96%	102%	90%	90%	52%	63%	106%	109%	125%	87%	52%	57%	33%	95%	113%	105%	91%	118%	91%	93%	77%	83%	77%	90%	93%	48%	54%
Singida	Iramba DC	Scale-up: Saturation	98%	120%	97%	80%	100%	100%	133%	103%	114%	92%	75%	72%	83%	98%	135%	163%	88%	49%	100%	86%	142%	141%	117%	106%	97%	70%	89%	92%	98%	116%	132%	134%	46%
Singida	Itigi DC	Sustained	130%	139%	130%	0%	94%	161%	125%	91%	119%	90%	117%	142%	157%	150%	176%	206%	115%	66%	0%	100%	174%	170%	94%	113%	106%	136%	140%	136%	132%	147%	106%	107%	76%
Singida	Manyoni DC	Sustained	80%	97%	79%	40%	97%	85%	105%	97%	90%	91%	64%	79%	79%	86%	96%	109%	49%	57%	40%	105%	90%	111%	91%	90%	90%	70%	70%	73%	70%	89%	95%	50%	52%
Singida	Mkalama DC	Sustained	80%	100%	79%	50%	100%	96%	86%	92%	92%	93%	60%	59%	49%	51%	83%	83%	57%	90%	50%	119%	112%	104%	94%	104%	93%	52%	72%	68%	79%	125%	132%	85%	55%
Singida	Singida DC	Sustained	68%	91%	66%	0%	92%	91%	89%	90%	109%	105%	56%	51%	53%	61%	53%	56%	97%	73%	0%	125%	96%	88%	104%	112%	103%	51%	55%	48%	49%	48%	50%	98%	87%
Singida	Singida MC	Sustained	113%	130%	112%	33%	118%	116%	133%	114%	90%	90%	82%	94%	119%	120%	147%	174%	96%	61%	33%	100%	143%	167%	91%	90%	93%	117%	115%	130%	130%	128%	128%	104%	62%
Songwe	Ileje DC	Scale-up: Saturation	95%	122%	93%	50%	67%	120%	138%	96%	104%	112%	100%	90%	93%	97%	95%	111%	94%	72%	50%	100%	152%	133%	103%	90%	94%	92%	98%	90%	89%	88%	96%	96%	71%
Songwe	Mbozi DC	Scale-up: Saturation	98%	123%	97%	7%	46%	112%	158%	113%	90%	90%	100%	101%	91%	104%	115%	138%	95%	67%	7%	90%	136%	165%	90%	98%	90%	93%	95%	96%	98%	94%	104%	91%	73%
Songwe	Momba DC	Scale-up: Saturation	109%	171%	106%	33%	131%	190%	190%	95%	91%	95%	120%	106%	103%	129%	102%	102%	103%	76%	33%	116%	181%	223%	92%	126%	102%	117%	105%	100%	103%	101%	102%	110%	79%
Songwe	Songwe DC	Scale-up: Saturation	102%	143%	100%	100%	96%	112%	189%	101%	102%	100%	90%	93%	103%	105%	110%	128%	91%	67%	100%	100%	136%	202%	120%	104%	91%	109%	100%	103%	104%	84%	101%	82%	69%
Songwe	Tunduma TC	Scale-up: Saturation	89%	91%	89%	43%	100%	91%	96%	106%	99%	93%	104%	95%	90%	96%	74%	109%	90%	82%	43%	91%	91%	91%	90%	90%	99%	93%	90%	73%	66%	69%	81%	88%	86%

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Region	PSNU	Prioritization	96%	104%	96%	26%	85%	101%	118%	100%	97%	94%	94%	92%	95%	95%	226%	4348%	239%	128%	26%	88%	109%	121%	97%	100%	100%	99%	95%	95%	93%	92%	114%	86%	71%
			All	All	All	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Male	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female	Female
			Total	<15	15+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+	<01	01-04	05-09	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Tabora	Igunga DC	Scale-up: Saturation	106%	122%	105%	0%	95%	130%	144%	90%	90%	90%	94%	95%	113%	105%	132%	161%	106%	77%	0%	79%	119%	158%	93%	90%	95%	110%	99%	108%	94%	124%	174%	112%	75%
Tabora	Kaliua DC	Scale-up: Saturation	105%	102%	105%	80%	96%	107%	101%	90%	116%	90%	120%	103%	116%	104%	117%	139%	93%	70%	80%	100%	104%	102%	90%	109%	109%	128%	95%	93%	94%	92%	127%	93%	84%
Tabora	Nzega DC	Scale-up: Saturation	93%	109%	92%	0%	49%	115%	122%	102%	98%	94%	90%	87%	90%	102%	107%	122%	79%	72%	0%	93%	119%	141%	94%	94%	86%	97%	85%	84%	89%	93%	124%	80%	73%
Tabora	Nzega TC	Sustained	89%	85%	89%	0%	75%	102%	92%	102%	100%	90%	88%	87%	87%	84%	84%	81%	91%	96%	0%	50%	98%	97%	115%	98%	89%	88%	86%	86%	87%	88%	83%	92%	97%
Tabora	Sikonge DC	Sustained	125%	124%	125%	50%	89%	135%	153%	90%	92%	95%	102%	118%	147%	136%	168%	207%	132%	78%	50%	97%	106%	147%	98%	89%	98%	130%	119%	116%	143%	154%	204%	129%	78%
Tabora	Tabora MC	Attained	90%	95%	90%	0%	107%	94%	108%	90%	90%	90%	87%	88%	75%	82%	88%	97%	67%	75%	0%	92%	99%	91%	104%	92%	90%	87%	87%	94%	93%	93%	116%	96%	88%
Tabora	Urambo DC	Scale-up: Saturation	88%	111%	87%	0%	113%	111%	102%	97%	90%	90%	87%	88%	85%	92%	91%	99%	78%	75%	0%	93%	110%	157%	95%	90%	90%	87%	88%	80%	77%	80%	99%	80%	76%
Tabora	Uyui DC	Scale-up: Saturation	90%	110%	89%	67%	90%	119%	100%	91%	90%	90%	98%	87%	92%	88%	101%	118%	83%	79%	73%	90%	121%	133%	91%	107%	90%	90%	87%	76%	66%	84%	118%	84%	72%
Tanga	Bumbuli DC	Sustained	90%	89%	90%	0%	75%	82%	88%	90%	110%	89%	104%	97%	58%	85%	86%	88%	72%	64%	0%	100%	88%	104%	92%	89%	109%	102%	95%	75%	89%	99%	100%	100%	81%
Tanga	Handeni DC	Sustained	77%	86%	76%	0%	105%	79%	86%	102%	91%	90%	75%	85%	85%	65%	83%	79%	95%	63%	0%	117%	77%	89%	90%	93%	90%	71%	67%	66%	67%	63%	81%	91%	59%
Tanga	Handeni TC	Sustained	93%	96%	93%	0%	114%	79%	100%	112%	90%	91%	93%	97%	89%	88%	81%	83%	102%	53%	0%	107%	104%	96%	103%	90%	90%	87%	86%	84%	102%	128%	128%	83%	71%
Tanga	Kilindi DC	Sustained	83%	81%	83%	0%	89%	74%	95%	90%	90%	90%	94%	96%	92%	87%	90%	90%	78%	51%	0%	78%	73%	86%	90%	90%	95%	87%	70%	69%	73%	84%	83%	100%	62%
Tanga	Korogwe DC	Scale-up: Saturation	86%	101%	85%	33%	100%	94%	91%	93%	104%	97%	87%	89%	83%	81%	81%	87%	94%	98%	33%	96%	87%	138%	90%	90%	90%	100%	66%	82%	80%	79%	80%	86%	99%
Tanga	Korogwe TC	Sustained	144%	207%	142%	50%	185%	148%	254%	121%	90%	89%	92%	92%	141%	129%	184%	221%	102%	62%	50%	146%	186%	300%	90%	90%	90%	112%	145%	187%	195%	231%	221%	171%	75%
Tanga	Lushoto DC	Scale-up: Saturation	103%	103%	105%	33%	70%	117%	138%	107%	99%	90%	82%	93%	96%	87%	135%	152%	100%	99%	33%	85%	117%	76%	107%	91%	90%	87%	86%	119%	105%	140%	149%	97%	99%
Tanga	Mkinga DC	Sustained	96%	102%	96%	50%	88%	103%	111%	117%	108%	94%	97%	97%	91%	87%	106%	92%	100%	97%	50%	106%	93%	108%	91%	94%	94%	90%	99%	99%	95%	89%	111%	88%	83%
Tanga	Muheza DC	Scale-up: Saturation	90%	106%	89%	33%	57%	92%	119%	104%	111%	103%	125%	91%	95%	95%	103%	119%	75%	55%	33%	109%	101%	140%	107%	94%	89%	86%	69%	86%	82%	89%	95%	79%	50%
Tanga	Pangani DC	Sustained	97%	110%	96%	0%	107%	109%	124%	128%	91%	90%	92%	99%	121%	112%	96%	94%	111%	72%	0%	108%	114%	117%	127%	91%	92%	77%	78%	100%	95%	102%	105%	104%	88%
Tanga	Tanga CC	Scale-up: Saturation	114%	111%	114%	22%	90%	90%	147%	110%	110%	90%	82%	73%	86%	121%	157%	167%	103%	66%	22%	91%	90%	140%	119%	90%	110%	89%	99%	133%	133%	142%	169%	141%	95%

APPENDIX B – Budget Profile and Resource Projections

B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

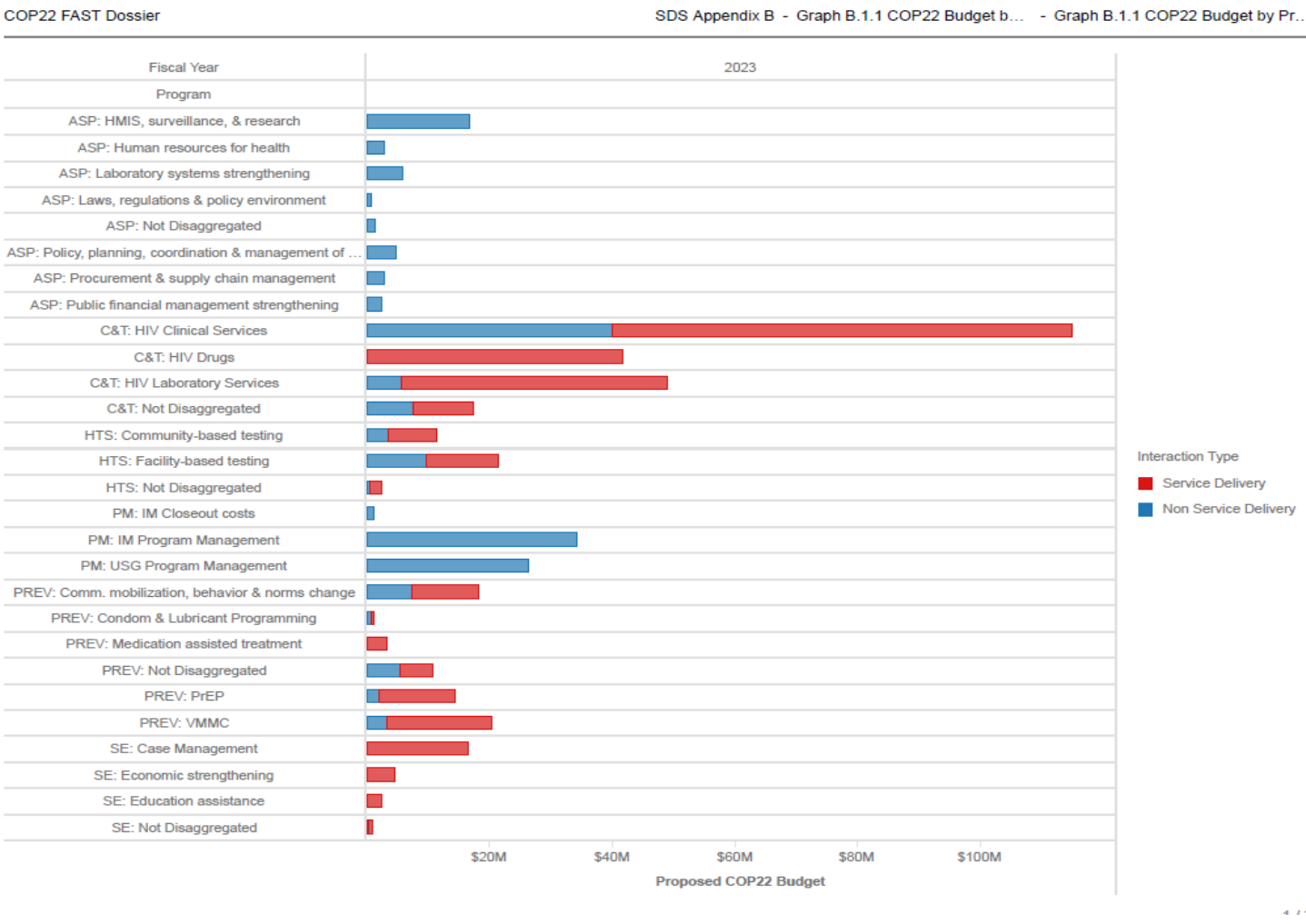


Table B.1.2 COP22 Budget by Program Area

COP22 FAST Dossier — SDS Appendix B - Table B.1.2 COP 22 Budget by... - Table B.1.2 COP22 Budget by Pro...

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		$184,575,861	$265,924,139	$450,500,000	41%	59%	100%
C&T	Total	$53,401,901	$169,979,058	$223,380,959	24%	76%	100%
	HIV Clinical Services	$39,985,371	$75,068,089	$115,053,460	35%	65%	100%
	HIV Drugs		$41,791,363	$41,791,363		100%	100%
	HIV Laboratory Services	$5,746,245	$43,306,493	$49,052,738	12%	88%	100%
	Not Disaggregated	$7,670,285	$9,813,113	$17,483,398	44%	56%	100%
HTS	Total	$13,489,346	$21,577,468	$35,066,814	38%	62%	100%
	Community-based testing	$3,416,543	$7,984,503	$11,401,046	30%	70%	100%
	Facility-based testing	$9,702,803	$11,655,410	$21,358,213	45%	55%	100%
	Not Disaggregated	$370,000	$1,937,555	$2,307,555	16%	84%	100%
PREV	Total	$18,703,955	$49,832,434	$68,536,389	27%	73%	100%
	Comm. mobilization, behavior & norms change	$7,410,952	$10,975,502	$18,386,454	40%	60%	100%
	Condom & Lubricant Programming	$600,000	$500,000	$1,100,000	55%	45%	100%
	Medication assisted treatment		$3,306,261	$3,306,261		100%	100%
	Not Disaggregated	$5,449,619	$5,272,774	$10,722,393	51%	49%	100%
	PrEP	$1,920,582	$12,551,699	$14,472,281	13%	87%	100%
	VMMC	$3,322,802	$17,226,198	$20,549,000	16%	84%	100%
SE	Total	$73,880	$24,535,179	$24,609,059	0%	100%	100%
	Case Management		$16,645,387	$16,645,387		100%	100%
	Economic strengthening		$4,611,462	$4,611,462		100%	100%
	Education assistance		$2,398,330	$2,398,330		100%	100%
	Not Disaggregated	$73,880	$880,000	$953,880	8%	92%	100%
ASP	Total	$37,137,961		$37,137,961	100%		100%
	HMIS, surveillance, & research	$16,753,956		$16,753,956	100%		100%

Table B.1.3 COP22 Total Planning Level

COP22 FAST Dossier — SDS Appendix B - Table B.1.3 COP 22 Total Plan... - Table B.1.3 COP22 Total Planning...

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	$71,643,255	$378,856,745	$450,500,000
Tanzania	$71,643,255	$378,856,745	$450,500,000

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

COP22 FAST Dossier | SDS Appendix B - Table B.1.4 COP22 Resource ... - Table B.1.4: COP22 Resource Allo...

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Tanzania	**Total**	**$223,380,959**	**$35,066,814**	**$68,536,389**	**$24,609,059**	**$37,137,961**	**$61,768,818**	**$450,500,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Females	$9,875,746	$2,834,667	$14,269,313	$3,722,108	$360,000		**$31,061,834**	4%	8%	21%	15%	1%		**7%**
	Key Pops	$613,274	$1,615,906	$16,475,754	$378,150	$1,847,887		**$20,930,971**	0%	5%	24%	2%	5%		**5%**
	Males	$1,615,819	$936,889	$21,040,000				**$23,592,708**	1%	3%	31%				**5%**
	Non-Targeted Pop	$192,533,861	$29,519,352	$15,339,343	$8,280	$33,980,074	$61,768,818	**$333,149,728**	86%	84%	22%	0%	91%	100%	**74%**
	OVC			$686,979	$20,313,021			**$21,000,000**			1%	83%			**5%**
	Pregnant & Breastfeeding Women	$16,187,312		$565,000		$400,000		**$17,152,312**	7%		1%		1%		**4%**
	Priority Pops	$2,554,947	$160,000	$160,000	$187,500	$550,000		**$3,612,447**	1%	0%	0%	1%	1%		**1%**

B.2 Resource Projections

COP22 resources were carefully allocated by considering Tanzanian beneficiaries and national government priorities stipulated in the Health Sector HIV Strategy V. The PLHIV estimates that were provided by the UNAIDS from Spectrum - Naomi model determined the treatment needs for the country and were further broken down per each region and PSNU depending on PLHIV population estimation, coverage, and treatment gaps.

The Tanzania PEPFAR team ensured mandatory earmarks, initiatives and programmatic controls are met and IP level budgets are set to meet these requirements. Additional considerations have been given to expanding PrEP for AGYW and KP as these program areas are key in ending the epidemic in Tanzania. Expansion of these program areas has been reflected in both commodities budget and the data pack.

Above site investments have been strategically aligned with treatment and prevention programs to sustain the current gains and continue to build capacity and resilient health and information systems in Tanzania.

Alignment with other funding was also considered; commodities budget is funding a national supply plan in which there is mutual agreement on the HIV commodities funding split between GFATM, GOT, and PEPFAR/T to ensure no funding gap. To maximize programmatic impact of the resources for PMTCT, COP22 will support technical assistance to non-PEPFAR sites in addition to the continued support to PMTCT PEPFAR sites. Geographical distribution of GFATM funded interventions was also reviewed for alignment with COP22 plan to ensure no funding is duplicative.

APPENDIX C – Tables and Systems Investments for Section 6.0

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$700,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.35	8.74	Updated data on the status of HIV epidemic in the country including HIV prevalence, incidence, and progress towards UNAIDS 95-95-95 targets and KP population size estimates to inform improvement of the national HIV programme.	It is not included in local HIV response plans	BBS Assessment among MSM, PWID, FSW in select regions on Mainland (including Dar) plus new BBS in Zanzibar to inform targeted epidemic control and ensure equitable HIV prevention and care services using UpToDate data. Currently there is a dearth of HIV burden data among KP in Tanzania.	COP21	COP23
$1,106,455	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.35	8.74	Improved Data Quality (Timeliness, completeness and Accuracy) across data systems. Improved Data use for program planning and monitoring	Lack of technical capacity	Improve the quality of HIV data in CTC2/3, DHIS2, DATIM and other national data systems. Conduct routine triangulation of data sources for ongoing program monitoring and remediation. Identify root causes of data quality issues, develop strategies/best practices to address issue. Develop, disseminate and regularly update a Data Quality Improvement toolkit. Support GoT to update national DQA guidelines. Develop data driven CQI activities for improved service delivery related to programmatic priorities Continuously maintain, improve and develop informatics applications that allow PEPFAR and its partners to conduct real-time granular program monitoring (lab visual, IQSMS, etc…) and	COP21	Post COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
									institute remediation strategies in a timely manner.		
$25,477	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.11	7.42	Coordinated CLM activities: -Training of CSOs, Revision of CLM tools, Data collection by Beneficiaries from CSOs, coordination of stakeholders meeting to disseminate CLM results. Coordination of KVP stakeholders meetings, advocating stigma, discrimination and violence among KVP	Lack of technical capacity	Provision of Technical Assistance in supporting and coordination of the Community Led Monitoring activities at National and Sub national levels. Provision of support and coordination to the KVP forum at national level	COP21	Post COP25
$38,216	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiency	12. Technical and Allocative Efficiencies	4.93	7.60	Annual PLHIV estimates for regions and councils produced from SPECTRUM	Lack of technical capacity	Support the Implementation of SPECTRUM	Prior to COP 18	Post COP25
$1,335,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.35	8.74	Improve quality of Laboratory program data Alignment of CTC3 database with DHIS2 and DATIM for HIV program data exchange Integration of	Lack of technical capacity	Integration of eSRS (electronic Sample Referral System) with CTC2/3 and other Laboratory systems to ensure functionality improvement in provision of timely and accurate data Update and Maintain DHIS2 system ability to exchange data with facilities and other systems through the HIM.	COP21	COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							NHCR with EMR/CTC to provide patient data de-duplication and Unique Identification of clients.		Improve the availability of cause-of-death information to better understand mortality among PLHIV. Assess the current completeness of mortality reporting in CTC2 and potential data gaps. Assess current practices for recording cause-of-death information in patient files. Support the standardized capture of cause-of-death information in CTC2 and other patient-level systems including the potential use of ICD-10 coding. Support the scale-up of the use of unique identification in CTC2 and other client-level HIV data systems. Assure connectivity with the National Health Client Registry through the HIM.		
$8,000,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.35	8.74	Updated national and sub-national data on the status of HIV epidemic in the country including HIV prevalence, incidence, and progress towards UNAIDS 95-95-95 targets to inform improvement of the national HIV programme	Lack of technical capacity	Planning, development and implementation of the Tanzania HIV Impact Survey 2.0	COP21	COP23
$340,000	ASP: Policy, planning, coordination & management of disease control	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.11	7.42	Update the national HIV prevention, care and treatment, HTS guidelines (rapid test algorithm) and	Lack of technical capacity	World Health Organization to promote and support GoT rapid adaptation of evidence-based policies and programs for prevention, care and treatment of HIV.	COP22	COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
	programs-NSD						TB treatment guidelines.				
$131,076	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.11	7.42	Rollout of DTG10, MMD among pediatric and implementation of triple elimination of HIV, Syphilis and hepatitis B	Lack of technical capacity	UNICEF to promote and support GoT rapid adaptation of evidence-based policies and programs for prevention, care and treatment of HIV for attaining and sustaining HIV epidemic control among children and adolescents and eliminating vertical transmission of HIV, syphilis and Hepatitis B.	COP22	COP25
$100,000	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	7.83	8.39	Finalization of National MAT services Guidance Provision of quality MAT services	Legal, policy or regulatory constraint	TACAIDS will Collaborate with the Parliamentary AIDS committee in advocating for enabling policy and legal environment to achieve epidemic control (orientation, policy review) Support the DCEA in development of Key National documents relevant to MAT service provision and provide oversight of the MAT clinics as well as Surveillance and research activities at national level.	COP22	Post COP25
$160,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Training in institutional prevention programs	9. Quality Management	5.76	7.38	Availability of high quality and updated HIV surveillance data among KP and general population following successful engagement of key stakeholders and improve HIV programme	Lack of technical capacity	Coordination of the Faith and Community Initiative activities at the National level including Stigma Mitigation Strategies. Support Coordination of the Surveillance related Activities in Country such as The THIS 2.0 and BBS	COP21	COP23

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
									Oversight, coordination and technical support of surveillance, research and evaluation activities including THIS 2.0, KVP BBS, KP HIV prevalence and size estimates consensus setting, recency surveillance and other clinical surveillance using routine collected data. In addition, to participate in engagement of stakeholders, monitoring and dissemination of results and findings utilization to improve HIV/TB programming in the country.		
$35,000	ASP: Public financial management strengthening -NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiency	12. Technical and Allocative Efficiencies	4.93	7.60	1. A tool integrating NASA,TIC,ABC/M and NHA showing host government contributions to HIV response 2. Financial analysis from integrated financial data (NASA,TIC,ABC/M and NHA) to inform allocation of HIV domestic resources	Lack of technical capacity	Support the TACAIDS on Integration of the NASA, Investment Case, NHA and ABC/M into strengthening public Domestic resource Allocations to support the HIV epidemic response as informed by the performance data for efficiencies.	COP20	COP24
$100,108	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.11	7.42	Provide recency testing across all testing points included as part of the HTS business plan Minimum policy requirement implemented across regions	Lack of technical capacity	Conduct quarterly joint supportive supervision with MOH, NACP, and USG actors to oversee the implementation of key HIV programs activities following the current Minimum Policy requirements (Example MMD, Use of Optimized ART regimen for pediatric and Adult, IPT, viral load, and DBS testing, etc	COP21	Post COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
									Work in collaboration with MoH to support surveillance activities including THIS 2.0, KVP BBS, recency and other routine surveillance activities at sub-national level (R/CHMT). Conduct pre-planning meetings with RHMTs and key implementers to discuss priorities and evidence-based planning for HIV prevention, care and treatment in CCHPs. Support the utilization of ECHO platforms for coordination and response to performance management and utilization of EOC for recency response by R/CHMT and linking with the available FELTP residents in councils. Support the implementation of Task sharing policy in selected R/CHMT (NIMART mentorship and SS for Quality management and reporting) and use of the WISN/WAO and POA tools for HRH Management		
$55,000	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Training in supply chain systems	8. Commodity Security and Supply Chain	5.40	7.22	Improved laboratory services and commodities management, data visualization to inform on number of samples received, accepted, tested, rejected and turnaround time	Lack of technical capacity	Provide oversight on implementation of supply chain management including eLMIS; coordinate the PT/EQA distribution, result return and CQI activities to facilities (for HIV Rapid Testing, VL, EID, TB and recency testing,). Provide oversight of sample referral networks and result return system and HIVRTCQI including national competency and certification program for HIV Rapid Testers/testing facilities.	COP21	COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							and overall quality of Laboratory testing		Support the selected councils and laboratories to be accredited through SLMTA process.		
$1,085,928	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.11	7.42	Revised National HIV care and treatment guideline Implementation of quality comprehensive services in the regions.	Lack of technical capacity	Support MOH to provide oversight and coordination including comprehensive supportive supervision and mentorship of HIV services in VMMC, TB/HIV, pediatric, Adult, PMTCT/EID, Community, CECAP, GBV,QI/QM, surveillance, Shared learning through ECHO and establishing Communities of Practices. MOH to revise the 2019 HIV care and treatment guidelines to incorporate developments effected through circulars and integrate new evidence-based HIV care and treatment policies. Contribute to Policy actions that will accelerate review, adoption, and implementation of evidence-based HIV policies and guidelines	COP21	Post COP25
$170,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	Implementation of the Task sharing Policy and ensure fidelity of the NIMART services by all cadres and actors.	Lack of sufficient HRH	MOH and PORALG to provide oversight and support in the implementation of the Task Sharing policy, including the NIMART approach to ensure all identified cadres listed in the policy are trained to provide effective HIV & AIDS services.	Prior to COP 18	COP25
$50,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Service organization and management systems	9. Quality Management	5.76	7.38	updated PLHIV and KP size estimates and data on the status of HIV epidemic in the country including HIV prevalence, incidence,	Lack of technical capacity	Support the MOH's/NACP's national coordination, monitoring and implementation of surveillance activities including THIS 2.0, recency, KVP BBS and HIV prevalence and population size estimate consensus and dissemination of the results to	COP21	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							proportion of recent infection among newly diagnosed HIV clients and progress towards UNAIDS 95-95-95 targets among general population and KP.		policy makers and inclusion of the results in informing the NMSF.		
$400,000	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22		Lack of managerial capacity	MOH to provide oversight for DNO implementation and oversee implementation of supply chain activities for HIV/TB laboratory commodities. Coordinate laboratory information systems and Laboratory Quality assurance programs. Support implementation of HIVRTCQI including competency assessment for testers and certification program. Coordinate laboratory biosafety and waste management activities and oversee laboratory trainings including validation of laboratory equipment and Biosafety Cabinets.		
$3,618,158	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.11	7.42	Ensuring quality and reliable test result, Improved testing efficiencies and sustainability of laboratory testing services, reduced turn around time, faster linkage to care and improved competency of laboratory staff	Lack of technical capacity	Provide national TA in the implementation of diagnostic network optimization (DNO) 2022 recommendations on VL, HEID and TB. Ensure continued laboratory quality improvement activities (accreditation SLMTA/SLIPTA, PT/EQA, Recency testing QA/QC, calibration, Biosafety cabinet certification). Accelerate HIVRTCQI, Certification program and waste management activities. Conduct and improve surveillance at ILI/ARI/SARI sentinel sites and POEs; with emphasis on laboratory	COP22	COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							and health care workers		confirmation to ensure rapid identification of outbreak cases specifically COVID-19 and other Respiratory Infections of Public Health Importance.		
$380,371	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	8. Commodity Security and Supply Chain	5.40	7.22	Improved laboratory commodities management, data visualization commodities availability and utilization, prevent reagents and consumables wastage due to expiration and ensure adequate resources are available to meet all testing demand	Lack of technical capacity	Provide the national Technical Assistance on laboratory supply chain management including quantification and forecasting in all VL/HEID/TB testing laboratories including support timely commodities distribution to testing laboratories and reporting. Leverage above-site laboratory supply chain data for improved HIV service delivery. Conduct routine analyses of supply chain data and monitor forecasting, pipeline, consumption, distribution and stock levels. Strengthen national reporting from testing laboratories and POCT sites.	COP21	COP25
$360,000	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	9. Quality Management	5.76	7.38	Improved laboratory infrastructure to avoid interruption of testing services and to maintain sample quality, protect PEPFAR investments with regards to reagents and testing supplies. Oversees and provides quality assurance materials and testing practices	Lack of technical capacity	Provide maintenance support of NIMR infrastructure and utilities for National HIV Reference Laboratory for effective, efficient, and safe operations for proficiency testing (PT)/EQA, Recency QA/QC and all areas of laboratory testing, to prevent service interruption, reduce long turn-around-time and improve quality of HIV rapid testing, VL, EID, TB for ensured quality of laboratory services and safe working environments.	Prior to COP 18	Post COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							on a National level.				
$297,285	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Training in HMIS systems or processes	14. Epidemiological and Health Data	6.35	8.74	Establishment of the Non Research Determination (NRD) system in Tanzania to allow for shared scientific learning publications for improved HIV/TB programming for epidemic control.	Lack of technical capacity	Support the National Health Research Ethics Review Committee (NatHREC) in the areas of public health ethics and scientific oversight; and to support the creation of a non-research determination process.	COP21	COP25
$1,055,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	Pre-service training	7. Human Resources for Health	6.96	7.58	15 Field Epidemiologist Graduate from Cohort 14 of the Advanced FELTP program and enrollment of 15 residents into cohort 15 15 HCW are trained on Intermediate FELTP under Cohort 6 and 15 are enrolled into Cohort 7 Business Model for National HRHIS for reporting the HRH_STAFF indicator is developed as well as the	Lack of sufficient HRH	Support of the competency-based tiered field epidemiology Intermediate & Advanced courses (cohort 14 and 15) program for surveillance and disease response capacity to sustain the Epidemic response. Support the ongoing development and implementation of the business model for the national Human Resource for Health Information System (HRHIS) to allow reporting of the PEPFAR MER HRH_STAFF_NAT indicators and development of the national annual HRH country profile (deliverables)	Prior to COP 18	COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							national HRH country profile.				
$800,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Training in coordination and management of health systems	9. Quality Management	5.76	7.38	Accreditation of 4 ECHO clinics for CPD points as part of Distance Learning Establishment of 3 hubs for ECHO to support decentralization and improve shared learning Establishment of 35 new ECHO spokes in high burden facilities to improve shared learning and improve quality of care for epidemic Control Establishment of the 3 communities of practices for HIV/TB to ensure knowledge retention and improve services for the TB/HIV clients	Physical infrastructure not complete/further investment needed by donors	Strengthening of the Center for Distance Education (CDE) to be a super hub for ECHO, including running of pre-service and in-service trainings for HCWs for key HIV interventions. Build on established Centre for Distance Education (CDE) e-learning platform and module development to strengthen implementation of key strategies to speed scale-up of DSDMs and expanding access to virtual learning support at site level. Support utilization and infrastructural use of virtual platforms for shared learning and establishment of communities of Practice for improved quality of care in resource constrained sites through ECHO Project.	COP21	COP25
$57,887	ASP: Policy, planning, coordination & management of disease control	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to	6. Service Delivery	6.11	7.42	Quarterly and annual KVP forum meetings conducted, ongoing dialogue with stakeholders	Lack of technical capacity	Support KVP Forum Activities - Coordinate quarterly and annual meetings for the KVP forum, Coordinate dialogue around the issues of stigma, discrimination and violence against KVP with stakeholders	COP21	Post COP25

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
	programs-NSD		subnational levels				around the issues of stigma, discrimination and violence against KVP		Coordinate KP-focused CLM activities		
$1,040,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Surveillance	14. Epidemiological and Health Data	6.35	8.74	updated data on the status of HIV epidemic in the country including HIV prevalence, incidence, and progress towards UNAIDS 95-95-95 targets and KP population size estimates to inform improvement of the national HIV programme in Mainland Tanzania.	It is not included in local HIV response plans	BBS Assessment among MSM, PWID, FSW in select regions on Mainland (including Dar) plus new BBS in Zanzibar to inform targeted epidemic control and ensure equitable HIV prevention and care services using UpToDate data. Currently there is a dearth of HIV burden data among KP in Tanzania.	COP21	COP23
$300,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.56	10.00	Ensuring quality and reliable test result, Improved testing efficiencies and sustainability of laboratory testing services, reduced turnaround time, faster linkage to care and improved competency of laboratory staff and health care workers	Lack of technical capacity	Provide national TA in the implementation of diagnostic network optimization (DNO) 2022 recommendations on VL, HEID and TB. Ensure continued laboratory quality improvement activities (accreditation SLMTA/SLIPTA, PT/EQA, Recency testing QA/QC, calibration, Biosafety cabinet certification). Accelerate HIVRTCQI, Certification program and waste management activities	COP22	COP23
$400,000	ASP: HMIS, surveillance, & research-NSD	Pregnant & Breastfeeding Women: Not	Evaluations	14. Epidemiological and	6.35	8.74	To reconstruct the PMPTC clinical cascade, identify gaps in	It is not included in local HIV response plans	The evaluation will estimate the number of HIV-positive pregnant women identified, those who received ARVs, those who	COP22	COP23

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
		disaggregated		Health Data			the PMTCT cascade, and provide recommendations to improve the PMTCT cascade		delivered in the facility, and those linked to HIV care and treatment after PMTCT. The evaluation will also examine infant outcomes by following mother-infant pairs. This evaluation will consider the PMTCT cascade in Tanzania to better understand areas of service delivery that require further support and identify service delivery models that achieve maximum public health impact. The evaluation will be conducted in sample of health facilities across regional zones in Tanzania.		
$850,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Research	14. Epidemiological and Health Data	6.35	8.74	Improved programmatic and epidemiological data availability for timely evidence based decision making at different levels.	Lack of Financial Resources	The African Cohort Study (AFRICOS) is a long-term prospective observational HIV-focused cohort study with the broad primary objective to longitudinally assess the impact of clinical practices, biological factors and socio-behavioral issues on HIV infection and disease progression in an African context. The cohort enrolls 18 - 64 years old and since 2019 the cohort has been expanded and scaled to include adolescents aged 15-24 years, in order to provide HIV-related outcomes for this critical age group. Volunteers are followed for 15 years.	Prior to COP 18	Post COP25
$50,000	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Lab accreditation	10. Laboratory	6.56	10.00	Improved laboratory services and clinical outcomes of served military and civilian population.	Lack of technical capacity	Provide coordination and oversight of Laboratory Quality Management System (SLMTA, SLIPTA, Accreditation) for 1 TPDF Hospital Laboratory	COP19	COP23

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$380,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	7.00	8.66	Frequent DQAs conducted by an independent organization will improve data quality through triangulation, reduce program under performance caused by data-issues, and help address challenges/shortcomings that affect data quality.	Lack of technical capacity	The purpose of this activity is to contract an indigenous organization to assist the DoD/WRAIR-Tanzania team located at the United States Mission in Dar es Salaam with ensuring the accuracy of reported accomplishments by conducting external Data Quality Assessments (DQAs) specified in the annual Country Operational Plan (COP) guidance and approved in the annual Tanzania COP at facilities supported by funding from the US President's Emergency Plan for AIDS Relief (PEPFAR).These DQAs would be helpful not only for a comprehensive program monitoring, but also for focusing on improving program specific indicators, if needed.	COP21	COP25
$300,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	3. Civil Society Engagement	7.08	8.33	CSOs contribute to National HIV epidemic control by initiating projects that support individuals and communities affected by HIV/AIDS	Lack of Financial Resources	AFHR will support projects that will; 1. Address stigma, discrimination and GBV. 2. Promote care and treatment, and adherence to treatment 3. Promote HIV/AIDS Prevention 4. Demand creation for HIV/AIDS services 5. Promote friendly services 6: Capacity building	Prior to COP 18	COP23
$500,000	ASP: Laboratory systems strengthening -NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.56	10.00	Improved laboratory commodities availability, reduced waste, optimized placement and utilization of equipment, reduced sample turnaround time	Lack of technical capacity	Implement laboratory network optimization recommendations to improve efficient distribution and consumption of respective VL reagents and consumables	COP21	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							and reduced cost per test.				
$500,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22	Improved data usage and evidence-based supply chain decision-making by management teams and health care workers	Lack of technical capacity	Roll out of IMPACT teams' approach and Build capacity in data use for supply chain decision making	COP20	COP22
$400,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22	Improved commodity availability through bimonthly distribution, Stock on Hand data for all program commodity available monthly national wide Improved quality of data by having order processing (requisition for resupply) for facility level system (AfyaCare) linked with eLMIS automatically Visibility of additional supply chain KPI including score card available in the supply chain portal and eLMIS	Lack of technical capacity	Support redesign logistics system and eLMIS expansion to cover all regions, eLMIS integration with facility level systems (GoTHOMIS & AfyaCare) , and incorporate additional indicators such as score cards into the Supply Chain portal	COP20	COP22
$200,000	ASP: Procurement	Non-Targeted Pop: Not	Forecasting, supply chain	8. Commodit	5.40	7.22	Improved data quality and by	Lack of technical capacity	Support the Bottom-Up Quantification (BUQ) and	COP22	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
	& supply chain management-NSD	disaggregated	plan, budget, and implementation	y Security and Supply Chain			extension improved availability of health commodities at service delivery point through increased accountability and ownership of the quantification process by health facilities eLMIS upgraded to the latest version of OpenLMIS version 3 and support better visualization (dashboards), analytics, use of master data for better quality data and use		forecasting exercises for the HIV program including eLMIS upgrading to the latest version and use of standardized master data		
$250,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22	Improved data visibility for decision making across all levels of supply chain. Ordering process will be enhanced.	Lack of technical capacity	Facilitate access and interoperability between MSD E10, Wambo and eLMIS to improve Information and data sharing regarding commodity procurement and deliveries	COP20	COP22
$150,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22	Improved commodity availability through improved collaboration (all stakeholders) and quantification	Lack of technical capacity	Build capacities for stronger governance and oversight for demand and supply planning of ARVs and HIV lab commodities from facility to National level (mainland and Zanzibar)	COP22	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
							accuracy (all stakeholder participation, ensuring all input data/information available) Improved accountability, alignment, transparency and efficient implementation of ARV and HIV laboratory commodity related interventions				
$1,000,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.40	7.22	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Ensure the continuity of the demand planning activities during the transition between GHSC-TA and Next Generation (periodic quantification and forecasting reviews, DQA, pipeline reviews and order placement)	COP22	COP24
$500,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in coordination and management of health systems	9. Quality Management	5.76	7.38	Non-Targeted Pop: Not disaggregated	Training in coordination and management of health systems	Establishing the Supply Chain Portal to increase data visibility among the stakeholders and GoT decision makers	COP22	COP24
$800,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	9. Quality Management	5.76	7.38	Scaled interoperable and client based information Systems and increase availability of client level data for improved care and treatment	Lack of technical capacity	Strengthen PORALG information systems (i.e GoTHOMIS) to manage client level HIV services through improve integration of the Muungano Gateway and Health Information Mediator	COP20	COP24

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$250,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	Institutionalized evidence based HRH planning, budgeting and optimized allocation	Lack of sufficient HRH	Strengthening human resources systems for effective planning and enhanced HCWs performance in the delivery of HIV services	COP20	COP22
$1,200,000	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	5.32	9.88	Direct and Supporting HIV/AIDS services are provided without financial limitation to clients who needs them	Lack of information on costs and program requirements	Strengthen Domestic resources Mobilization and integration of HIV/AIDS and support services into existing and proposed new Universal Health Insurance strategy	COP20	COP23
$1,000,000	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiency	12. Technical and Allocative Efficiencies	4.93	7.60	Increased tracking and allocative efficiencies of domestic resources for HIV services	Lack of technical capacity	Improve the efficient use of HIV resources by strengthening and extending PFM and Health Governance systems to lower-level governments	COP20	COP24
$950,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Service organization and management systems	9. Quality Management	5.76	7.38	Zanzibar health systems is strengthen to responsive to unmet needs of the program and it's sustainability	Lack of technical capacity	Leverage Domestic Resources to support Zanzibar Health System Strengthening through integration of HIV services into facility level and cross sectoral planning	COP20	COP23
$350,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	PEPFAR supported HCWs are aligned and transitioned to GOT public service	Lack of sufficient HRH	Engaging local partners and build their capacity in on identify innovative and sustainable solutions to HRH recruitment, deployment, and transition to GOT public service	COP20	COP23
$350,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	Monitored performance of PEPFAR supported HCWs based on service delivery targets	Lack of sufficient HRH	Further review and align HRH staffing to sustain service delivery, adaptations and capacity of local partner, host Government and faith-based organizations to build HRH resiliency and sustainability	COP19	COP23

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$350,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	More efficient allocation of HRH improves private health facility capacity to address HIV epidemic	Lack of sufficient HRH	Leverage matching private sector funds for TA to develop a modified WISN-POA to optimize HCW allocation in faith based health systems	COP22	COP24
$150,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	4. Private Sector Engagement	9.03	7.90	A blended-financed revolving fund will enable the faith-based health system to sustainability support the HIV program	Insufficient private sector financing	Attain sustainable epidemic control through blended and innovative financing (e.g. though revolving fund) to increase self-reliance of private health providers	COP22	COP25
$500,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	4. Private Sector Engagement	9.03	7.90	Utilization of faith-based supply chain improves efficiency in providing HIV commodities	Physical infrastructure not complete/further investment needed by donors	Use and build private faith-based medical supply chain to maximize efficiency and establish long-term sustainability in procurement, warehousing and distribution of HIV/AIDS and other health commodities.	COP22	COP23
$250,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Private sector engagement	4. Private Sector Engagement	9.03	7.90	GOT adaption of TMA will increase use of private sector providers and the sustainability of HIV response	Legal, policy or regulatory constraint	Reinforce Total Market Approach (TMA) policy commitment by GoT for condoms and advocate TMA policy for HIVST and PrEP	COP21	COP23
$250,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiency	12. Technical and Allocative Efficiencies	4.93	7.60	TA will increase use of the $8.8M CRDB loan guarantee and will mobilize domestic resources in the response to HIV epidemic	Lack of Financial Resources	Provide TA that mobilizes local commercial funds (e.g., CRDB) to private health facilities for provision of quality HIV and other health services	COP21	COP23
$657,000	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiol	6.35	8.74	Improved data integration and	Lack of technical capacity	Continue to support the HIM and the Community system (OpenSRP)	COP21	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
	& research-NSD	disaggregated		ogical and Health Data			use for decision making		towards the vision for long-term sustainability including integration of relevant systems (OVC, CTC2, EMRs, NHCR) to facilitate unique identification of PLHIV.		
$250,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	6.96	7.58	Strengthened host government capabilities	Lack of technical capacity	Work with professional associations and GOT in strengthening the capability of National HRHIS for optimized and data driven workforce alignment to service delivery needs	COP22	COP23
$800,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	7.00	8.66	Increase capacity of health facilities to use service delivery data in improving the quality of care	Lack of technical capacity	Support analytical capacity and data visualization to champion evidence-based programming and support the scale of Makole Model for improved quality of care	COP21	COP23
$450,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	5. Public Access to Information	7.33	9.00	Design and implementation of evidence-based SBC messaging and materials aiming at HIV/AIDS stigma reduction	Lack of technical capacity	Support MOH in the design and implementation of HIV-related SBC messaging and materials, including those related to COP 22 priorities such as PrEP demand creation and stigma reduction	COP21	COP24
$250,000	ASP: Laws, regulations & policy environment-NSD	Priority Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	7.08	8.33	Improved enabling environment for the National HIV response	Legal, policy or regulatory constraint	Advocate for Policy actions essential to accelerate review, adoption, and implementation of evidence-based HIV policies and guidelines for increased equity of care	COP21	COP22
$300,000	ASP: Laws, regulations & policy environment-NSD	Priority Pops: Not disaggregated	Civil society engagement	3. Civil Society Engagement	7.08	8.33	Strengthened CLM systems to support for effective client outcomes	It is not included in local HIV response plans	Implement data-driven and action-oriented Community Led Monitoring to advance equity and to support improvement in programs for unreached populations	COP22	COP24
$250,000	ASP: Procurement & supply chain	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and	8. Commodity Security and	5.40	7.22	Effective regulatory environment for quality, safety,	Legal, policy or regulatory constraint	Streamline the process of importation and registration of medicines according to the	COP22	COP22

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
	management-NSD		implementation	Supply Chain			and efficacious resulting into increased access		national standards to assure quality safety and efficacy		
$200,000	ASP: Public financial management strengthening -NSD	Non-Targeted Pop: Not disaggregated	Technical and allocative efficiency	12. Technical and Allocative Efficiencies	4.93	7.60	Sustainability plan developed and strategic financial alignment strengthened	Lack of information on costs and program requirements	Scale ABC/M and strengthen strategic alignment and accountability across donor, public, and private resources to maximize efficiency, impact, and sustainability of the HIV/AIDS response	COP22	COP23
$360,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Females: Young women & adolescent females	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.11	7.42	Strengthened Coordination of National and Regional Government, Non-Government organization and DREAMS/AGYW partners	Lack of technical capacity	Strengthen Coordination of National and Regional Government, Non-Government organization and DREAMS/AGYW partners to promote knowledge sharing between DREAMS, Global Fund and other AGYW partners to ensure optimal impact in 8 DREAMS Councils	COP20	COP23

APPENDIX D– Minimum Program Requirements

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Tanzania has adopted and implemented a test and start policy, which is aligned with WHO guidance.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	The TLD transition moved quickly to cover 96% of eligible clients as of July 2021. Tanzania placed peds DTG10mg orders in June 2021 and orders have arrived in country. Transition meetings are planned for April 2022.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	More than 90% of eligible clients were on 3MMD by the end of COP20. 6MMD started in Dar es salaam in March 2020, and 90% of eligible clients were receiving 6MMD by October 2021. National roll out started in August 2021 and more than 600,000 clients were enrolled by December 2021. Next steps include continued monitoring of stock levels and progress as well as advocacy for MMD for <5s.
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	By FY21 Q4, 82% of PEPFAR FY21 Q4 TX_CURR had completed TPT of the total on ART for PEPFAR. Current focus is on targeted interventions for children and underperforming geographic areas. A transition to 3HP is anticipated in COP22. Advocacy for DSD for TPT is an area for follow-up.
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	VL reagent stock-out has stabilized, but challenges persist for EID. Overreliance on low throughput platforms have contributed to persistently suboptimal viral load and EID coverage. Minimal transparency of stock distribution from MSD to sites is also a challenge. PEPFAR is currently prioritizing use of high-through-put platforms within the existing network and is working with GOT on an updated DNO exercise to support lab optimization and supply chain strategies to ensure efficiencies and uninterrupted HVL testing. The DNO results will inform program strategies on sample transportation, turnaround time, lab capacity, and platform selection.

Case Finding	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	National self-testing shortages were expected to be gap filled by PEPFAR through a consignment scheduled for August 2021 arrival. Unfortunately, delays in the consignment resulted in the order being fulfilled in late November 2021.These kits have been insufficient to sustain the program in the context of perpetual delays in the GFATM consignment. HIV ST stock is back on track and program performance is expected to improve in Q2/Q3 of FY23.
Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)	PrEP scale-up started in October 2021. Weekly data was collected for monitoring and more than 34,000 PrEP_NEW clients have been enrolled since then. Programmatic focus will emphasize retention, demand creation, quality assurance, and consistent commodity supply moving forward.
8) 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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	OVC packages of services have been aligned. Focus is currently on increasing enrollment of CLHIV and providing prevention services to children aged 10-14. An updated target setting approach developed at the end of COP20 is being used to set COP22 targets to ensure target setting is in lined with HIV burden.
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	While Tanzania has several laws and policies that condemn and prohibit stigma and discrimination, a National Strategy on Stigma and Discrimination will be spearheaded by TACAIDS in line with the National Multi-sectoral Framework 2019-2023 that aims for zero HIV stigma and discrimination. While the legal framework is generally supportive, the penal code criminalizes some acts of KP, leading those individuals to fear repercussions beyond stigma if they disclose their behaviors. Also, in spite of laws prohibiting stigma and discrimination, behaviors of some workplace

	colleagues, media institutions, health care workers, and religious organizations may lead key populations, AGYW, and other vulnerable groups to experience stigma and discrimination. Moving forward, the focus will be on developing the National Stigma and Discrimination strategy. This is being spearheaded by TACAIDS and meetings have already convened. An updated legal and policy environment assessment is being explored with UNAIDS. PEPFAR will support a review and revision of training curricula for workplace, HCWs, and religious institutions, creating updated communication materials, and incorporating stigma and discrimination reviews for CQI/CLM. GFATM will also prioritize ensuring funding is available for an updated stigma index – to include MSM, FSW, and other KP groups – as part of their ongoing reprogramming.
10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	The GOT prohibits user fees for HIV, TB, and MCH services in public and private settings. There is no evidence of user fees.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	CQI is integrated into all facilities and in line with national policies. CQI is incorporated into work plans.
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Treatment and VL literacy is integrated into facility and community-level counseling and communication activities. Stigma reduction messaging is also ongoing.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	Tanzania is on track towards its contribution to local, indigenous prime partner funding. There is evidence of progress towards local, indigenous partner direct funding, and PEPFAR will do a landscape of possible women-led and KP-led organizations in Tanzania (both PEPFAR and

	non-PEPFAR funded) to explore the possibility of direct funding.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	GOT has established an AIDs trust Fund and is exploring an HIV levy and partnerships with private sector entities to channel funds. ABC, NASA, and test case costing studies have been conducted to inform larger plans. GOT will establish a working group under the Prime Minister's Office and led by TACAIDS to further discussions on a sustainability road map for Tanzania's HIV program.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR uses the CTC2 system from HIV clinics to track outcomes among clients in care, including morbidity. Efforts are underway to improve tracking of cause of death in the CTC2 system. COP21 activities will focus on assessing the situation and defining an implementation plan. COP22 will focus on scaling up implementation.
16) 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 was never approved by GOT. Work in COP21 to define an implementation plan for a national-scale-up. COP22 will focus on scaling up implementation

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

PEPFAR/T continues to work with the Government of Tanzania to monitor progress towards sustainability of the HIV response. COP22 implementation will provide an opportunity to work closely with the GOT – through a new TACAIDS-supported TWG – to develop a roadmap for sustainability. Currently, however, SID assessments, which have been conducted every other year since 2015, provide the primary metrics through which PEPFAR/T assesses sustainability. The most recent SID 2021 findings demonstrate that there has been improvement across almost all domains over years. Tanzania, however, still receives substantial external financing for its national response to HIV and AIDS and domestic resource mobilization, although just one component of sustainability, is essential for Tanzania to reach its full potential to sustain the gains made to address HIV/AIDS over the last 19 years.

1. Misalignments between Investments and Outcomes

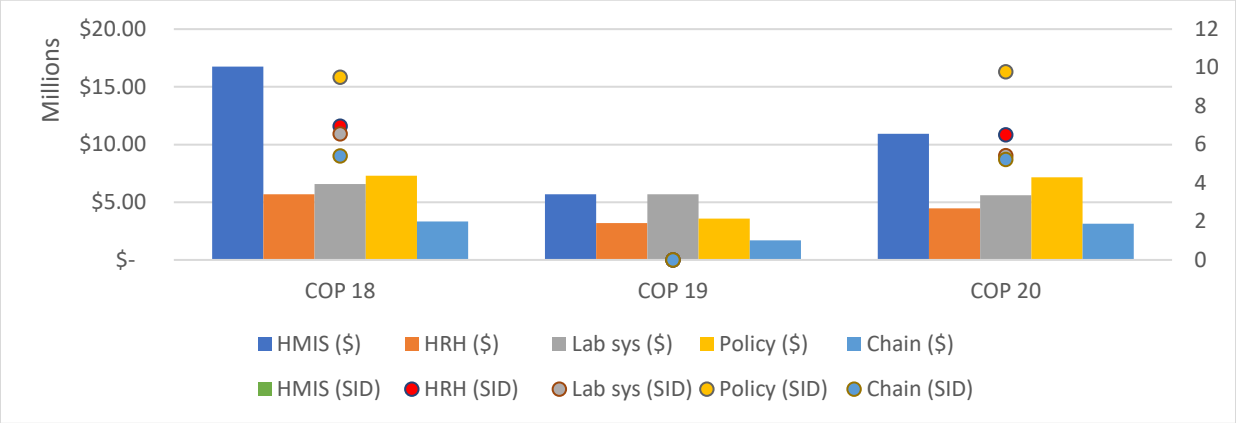
PEPFAR/T investments have been directed to interventions that rapidly accelerate epidemic control goals as evidenced by available data. Harmonization and alignment with GFATM support is emphasized to ensure there is no overlap, synergies are leveraged, and there is no gap in HIV program commodities.

- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

Systems-related (above site programs) expenditures when compared to changes in relevant SID scores demonstrate where cumulative investments in these areas have contributed to improvements in SID scores over time. In the figure E.1.1 below, the trend in expenditure decline corresponds to a slight decline in SID scores for three elements (HRH, Laboratory, and Supply Chain). On the other hand, the Policy & Governance element together with Planning & Coordination element scores increased despite a slight decrease in expenditures from COP18 to COP20.

As measured by the SID, the GOT's capacity to develop policies, strategic plans, and to implement and coordinate has increased. However, as noted above the funding landscape demonstrates that the HIV program is almost wholly donor dependent especially when it comes to service delivery. Any budget cut, therefore, has the potential to impact program performance.

Figure E.1.1. Tanzania Trends in Investments and SID Scores for System-Related Elements



The Responsibility Matrix ratings in Figure E.1.2 indicate the which major funder is primarily responsible for each program component and/or investment area. While the GOT has primary functional responsibility across all elements, both resource allocation and disbursement is limited.

Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix

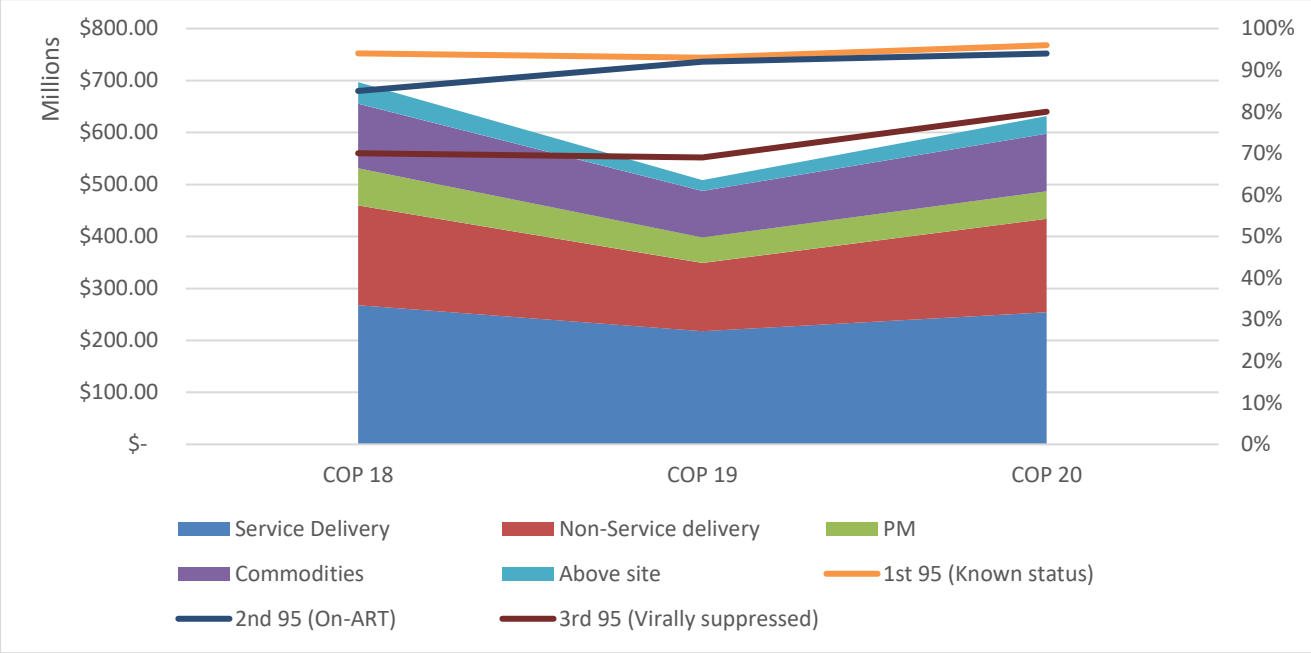
% Primary Responsibility Ratings from Responsibility Matrix			
Functional Element	Host Country	PEPFAR	GFATM
Site-level Program	100%	6%	6%
Commodities	100%	33%	33%
Health Workforce	100%	33%	0%
Above site (systems) Programs	100%	4%	4%
Program management	100%	50%	50%

- ***Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country's Status of Achieving HIV/AIDS Epidemic Control:***

The figure E.1.3 below shows trends in service delivery, commodities, non-service delivery, above site program, and program management spending in Tanzania. These trends help us understand investment strategy and where there is a need for optimization based on program priorities and needs.

Most of PEPFAR/T's investments are channeled to service delivery, followed by commodities. PEPFAR/T's spending decreased from COP18 to COP19 and increased from COP19 to COP20 in all program areas in line with budget allocated. Despite great strides towards achieving the 95-95-95 Goals a reduction in expenditure corresponds to a decline in performance. PEPFAR/T, will ensure future financial transitions are done strategically in order not to interrupt service delivery to clients already receiving the services.

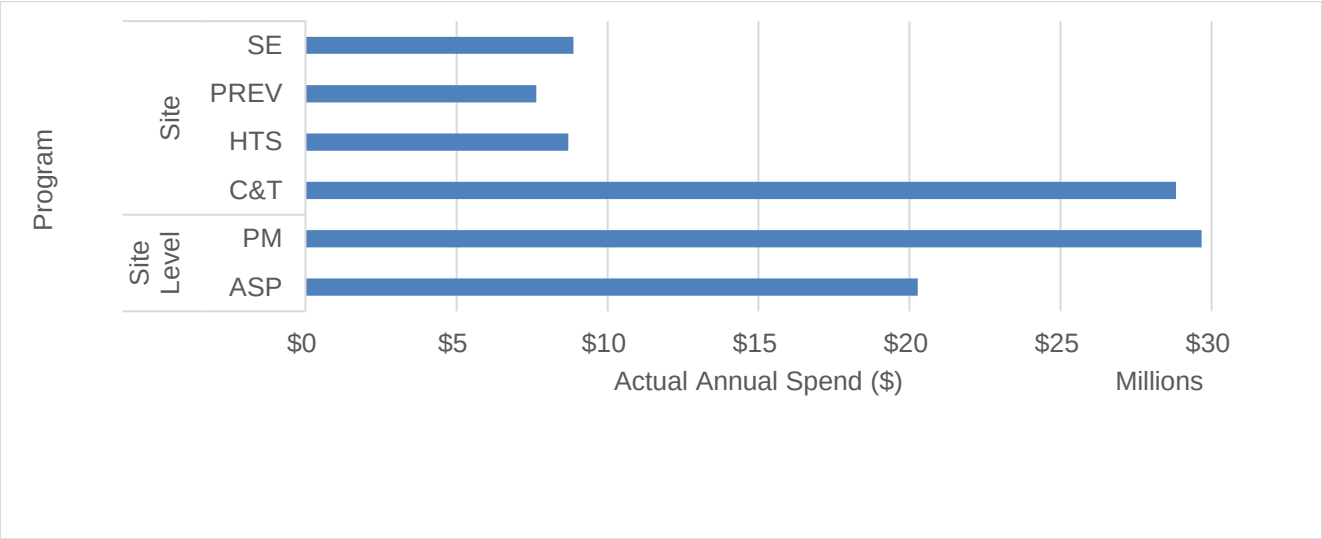
Figure E.1.3. Tanzania PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status



- **HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:**

Figure E.1.4 shows COP20 expenditure data for staff by program area and by site and above-site levels. The figure shows that, PEPFAR/T's investment in COP20 was dominated by program management followed by care and treatment program areas. Nevertheless, site level staff spending surpasses non-site level, which includes PEPFAR program management spending. This is done to ensure quality services are provided at sites. The GOT still plays a primary role in hiring healthcare workers in facilities while PEPFAR/T and GFATM fill in site-and community-level gaps with critical need. PEPFAR/T also focuses on staffing needs to provide technical assistance.

Figure E.1.4. Tanzania COP20 Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery



2. Areas for Transition

PEPFAR/T continues to strengthen government systems, private sector, and community-led efforts to achieve and sustain epidemic control with a long-term goal of full governmental functional and financial ownership. The sustainability landscape, as demonstrated by SID 2021 identifies Governance, Leadership and Accountability domain with obvious areas for the GOT to take on greater responsibility. In addition, PEPFAR/T will begin to explore the requirements needed to transition specific interventions, such as VMMC, where the need for urgent scale-up has been overtaken by the need to maintain a baseline level of services. PEPFAR/T will explore this, and other program areas, in the context of the new TACAIDS TWG on sustainability. In COP22 PEPFAR Tanzania will also provide PMTCT technical assistance to a selection of non-PEPFAR PMTCT sites with the goal of ensuring that the GOT can maintain implementation of identified best practices after one year. PEPFAR/T will also review any new programmatic requests through a sustainability lens and look for opportunities to leverage existing GOT systems to support program activities. For example, PEPFAR/T will investigate an approach to incorporate vocational training opportunities into MAT programs by looking at GOT vocational training systems.

In terms of financial responsibility, GOT contributes about 12% of all HIV program implementation costs, with the rest being covered by PEPFAR and GFATM. In COP22 PEPFAR/T will disseminate ABC/M findings more broadly and explore opportunities to use the findings to determine the real costs of Tanzania's HIV/AIDS program. This information can guide budgeting discussions and program efficiencies to provide a realistic target for domestic financing and inform decisions about sustaining the HIV response in Tanzania. In addition, in COP22 PEPFAR/T will continue to collect data that will be used for monitoring the functional and financial competencies necessary to assume domestic responsibility.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

In COP22, PEPFAR/T will collaborate with the GOT, key stakeholders, and local IPs to develop a clear pathway to gradual country ownership of a sustainable HIV response. The strategy will include identifying areas that need further support and opportunities for the GOT or other partners (e.g., CSOs, private sector, etc.) to absorb greater responsibility. For example, in the context of HRH, Tanzania is faced with a critical shortage of HCWs to provide quality health services, however, the GOT is limited in its ability to hire these staff. PEPFAR/T will work with the GOT to optimize allocation of health workers in areas that have the greatest unmet need PEPFAR/T will continue to align contracted HCWs with GOT scopes of work and other requirements to ensure absorption when the time comes. In the context of supply chain, PEPFAR/T has been working to ensure that the GOT has ownership over all supply chain system capabilities, such as quantification, forecasting, supply ordering, and oversight of in-country logistics.

As noted throughout this document, as an outcome of COP22 discussions, the GOT will establish a sustainability TWG under the multisectoral coordination of the Prime Minister's Office in collaboration with TACAIDS, MOH, PO-RALG, civil society, and the private sector. The working group will drive discussions and develop a roadmap for a sustainable HIV epidemic response in Tanzania.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting)

Robust health information systems are a vital component of sustained epidemic control in Tanzania. Building upon previous year's investments, COP22 above-site investments will continue efforts to strengthen patient-level systems that enable the PEPFAR/T program to monitor clinical outcomes, retention, and programmatic improvements.

During COP21, USG drafted a Data Sharing and Data Access Memorandum of Understanding with the GOT to govern the use of patient level, aggregate-level, and qualitative data for tracking patient level outcomes over time as well as services delivered to beneficiaries and communities. The MOU will also govern how all parties publicly share analyses generated from national data sources to ensure adherence to national guidelines and ensure safeguarding of sensitive patient level data. Data will assist technical advisors, practitioners, and managers within the USG and the GOT to make informed decisions to monitor the programmatic goals put in place for COP22. Collaborative engagement for continual data review and use in the national HIV response will foster stakeholder buy-in and country-ownership of disseminated results at all levels. Review of the MOU is still ongoing, but final endorsement is expected by the start of COP22 implementation.