TANZANIA

Country Operational Plan

(COP) 2017

Strategic Direction Summary

March 2, 2017

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1.0 Goal Statement

Working collaboratively across U.S. Government agencies, the Government of the United Republic of Tanzania (GOT), implementing partners (IPs), multilateral representatives, and civil society representatives, the U.S. President's Emergency Plan for AIDS Relief in Tanzania (PEPFAR/T) has developed a Country Operational Plan (COP) to achieve sustained epidemic control in Tanzania by scaling up coverage in the 81 councils with the highest HIV burden, out of a total of 178 councils in Tanzania. Based on a review of council boundaries, updated epidemiologic data, and the results and program data from FY 2016, the interagency team decreased from the 84 priority councils included in COP 2016 to a focus on 81 councils.

For COP 2017, seven councils achieved the new PEPFAR designation of "attained" whereby coverage has already reached 81% or more in both male and female populations across all age groups. In addition, approximately 78% of the 1.4 million persons living with HIV (PLHIV) live in 81 Scale-Up Councils where PEPFAR/T seeks to reach 80% coverage of all PLHIV on antiretroviral therapy (ART) by 2017. The remaining 90 Sustained Councils will continue to be supported by PEPFAR through passive enrollment of clients.

Within the Scale-Up Councils, IPs will focus on implementing "Test and Start" through site-level targets in areas of highest HIV burden among general, key, and priority populations. PEPFAR/T will continue supporting a standard package of prevention, care, treatment, and support for beneficiaries in all council types with greater focus on demand creation for services in Scale-Up Councils. In addition, PEPFAR/T's combination prevention activities focus on key populations (Female Sex Workers, Men who Have Sex with Men, and Injecting Drug Users), adolescent girls and young women (AGYW), and sexual partners of PLHIV.

This COP, however, comes at a time of uncertainty with regards to key populations, as the GOT took actions in late 2016 and early 2017 to prevent what it termed the "spread of homosexuality". Important resources, such as community-based drop-in-centers, are now restricted. The pending new GOT Key Populations guidelines will in large part determine how effective PEPFAR interventions will be for the KPs, especially MSM.

Planned interventions for all populations include partner notification and treatment, index client-based testing of families, siblings, and social networks through incentivized peer referrals, condom use, targeted testing of TB suspects, and patients with sexually transmitted infection (STI). These interventions aim to optimize identification of PLHIV, linkages to services, uptake of ART, retention, and adherence. PEPFAR/T will also continue to support core services for orphans and vulnerable children (OVC) in Scale-Up Councils.

In 2016, the GOT undertook substantial policy revisions to achieve the UNAIDS 90-90-90 goals by 2020 and move Tanzania closer to epidemic control. In October 2016, after review of the 2015 WHO guidelines and available funding, the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) adopted Test and Start nationwide. In addition, the service delivery model (SDM) will be revised and adjusted to standardize and increase the length of time between visits and facilitate access to refill medications in the community for stable patients, which may help decongest clinics and allow more patients to be placed on

treatment. Eligibility criteria for the various SDMs are based on the clinical characteristics of the patient (stable and unstable and the presence of co-morbidities) and the type of client population (i.e. adults vs. children; pregnant and breast feeding women; and key populations).

In March 2016, MOHCDGEC signed the Task Sharing policy, which is now being finalized through the development of an implementation plan, which is expected to be approved in May 2017. This draft plan includes provisions for training of nurses with appropriate curricula to dispense ARVs and for trained community health care workers to perform rapid HIV testing. A pre- and in-service training package for nurse-initiated and managed ART was presented to the MOHCDGEC for review in April of 2017. PEPFAR/T continues to work closely with MOHCDGEC and the President's Office of Regional Administration and Local Government (PORALG) to operationalize the Task Sharing policy and to identify and implement other efficiencies, such as community ARV delivery. In addition, to address the third 90, MOHCDGEC, PORALG, and PEPFAR/T began scale-up of routine service throughout the country.

Recognizing the need to scale-up access to HIV/AIDS care and treatment, as well as reduce dependency on PEPFAR and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) to finance the national response, the GOT appointed the AIDS Trust Fund (ATF) board and disbursed funds to the ATF in 2016. The GOT also finalized the Health Financing Strategy (HFS), including a scale up of the Community Health Fund to an additional 51 local government authorities. Ongoing policy discussions with national HIV stakeholders will complement continued consultations and advocacy for increased Domestic Resource Mobilization (DRM) from both public and private sector resources. Furthermore, PEPFAR/T has been working with the GOT to allocate sufficient resources to support the cost of commodity distribution of ARVs. PEPFAR/T is collaborating with GFATM and other donors to advocate that the GOT utilize the ATF and other domestic resources to support key strategic priorities, including commodities, to ensure more patients are enrolled on ART. In COP 2017, PEPFAR/T is also projecting the three-year commodity requirements that will be needed to align with the GFATM funding request for 2018-2020. PEPFAR/T will also continue to work with the GOT to develop a plan to phase out U.S. Government-to-Government (G2G) activities and salary support across all mechanisms and transition to GOT financial support. This is evidenced by the reduced above-site G2G funding level of approximately $5.4 million in COP 2017.

PEPFAR/T will continue to work with the GOT in 2017 to transition out of PEPFAR direct service delivery support provided to all sites serving fewer than 10 ART or PMTCT patients on treatment per year.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden, and Epidemic Profile

According to UNAIDS,[1] adult HIV prevalence in Tanzania is estimated at 4.7% for 2015, with regional HIV prevalence ranging from 0.2% (Kaskazini Unguja, Zanzibar) to 15.4% (Njombe)[2]. UNAIDS estimates indicate a total of 1.4 million Tanzanians living with HIV in 2015, out of a total population of 51,254,746. An estimated 54,000 new infections and 36,000 AIDS-related deaths occur in Tanzania annually.

Since 2004, PEPFAR/T has worked closely with the GOT, GFATM, United Nations (UN) Agencies, and other donors to respond to the HIV epidemic. Tanzania has made significant strides in reducing prevalence, incidence, and AIDS-related mortality. However, more geographically targeted and population-focused interventions aimed at achieving universal access to ART in priority areas will be required to attain epidemic control.

Like many low-income countries in sub-Saharan Africa, Tanzania grapples with weak health infrastructure, poor quality data, shortages of health and social workers, high levels of HIV-related stigma, and cumbersome government procurement systems. PEPFAR/T supports the GOT in implementing the Third National Multi-Sectoral Framework on HIV and AIDS (NMSF III) and the Health Sector HIV Strategic Plan (HSHSP III 2013-2017), which closely correspond to the UNAIDS Fast Track Strategy, so that, by 2020, Tanzania will have tested 90% of all PLHIV, placed 90% of those testing positive on continuous ART, and have 90% of those on ART virally suppressed. This will be achieved by geographically prioritizing care, treatment, and prevention services in the councils with the highest burden and by focusing on core, evidence-based interventions.

Table 2.1.1 Key National Demographic and Epidemiological Data

	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	50,144,176	100	11,003,956	22	11,011,580	22	14,727,329	29	13,401,311	27	National Bureau of Statistics Estimation, 2016
Prevalence (%) (15-49)		4.69 (2015)					5.6		3.7		UNAIDS Spectrum Estimates, 2015
AIDS Deaths (per year)	35,659 (2015)	NA	5,105 (both male and female)			14	11,279	32	19,275	54	UNAIDS Spectrum Estimates, 2015
PLHIV	1,385,785 (2015)	NA	91,353 (both male and female)			7	776,355	56	518,071	37	UNAIDS Spectrum Estimates, 2015 (not rounded)

[1] http://aidsinfo.unaids.org/
[2] Tanzania 2011-12 HIV/AIDS Malaria Indicator Survey

Incidence Rate (Yr)	NA	0.21 (15-49 years old)									UNAIDS Spectrum Estimates, 2015
New Infections (Yr)	54,255	NA	6,482 (both male and female)			12	27,487	51	20,286	37	UNAIDS Spectrum Estimates, 2015
Annual births	1,911,313	NA			NA				NA		UNAIDS Spectrum Estimates, 2015
% of pregnant women with at least one ANC visit	5,519	96%			NA				NA		2010 Tanzania DHS
Pregnant women needing ARVs	85,886 [75,000 – 95,000]				NA				NA		UNAIDS Spectrum Estimates, 2015
OVC (2015)	3,305,429										2016 Estimated Population of MVC and OVC, 9-17 years population projection from NBS
Orphans (maternal, paternal, double) due to AIDS (2014)	810,000 [550,000-1,800,000] (2014)										UNAIDS, AIDS info, 2016
Notified TB cases (yr)	62,180 (2015) TB prevalence 295/ 100.000										Global Tuberculosis Report, 2016 TB Prevalence survey report Sept 2013
% of TB cases that are HIV infected	20,117										Global Tuberculosis Report, 2016
% of males circumcised	519,437		NA		268,233	52	NA		251,204	48	PEPFAR Tanzania Annual Program Results (APR) for FY 2016
Estimated Population Size of MSM*	49,700	NA	NA				NA				Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence	NA	25	NA				NA				Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014

Estimated Population Size of FSW	155,450	NA			NA				NA		Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
FSW HIV Prevalence	NA	26			NA				NA		Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Estimated population size of PWID	30,000	NA									Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
PWID HIV Prevalence	NA	36									Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Adolescent Girls and Young Women[2]	4,782,006	2.74			NA				NA		Calculations based on NBS (2014) projections and THMIS (2012)
Military Community[4]	61,632										Calculations based PEPFAR program data and partner information, FY 2013

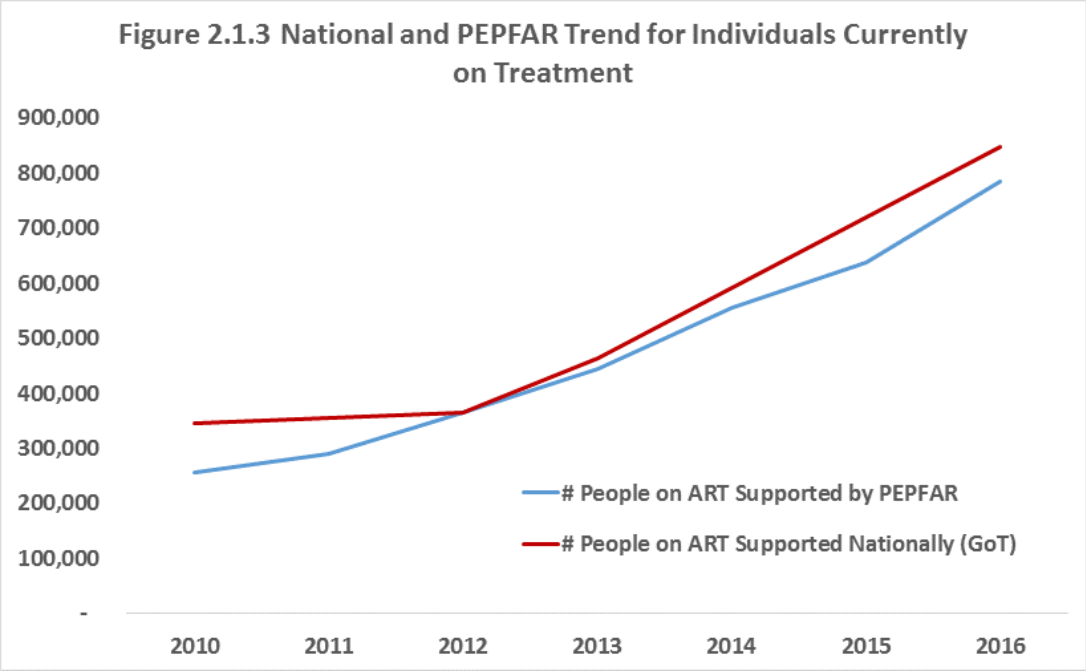
Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (12 months)										
					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate[1] (#)	HIV Prev (15-49 years) (%)	Total PLHIV (#)	PLHIV Diagnosed (#)	On ART (#)	ART Coverage (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	50,144,176	4.69 [2]	1,385,779 [2]	Not available	784,995[4]	57%	64,448	6,259,167[4]	270,169[4]	189,065[4]
Population less than 15 years	22,015,536	Not available	91,353[2]	Not available	50,891[4]	56%	5, 326	1,169665[4]	18,849[4]	13,562[4]
15-24 year olds	9,556,835	Not available	136,251[2]	Not available	734,104[4] (15+)	57% (15+)	Not available	5,089,502[4] (15+)	251,320[4] (15+)	175,503[4] (15+)
25+ year olds	18,571,805	Not available	1,158,175[2]	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Pregnant Women	1,321,141[6]	5.6 [5]	85,886 [2]	Not available	67,466[2]	78%[7]	Not available	984,708[4]	48,479[4]	54,404[4]
MSM	49,700 [8]	25 [8]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
FSW	155,450 [8]	26 [8]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
PWID	30,000 [8]	36 [8]	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Priority Pop (AGYW)	4,782,006[9]	2.74 [9]	131,027 [9]	Not available	Not available	Not available	Not available	Not available	Not available	Not available

[1] *National Bureau of Statistics Estimation, 2016.*
[2] *AIDS Info/UNAIDS National Spectrum Estimates, 2016*
[3] *THMIS 2011-2012*
[4] *PEPFAR Program Data, 2016, COP 2017 Datapack*
[5] *ANC Surveillance , 2011*
[6] *ANC Attendee data 2016*
[7] *75% of PW on ART*
[8] *Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014*
[9] *Calculations based PEPFAR program data and partner information, FY 2013*

It is important to note that these differences in HIV prevalence between urban (7.2%) and rural (4.3%) areas. Gender disparities are also significant between male prevalence (3.7%) and the nearly double prevalence among females of reproductive age (6.2%), with girls acquiring HIV at a younger age.[3] The PEPFAR-funded 2016-2017 Tanzania HIV Impact Survey (THIS) will provide updated prevalence and incidence estimates, as well as information about CD4 counts, viral load suppression, and adherence measured by plasma drug levels. Key populations (KPs) also play a critical role in HIV transmission dynamics. Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. Studies in Dar es Salaam estimate that HIV prevalence is 36% among people who inject drugs, 26% among sex workers, and 25% for men who have sex with men.[4] Services to KPs, especially MSM, are currently strained due to the recent and ongoing GOT actions to close community-based programs due to stated concerns of "promoting homosexuality."

Figure 2.1.3 shows national and PEPFAR trends for individuals current on ART from 2010-2016. The number of clients on ART has steadily increased over time; a large portion of support for individuals on ART is attributable to PEPFAR. Of the 1.4 million PLHIV in Tanzania, 784,995 were reported to be currently on ART by the end of FY16.

Figure 2.1.3 Tanzania National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

[3] Tanzania 2011-12 HIV/AIDS Malaria Indicator Survey

[4] *Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.*

Tanzania's national HIV program is donor dependent. PEPFAR and the GFATM are the two largest donors, contributing 98.8% of all public financing, according to the 2013-2014 Public Expenditure Review (2015) for HIV and AIDS. Moreover, the share of health sector (all areas of health) budget as a proportion of the total GOT budget has significantly declined from 10% in 2006/7 to approximately 7% in 2016/17. Donors to Tanzania's AIDS response are largely limited to PEPFAR and GFATM, with the UN and World Bank providing relatively small additional funding. There are currently no other bilateral donors anticipated in FY 2018.

PEPFAR/T is currently working with the GOT to effectively implement its funding allocation for ART and to the ATF. This collaboration will continue through FY 2018 as part of the ongoing strategy to address increased domestic resource mobilization for the national response to HIV and AIDS. As part of the funding request to the GFATM, the GOT will need to continue to meet expenditure targets for the health sector. Health financing activities in PEPFAR/T's above-site budget include working with the GOT to meet the growing financial needs of the HIV program.

The indicative allocation for HIV/AIDS from the GFATM for implementation in Tanzania from 2018-2020 is $408,487,081, inclusive of cross-cutting support for resilient and sustainable systems for health (~10%-15%). Out of this amount, it is estimated that approximately $75 million per year will support HIV commodities: ARV medicines, rapid test kits (RTKs), and laboratory reagents. Tanzania will submit this funding request to the GFATM on May 23, 2017, the details of which are being harmonized with the PEPFAR COP 2017, and the GOT budgeting processes.

PEPFAR/T plans to increase the funding portfolio for COP 2017, with an additional $30,000,000 in performance funding to reach a total planning level of $482,859,944 and $43,355,098 in additional central voluntary medical male circumcision (VMMC) funds. PEPFAR, together with the anticipated funding from the GFATM, will cover the majority of funding needs for commodity procurement through FY 2018, complemented by a $4.6 million contribution from the GOT, as well as the GOT's continued commitment to financing the cost of logistics in country. The GOT supports health worker salaries and other personnel emoluments for the delivery of HIV services, totaling approximately $28.5 million annually. Based on a 2016 study of current practice in HIV service delivery, 47% of worker's time is devoted to HTS, 27% to ART, and 24% to laboratory.

Recognizing the funding limitations in the context of a growing HIV care and treatment program, Tanzania's national strategic plans and funding proposal for HIV and AIDS have followed the UNAIDS investment approach, which prioritizes particular activities, populations, and geographies for maximum impact. The NMSF III, for example, prioritizes investments by intervention category, while the GFATM HIV/TB Concept Note prioritizes prevention activities for key and priority populations in the top ten high prevalence regions. PEPFAR/T support prioritizes high-impact service delivery in the 84 Scale-Up Councils. Even in the context of prioritization for highest impact, as the number of PLHIV on treatment continues to grow, DRM will need to increase substantially to reach the Fast Track Goal of 90-90-90 by 2020. PEPFAR/T has reviewed a scale-up plan with MOHCDGEC to achieve the Fast Track Goal and will continue to plan with the GOT, including PORALG, and GFATM to determine resource needs based on this scale-up plan. In addition, PEPFAR/T is ensuring that the 90-90-90 goals are reached for specific sex and major age disaggregation bands of targeted populations.

Table 2.2.1 Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GFATM	% GOT*	% Other
Clinical care, treatment and support	$227,787,733	53.8%	42.8%	3.4%	0.1%
Community-based care, treatment and support	$30,048,113	100%	0%	0%	0%
PMTCT	$40,377,176	98.9%	0.4%	0.7%	0%
HTS	$53,127,748	68.7%	6.1%	25.2%	0%
VMMC	$23,232,838	100%	0%	0%	0%
Priority population prevention	$19,306,802	78.5%	9.5%	0%	12%
Key population prevention	$10,893,941	60.5%	39.5%	0%	0%
OVC	$34,111,392	90.2%	0%	0%	9.8%
Laboratory	$22,140,454	69.2%	0%	30.8%	0%
SI, Surveys and Surveillance	$12,210,139	97.1%	2.9%	0%	0%
HSS	$12,427,378	27.6%	44.8%	0%	27.6%
Other	$18,473, 399	21%	77%	2%	0%
Total	**$504,137,112**	**67%**	**25%**	**6%**	**2%**

*GOT data from Tanzania's Annual Report to the Global Fund on Willingness to Pay and doesn't capture infrastructure and human resource contributions at the intervention levels as defined by the COP.

Table 2.2.2 Procurement Profile for Key Commodities in FY Oct 2015-Sep2016 (USD)

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	Other
ARVs	178,378,733.	51,713,213	117,431,937	9,233,581	-
Rapid test kits	24,266,256	12,368,393	10,401,106	1,496,756	-
Other drugs	-	-	-	-	-
Lab reagents (CD4)	19,911,933	499,660	18,395,467	1,016,805	-
Condoms	1,139,400	324,000	756,000	59,400	-
Viral Load commodities	112,492	-	106,848	5,644	-
VMMC kits	4,778,060	4,778,060	-	-	-
MAT	106,500	106,500	-	-	-
Other commodities(HEID)	3,731,064	1,674,345	1,810,385	246,334	-
Total	**$227,539,878**	**$66,579,611**	**$148,901,743**	**$12,058,520**	-

***Commodity costs include associated storage and distribution expenditures*

Table 2.2.3 U.S. Government Non-PEPFAR Funded Investments and Integration

Funding Source	Total U.S. Government Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$14,135,00	$11,017,319	6	$73,676,863	Maternal and Child Health
USAID TB	$7,500,000	$4,106,282	8	$81,297,635	TB control
USAID Malaria	$46,000,000	$7,237,670	7	$73,714,766	Malaria control
Family Planning	$26,400,000	$11,278,846	9	$89,733,065	Family planning
NIH	0	0	0		110 various studies in Tanzania
CDC (Global Health Security)	$4,600,000	0	0	$5,749,484	Global Health Security, Malaria, FELTP
Peace Corps	$ 2,790,147	$ 2,790,147	1	$113,000	Community health
Total	**$101,425,147**	**$36,430,264**	**32**	**$324,275,813**	

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	4,662,292	$0	$4,662,292	1	$0	New innovations in vAGYW prevention, care, and treatment
VMMC Central Funds	$46, 000,611	$0	$46,000,611	6	$17,557,394	Increase VMMC Coverage
Other PPP						
Total	**$50,662,903**	**$0**	**$50,662,903**	**7**	**$17,557,394**	

2.3 National Sustainability Profile

The Sustainability Index and Dashboard (SID) was last completed through a combination of desk reviews, individual consultations with MOHCDGEC (including technical working group meetings) and Tanzania AIDS Commission (TACAIDS) staff, , the Joint UN HIV Programme Working Group, and civil society engagement meetings during the period of January – March 2016. The final SID review took place in conjunction with a meeting of external stakeholders on March 16, 2016, during which a breakout session recommended activities for COP 2016 to address the identified sustainability weaknesses. The sustainability domains scoring in the red category range included Service Delivery, Laboratory, Domestic Resource Mobilization (DRM), and Technical/Allocative Efficiencies. The 2016 SID remains the guiding analytical document for assessing above-site level budgeting priorities in COP 2017.

To address the weaknesses in service delivery, PEPFAR/T is supporting the finalization of the operational plan for the Task Sharing policy, in conjunction with a differentiated HIV SDM. This will help decongest facilities and improve the quality of HIV clinical services. COP 2017 supports the realization of greater technical and allocative efficiencies in the existing HIV services delivery model, through implementation of the new WHO guidelines for the management of stable HIV patients. To decongest clinics and ensure that more patients can be seen with existing numbers of facilities and health care workers, PEPFAR/T is working with MOHCDGEC and PORALG to implement a new SDM in which stable patients will no longer be required to visit facilities on a monthly basis. Tanzania is working towards adopting other new SDM in alignment with WHO and as per the proposed revised National Guidelines for the management of HIV in stable patients such that ARV medicines will be available for pick-up in quantities of two or three months and clinical evaluations will be reduced to once every six months. In addition, ARV pick-up locations will be decentralized to be available closer to patients at dispensaries or other identified and approved community sites.

PEPFAR/T funding for health care workers (HCW) supports epidemic control through ensuring appropriate levels of human resources across the HIV care continuum, particularly at the community level in Scale-Up Councils. However, to ensure that Tanzania can sustainably meet the needs of the HIV/AIDS response, PEPFAR/T continues to work with the GOT to plan a phased transition of salary support from PEPFAR/T funded positions to the GOT. Next steps will also be driven by pending GOT guidelines for serving KPs, particularly at the community

level. A second Health Worker Salary Inventory for clinical, managerial, and community health workers was conducted in 2016. The findings from the inventory will inform the implementation of the transition plan from PEPFAR/T to the GOT, which will happen during COP 2017.

The availability and accessibility of life-saving ARVs is the cornerstone of epidemic control. While the GFATM and PEPFAR/T collectively procure commodities, PEPFAR/T also provides technical assistance (TA) to strengthening supply chain performance management in facilities providing HIV services, as well as national level institutions. Prior support has produced a significant increase in the availability of products at the Medical Stores Department (MSD), councils, and facilities. Moving forward, PEPFAR/T continues to support restructuring the supply chain system design that will enhance supply chain data analytics to both improve performance and streamline distribution. PEPFAR/T will also assist the Pharmaceutical Services Unit to work with performance metrics, to be used to hold MSD and facilities accountable to a minimum standard of service.

PEPFAR/T is currently working to accelerate access to high quality viral load monitoring, and will continue this positive trajectory in COP 2017. PEPFAR/T will continue to expand in-country laboratory capacity for viral load (VL) testing and establish an efficient sample transport and results' return systems. This will include a functional tracking system for sample transport. PEPFAR/T will also focus on implementation of a centralized laboratory database and interconnectivity networks through feeder viral load laboratories as well as the maintenance of infrastructure, equipment, and utilities. PEPFAR/T will assess the cost effectiveness of sample transport, results feedback, and viral load test unit cost in order to look for program efficiencies. Additional emphasis will be placed on ensuring an uninterrupted supply of viral load commodities to prevent stock-outs. Early warning indicators for stock-outs and backlogs are currently being developed along with rapid response plans and protocols to minimize stock-out emergencies and mitigate the effect of commodity shortages on program activities.

PEPFAR/T will also continue VL scale-up with further development, refinement and use of VL monitoring and evaluation (M&E) tools. PEPFAR/T will support quarterly meetings for the VL National Technical Working group to provide a regular forum that includes the GOT and implementing partners to discuss VL scale-up progress and review activities. Currently, TX_PLVS is an annual indicator, but PEPFAR/T will encourage systematic review on a quarterly basis to enable closer monitoring of the third 90. PEPFAR/T will continue to expand the ECHO (digital video-conferencing and distance learning network) program to build health care providers' technical capacity as well as improving the laboratory-clinical interface, and the timely return of results to patients. PEPFAR/T will also continue with investment and optimization of dedicated staff for VL testing and (through implementing clinical partners) establish and enhance clinical processes and structures to support scale up of VL testing. PEPFAR/T will work with GOT to standardize and disseminate Standard Operation Procedures for VL laboratories, sample transport hub networks, and for clinical management of VL results.

To address the current (COP16) problem of VL testing laboratories having huge backlogs of sample, as of April 2017 PEPFAR TZ has developed 30, 60, and 90 action plans to clear the VL sample backlog which includes prioritization of patient populations (Pregnant/Breast-feeding

women, Children, Patients' Suspected Failing on ART) for VL testing and establishing facility level quotas for routine monitoring based on how many plasma samples each regional laboratory could potentially process at 90% laboratory efficiency. The focus will be to ensure accuracy, reliability, and timeliness of VL testing and return of results to patients, including use of VL scorecard, high VL tracking logbook, and web-based dashboard.

Recognizing the need to scale up access to HIV/AIDS care and treatment, as well reduce the dependency on PEPFAR/T and the GFATM to finance the national response, the GOT has taken steps to promote DRM and financial sustainability; though significant increases in local investment remain essential. As noted earlier, the ATF and HFS are two examples. The focus of the HFS is to scale up health insurance coverage, strengthen value for money, and increase engagement of the private and informal sectors. PEPFAR/T also convened a diverse group of development partners to advocate that the GOT allocate sufficient funds for commodities, as well as pay off the arrears owed to MSD. This effort was ultimately successful; the GOT budgeted approximately $4.6 million for ART, $32.1 million to MSD to pay off arrears, and $16.1 million to fund annual supply chain management costs. PEPFAR/T continues to advocate that the GOT allocate sufficient funds to ensure future debts to MSD are not incurred.

PEPFAR/T was selected for PEPFAR's Sustainable Financing Initiative and has also prioritized DRM activities in COP 2017. PEPFAR/T prioritization of DRM entails support from the highest levels within the U.S. Mission in Tanzania and is the focus of an interagency communications strategy on health diplomacy. Specifically, health diplomacy activities include targeted communication of key messages and analyses on DRM to specific groups of stakeholders who are influential in mobilizing domestic resources. These include senior GOT decision-makers in Parliament, media, and national thought leaders, as well as visiting U.S. Congressional delegations, and Tanzanian civil society.

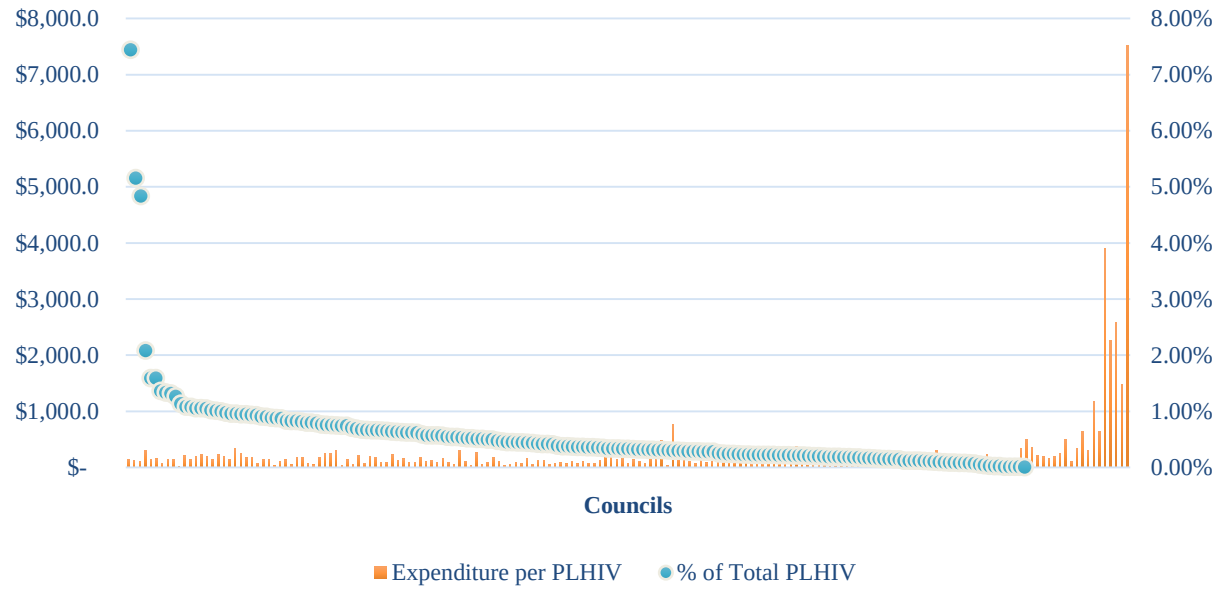
To address deficiencies in Tanzania's technical and allocative efficiencies, as identified through the SID process, PEPFAR/T is supporting the acceleration of Tanzania's adoption of the new WHO Service Delivery Guidelines. During the course of COP 2016 implementation, PEPFAR/T and GOT teams started to work together to address the policy, infrastructure, and human resources challenges of fully adopting these guidelines. Once fully adopted, the guidelines will serve to significantly decongest clinics and optimize the efficient delivery of HIV services. The focus for COP 2017 is to support GOT to operationalize distribution of ARVs through dispensaries that are closer to affected communities to ensure stable patients have access to quality ART services. New service delivery models will be implemented in alignment with the revised National Guidelines for the management of HIV.

Since the beginning of PEPFAR/T, the program has worked to strengthen government institutions, which are required for a sustained epidemic response. The focus in COP 2017 has been to continue to ensure a more coordinated and efficient funding approach to government institutions.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

At the start of FY 2017, Tanzania has 178 Councils or Sub-National Administrative Units (SNUs). The 2016 PEPFAR/T expenditure per PLHIV and percent PLHIV by SNU is presented in Figure 1.4.1. Figure 1.4.1 illustrates that spending per PLHIV across councils varied from $7 to $7526, with an average of $145 per PLHIV. Some of this extreme variation can be explained by the variance in the size of the programs. Seven out of ten SNUs with the highest average expenditure per PLHIV come from Zanzibar. Zanzibar's SNUs, which have the lowest prevalence and burden of HIV in the country, have expenditures per PLHIV ranging from $168 per PLHIV in Mjini up to $7526 in Kaskazini A. Excluding Zanzibar, spending in the councils varied from $7 to $764 per PLHIV. The FY 2016 expenditure data reflects the COP 2016 geographic prioritization and program pivot.

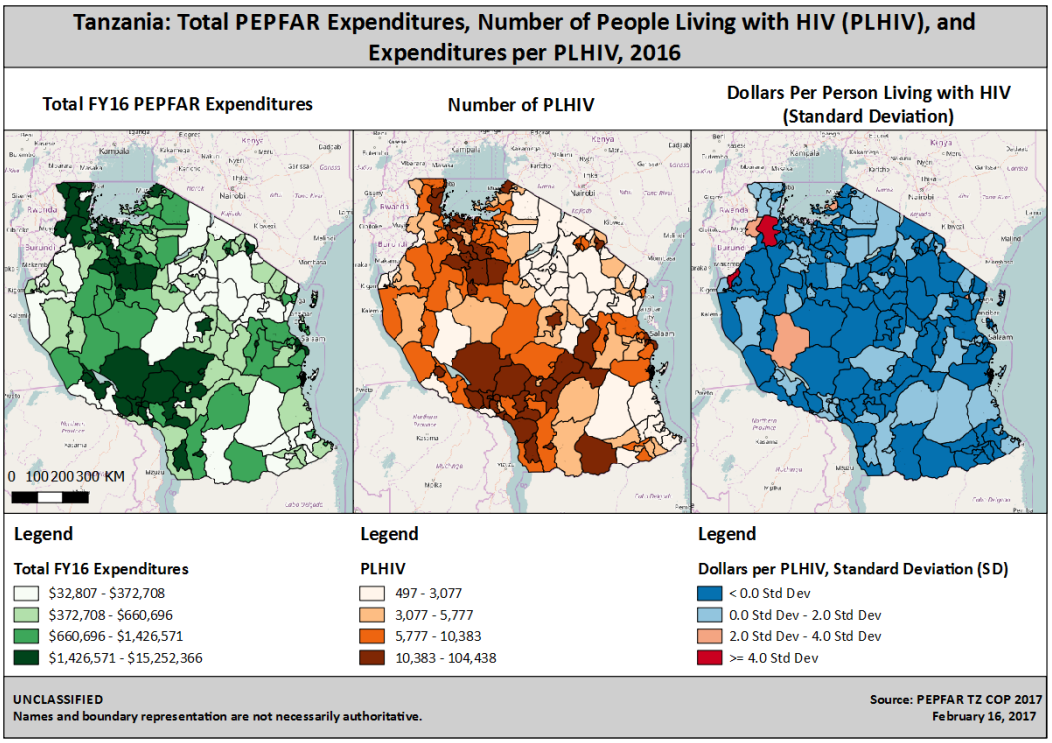
Figure 2.4.1: 2016 PEPFAR Expenditure per PLHIV and Percent of PLHIV by SNU



To further facilitate understanding of PEPFAR/T investments, alignment with HIV burden, and program efficiencies by SNU, PEPFAR/T used questions from COP 2017 guidance to review unit expenditure (UE). All outlier UEs were removed before setting implementing mechanism (IM) level budgets. In COP 2016, PEPFAR/T completed a detailed outlier analysis process and developed mitigation strategies implemented through quarterly program monitoring and partner management. By identifying high cost drivers for outlier IMs, the team actively worked with partners to derive efficiency gains through reduced spending where appropriate.

To maximize efficiency, given the rationalized landscape by partner and SNU and programmatic context, PEPFAR/T used FY 2016 IM SNU UE to set IM level budgets for partners in COP 2017. In COP 2016, PEPFAR/T used a flat line national UE for all partners. This method did not account for IM and SNU cost variations. For COP 2017, PEPFAR/T looked at the upper and lower UEs for each IM as a maximum and minimum, then examined the FY 2016 reported IM-SNU UE for all IM-SNUs between the two limits. A mechanism program UE was then calculated using a weighted average of the SNU-IM UEs for each partner. For new partners, a mechanism UE was created using a weighted average for all partners who provided that service

in the SNUs the new partners were taking over. Minor adjustments were also made to account for program context, e.g., various environmental factors in the councils where partners operate, where necessary. Applied UEs excluded commodities, program management, and strategic information, which were budgeted in a separate sheet. KP and PMTCT indicators used COP 2016 UEs after TWG consensus. UEs for HIV testing services (HTS) and community-based counseling and testing services (CBCTS) were recalculated due to a reported FY 2016 achievement issues. The recalculated UEs used were the reported FY 2016 expenditure divided by COP 15 target. PEPFAR/T will implement a routine monitoring strategy to ensure partners are able to implement programs effectively to achieve targets within their budget allocation.



2.5 Stakeholder Engagement

Engagement with external stakeholders to develop COP 2017 began in January 2017 with discussions involving the National AIDS Control Program (NACP), TACAIDS, UNAIDS, WHO, and GFATM. Discussion focused on the templates, tools, and processes that would be used in the COP submission, with particular attention to the inputs required to complete the Data Pack, PBAC and commodities calculator. At that time, PEPFAR/T and the GOT identified focal points for harmonizing three key data streams in planning:

1. Epidemiological estimates (estimated PLHIV by council)
2. Programmatic estimates (Current on Treatment by Facility – PEPFAR and non-PEPFAR supported sites)
3. Commodities estimates (financial gap analysis for procuring ARVs and lab supplies)

From January 24th – 27th, PEPFAR/T held a COP 2017 planning workshop to complete the first draft of the COP tools and reach consensus on the underlying assumptions. Representatives from the GOT, bilateral and multilateral development partners, and civil society were integrated with the PEPFAR/T and headquarter technical teams throughout this process. Particular attention was also paid to harmonizing the COP planning process with the development of the GFATM funding requests. In particular, the USG representative to the GFATM in Geneva and the GFATM Senior Fund Portfolio Manager met with the Minister of MOHCDGEC and worked with the COP planning team to ensure a common approach and data set informed both the PEPFAR and GFATM requests.

Subsequent to the COP planning workshop, feedback with external stakeholders was conducted through email communications and in-person consultations. PEPFAR shared COP guidance and tools with over 150 civil society organizations (CSOs) based throughout the country. They were provided an opportunity to share feedback electronically. In addition, dedicated meetings were held with the GOT and separately with civil society organizations, coordinated through the Non-State Actors' (NSA) constituencies of the GFATM Country Coordinating Mechanism. The NSA group also selected the representatives to the COP approval meeting, scheduled for April 19-21 in Johannesburg, South Africa. After COP 2017 is finalized and approved, PEPFAR/T will convene a follow-up meeting with an anticipated attendance of 100 CSOs, at least half of which are based outside of Dar es Salaam. This meeting will bring CSOs together with PEPFAR-funded partners to ensure that COP 2017 implementation is informed by active and ongoing feedback with PLHIV and other key civil society actors.

3.0 Geographic and Population Prioritization

Tanzania's seven Attained Councils represent 3% of the national HIV burden. The 81 Scale-Up Councils represent 78% of the national HIV burden. PEPFAR/T is currently operational in all 178 councils in the country, with a passive enrollment approach in 90 Sustained Councils. PEPFAR/T has realigned its investments to better correspond with the epidemiology, and has prioritized investments to increase ART coverage and to address the unmet need to achieve epidemic control in the highest burden councils. PEPFAR/T reviewed epidemiologic data and burden of disease at the council level, including total number of PLHIV and unmet need for ART. PEPFAR/T also took into consideration the location of key population hot spots. Given the need to balance the joint goals of accelerating the elimination of mother-to-child transmission of HIV and attaining sustained epidemic control in Scale-Up Councils, PEPFAR/T also prioritized diagnosis and ART initiation for HIV-positive pregnant women. COP 2017 builds on the pivot planned in COPs 2015 and 2016, where efforts were focused on the highest-burden councils to get maximum impact per dollar.

Table 3.1 Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP 2017†	# Current on ART (FY 2016)*†	# of SNU COP 2016 (FY 2017)	# of SNU COP 2017 (FY 2018)
Attained	35,773	39,506	-	7
Scale-up Saturation	1,085,648	579,223	40	81
Scale-up Aggressive	-	-	44	-
Sustained	264,364	149,727	94	90
Central Support	-	-	-	-

**Excludes _Military SNU*

†Using COP 2017 SNU prioritization

4.0 Program Activities for Epidemic Control in Scale-up, Attained, and Sustained Locations and Populations

4.1 Targets for Scale-Up, Attained, and Sustained Locations and Populations

Scale-up Locations and Populations
Based on initial geographic and population prioritization decisions for COP 2017, PEPFAR/T used the Data Pack to set FY 2018 treatment targets. Using council level PLHIV estimates based on PMTCT program data, PEPFAR/T selected councils with the largest HIV burden (81) in which to focus attention to reach epidemic control. These 81 Scale-Up to Saturation Councils were identified as having sufficient coverage to reach 80% ART coverage by FY 2018, taking into account expected loss to follow up (LTFU) for newly initiating ART patients. For the seven Attained Councils and the remaining 90 Sustained Councils, PEPFAR/T set targets based on passive enrollment.

In FY 2018, PEPFAR/T aims to enroll 360,030 new patients on treatment with the goal of supporting 1,245,251 patients on ART by APR 2018. This represents an increase in national coverage to nearly 90% and contributes to the 95% adult and 80% children ART coverage targets by 2017 in the HSHSP III. Based on these targets, the prioritized Scale-Up to Saturation Councils should at least reach 80% coverage of PLHIV by APR 2018. To reach these targets, PEPFAR/T employed a cascade approach to setting HIV testing targets and considered several critical program streams to most efficiently identify HIV-positive individuals and effectively link them to care and treatment. Given the high burden of TB/HIV co-infection in Tanzania, high rates of TB-related mortality in PLHIV, and the accessibility of these patients through existing PEPFAR-supported care programs and TB clinics, PEPFAR/T has committed to increasing the number of TB/HIV co-infected patients on ART in the next year. Tanzania will also begin offering routine HIV testing for TB suspects, increase testing with STI patients, and scale up the partner referral plus approach and network testing.

Given the need to balance the joint goals of accelerating the elimination of mother-to-child transmission of HIV and attaining sustained epidemic control in Scale-Up Councils, PEPFAR/T is continuing to prioritize diagnosis and ART initiation for HIV-positive pregnant women and lactating mothers. PEPFAR/T aims to reach 95% of pregnant women with HTC and initiate 95% of HIV-positive women on ART. The package for PMTCT will be the same for Scale-Up, Attained, and Sustained Councils. PEPFAR/T will continue to support the provision of care and treatment to a diminishing cohort of pregnant women currently enrolled on ART at PMTCT sites through FY 2018. The goal for early infant diagnosis (EID) is to reach 95% of HIV-exposed infants with HIV testing by 12 months and initiate 80% of eligible infants on treatment. The emphasis will be to increase viral load suppression rates to achieve at least 90% suppression among all PLHIV on treatment.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY 2018) HTS TST	Newly Identified Positive (APR FY 2018) HTS TST POS	Newly initiated on ART (APR FY 2018) *TX_NEW*
Adults			
TB Patients	37,996	14,622	15,044
Pregnant Women	839,877	27,442	23,191
VMMC clients	Not Available	Not Available	Not Available
Key populations	Not Available	Not Available	Not Available
Priority Populations	Not Available	Not Available	Not Available
Other Testing	4,943,142	361,865	337,429
Previously diagnosed and/or in care	Not Available	Not Available	Not Available
Total Adults	**4,163,151**	**280,423**	**278,104**
Pediatrics (<15)			
HIV Exposed Infants	42,900	1,101	1,101
Other pediatric testing	1,251,033	19,474	16,553
Previously diagnosed and/or in care	Not Available	Not Available	Not Available
Total Pediatrics	**1,293,933**	**20,575**	**17,655**

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Population size estimate (SNUs): 10-29yrs	Target - VMMC_CIRC (FY17)	Current coverage (end of FY2017)	Target - VMMC_CIRC (FY18); 10-29yrs	EIMC (FY18): <1 yr	Expected coverage: 10-29yrs (end of FY2018)
Bariadi DC	54,975	0	30%	23,981	0	80%
Biharamulo DC	64,215	0	25%	22,196	0	80%
Bukoba DC	57,642	21,687	68%	817	0	80%
Bukoba MC	28,883	0	119%	9,628	490	152%
Bukombe DC	46,788	0	96%	5,835	992	109%
Busega DC	41,156	15,574	106%	0	807	106%
Chato DC	75,156	21,442	62%	11,045	0	80%
Chunya DC	59,860	10,444	88%	4,485	1,087	95%
Geita DC	147,117	19,757	38%	52,213	0	80%
Geita TC	21,777	0	163%	7,802	0	198%
Igunga DC	79,824	22,577	88%	5,541	1,637	95%
Ileje DC	24,947	0	49%	4,795	0	80%
Ilemela MC	75,719	9,618	32%	5,599	0	80%
Iramba DC	47,273	0	44%	17,018	0	80%
Iringa DC	52,589	6,348	111%	0	797	111%

Iringa MC	36,647	5,179	80%	2,044	0	85%
Itilima DC	59,974	0	30%	26,050	0	80%
Kahama TC	52,112	18,546	102%	12,672	921	126%
Kalambo DC	40,494	0	45%	10,095	0	70%
Kaliua DC	82,111	27,423	73%	5,836	0	80%
Karagwe DC	69,236	13,906	41%	8,900	0	80%
Kibondo DC	52,224	0	38%	21,934	0	80%
Kigoma Ujiji MC	48,471	0	38%	20,358	0	80%
Kilolo DC	45,729	4,928	91%	1,994	649	95%
Kilombero DC	83,456	0	44%	30,044	0	80%
Kishapu DC	55,812	20,206	100%	0	1,040	100%
Kwimba DC	81,571	22,731	51%	3,201	0	80%
Kyela DC	46,046	22,983	85%	4,444	703	95%
Kyerwa DC	65,268	0	15%	29,106	0	80%
Ludewa DC	27,495	0	111%	2,245	412	119%
Magu DC	60,666	6,946	61%	3,168	0	80%
Makambako TC	20,454	10,262	81%	2,840	278	95%
Makete DC	19,775	0	99%	1,462	247	107%
Maswa DC	70,459	25,758	114%	0	1,349	114%
Mbarali DC	59,916	15,158	55%	5,003	0	80%
Mbeya City Council	89,729	35,586	83%	10,884	1,189	95%
Mbeya DC	62,558	0	210%	0	1,001	210%
Mbinga DC	74,838	2,302	78%	1,497	0	80%
Mbongwe DC	40,482	0	37%	16,730	0	80%
Mbozi DC	95,193	16,342	53%	8,060	0	80%
Meatu DC	58,610	0	30%	19,308	0	80%
Missenyi DC	42,103	9,234	39%	6,659	0	80%
Misungwi DC	70,979	16,785	41%	4,845	0	80%
Mlele DC	9,895	0	89%	31,619	0	408%
Momba DC	35,883	0	118%	0	894	118%
Mpanda DC	35,597	0	72%	7,815	0	94%
Mpanda TC	21,910	3,859	66%	1,687	0	80%
Msalala DC	51,497	20,000	39%	21,197	0	80%
Mufindi DC	55,744	0	113%	741	834	114%
Muleba DC	110,306	12,618	84%	11,633	1,891	95%
Musoma DC	34,821	0	44%	12,535	0	80%
Mvomero DC	62,074	0	44%	22,347	0	80%
Namtumbo DC	40,293	0	0%	32,234	0	80%
Ngara DC	61,423	0	12%	32,097	0	80%
Njombe DC	17,504	0	250%	5,835	253	284%
Njombe TC	29,132	7,149	88%	2,115	331	95%
Nkasi DC	54,974	9,901	79%	2,174	0	83%
Nyamagana MC	81,736	11,115	26%	7,627	0	80%
Nyang'hwale DC	30,910	0	0%	24,728	0	80%

Nyasa DC	28,876	0	0%	23,101	0	80%
Nzega DC	83,716	21,766	91%	3,626	1,672	95%
Rungwe DC	55,227	9,997	55%	11,465	0	80%
Sengerema DC	137,373	9,078	52%	5,029	0	80%
Shinyanga DC	66,626	20,325	83%	3,831	1,351	89%
Shinyanga MC	36,064	3,364	109%	692	520	111%
Sikonge DC	37,144	0	73%	3,823	0	83%
Singida DC	45,309	0	44%	16,311	0	80%
Songea DC	35,726	13,482	38%	15,099	0	80%
Songea MC	44,383	10,347	23%	25,160	0	80%
Sumbawanga DC	59,663	19,958	120%	0	1,390	120%
Sumbawanga MC	46,674	7,419	79%	1,178	0	81%
Tabora MC	51,510	13,518	72%	4,118	0	80%
Tarime DC	52,926	0	44%	19,053	0	80%
Tunduma TC	21,240	5,399	67%	1,097	0	80%
Tunduru DC	57,800	12,029	21%	34,211	0	80%
Ukerewe DC	68,829	0	21%	13,713	0	80%
Urambo DC	41,243	0	105%	1,609	0	109%
Ushetu DC	55,788	17,454	32%	12,672	0	80%
Uyui DC	81,008	28,898	73%	5,291	0	80%
Wanging'ombe DC	32,650	13,165	84%	3,731	459	95%
Total/Average	**4,363,804**	**672,563**	**68%**	**866,552**	**23,196**	**98%**

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	**Population Size Estimate** (scale-up **SNUs)**	**Coverage Goal (in FY 2017)**	**FY 2018 Target**
MSM	20,802	65%	13,521
FSW	107,604	85%	91,463
AGYW	245,599	85%	171,919
PWID	6,365	70%	5,410
TOTAL			

Table 4.1.4 Targets for OVC and Linkages to HIV Services

SNU	**Categorization**	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY 2018 Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY 2018 Target) OVC**

Kinondoni MC	ScaleUp Sat	129,071	75,894	60,715
Temeke MC	ScaleUp Sat	108,607	39,034	31,227
Ilala MC	ScaleUp Sat	94,486	42,330	33,864
Geita DC	ScaleUp Sat	79,171	48,434	38,748
Mbeya City Council	ScaleUp Sat	47,725	21,017	16,814
Mbozi DC	ScaleUp Sat	43,002	22,152	17,722
Sengerema DC	ScaleUp Sat	39,436	26,148	20,918
Igunga DC	ScaleUp Sat	38,013	15,113	12,090
Uyui DC	ScaleUp Sat	37,602	2,492	1,994
Kaliua DC	ScaleUp Sat	37,050	2,456	1,964
Chato DC	ScaleUp Sat	35,633	2,362	1,889
Kilosa DC	ScaleUp Sat	34,581	2,292	1,833
Bunda DC	ScaleUp Sat	32,990	5,442	4,353
Mbinga DC	ScaleUp Sat	31,039	19,548	15,639
Kilombero DC	ScaleUp Sat	30,255	5,986	4,789
Shinyanga DC	ScaleUp Sat	30,177	8,541	6,833
Morogoro MC	ScaleUp Sat	30,139	21,494	17,195
Mufindi DC	ScaleUp Sat	30,051	7,965	6,372
Mbarali DC	ScaleUp Sat	29,719	12,278	9,822
Rungwe DC	ScaleUp Sat	29,632	9,992	7,993
Lushoto DC	Attained	29,485	-	-
Moshi DC	ScaleUp Sat	28,713	24,263	19,411
Muleba DC	ScaleUp Sat	28,705	9,510	7,608
Mbeya DC	ScaleUp Sat	28,656	13,007	10,406
Chunya DC	ScaleUp Sat	28,566	7,571	6,057
Nyamagana MC	Attained	28,269	13,584	10,867
Iringa DC	ScaleUp Sat	28,023	8,638	6,910
Ilemela MC	ScaleUp Sat	27,038	4,638	3,710
Songea MC	ScaleUp Sat	26,020	10,541	8,432

Tabora MC	ScaleUp Sat	25,357	23,950	19,160
Msalala DC	ScaleUp Sat	24,831	24,811	19,849
Kishapu DC	Attained	24,717	2,293	1,835
Dodoma MC	ScaleUp Sat	24,464	9,726	7,781
Kwimba DC	ScaleUp Sat	24,104	2,604	2,083
Rorya DC	ScaleUp Sat	24,083	3,396	2,717
Kahama TC	ScaleUp Sat	23,932	14,499	11,599
Bagamoyo DC	ScaleUp Sat	23,787	6,824	5,459
Kilolo DC	ScaleUp Sat	23,628	8,586	6,869
Nzega DC	ScaleUp Sat	23,391	19,895	15,916
Maswa DC	ScaleUp Sat	22,998	1,525	1,220
Arusha City Council	ScaleUp Sat	22,955	5,949	4,759
Mvomero DC	ScaleUp Sat	22,809	2,262	1,810
Iringa MC	ScaleUp Sat	22,574	11,967	9,574
Nkasi DC	ScaleUp Sat	22,456	3,249	2,600
Bukombe DC	ScaleUp Sat	22,213	1,471	1,177
Sumbawanga DC	ScaleUp Sat	22,036	12,848	10,278
Wanging'ombe DC	ScaleUp Sat	21,287	4,333	3,466
Manyoni DC	ScaleUp Sat	20,912	3,223	2,578
Kyela DC	ScaleUp Sat	20,817	11,334	9,068
Njombe TC	ScaleUp Sat	20,664	7,232	5,786
Misungwi DC	ScaleUp Sat	20,492	2,639	2,111
Uvinza DC	ScaleUp Sat	20,400	601	480
Tanga City Council	ScaleUp Sat	19,282	6,420	5,136
Momba DC	ScaleUp Sat	19,174	725	580
Ushetu DC	ScaleUp Sat	19,061	26,194	20,955
Ludewa DC	ScaleUp Sat	18,711	5,015	4,012
Rufiji DC	ScaleUp Sat	18,576	5,701	4,561
Karagwe DC	ScaleUp Sat	18,012	3,017	2,414
Sumbawanga MC	ScaleUp Sat	17,990	9,344	7,475
Magu DC	ScaleUp Sat	17,780	2,062	1,650

Mkuranga DC	ScaleUp Sat	17,594	9,587	7,670
Shinyanga MC	ScaleUp Sat	16,965	12,227	9,782
Moshi MC	Attained	16,926	-	-
Makambako TC	ScaleUp Sat	16,659	-	-
Kigoma Ujiji MC	ScaleUp Sat	16,618	7,067	5,654
Iramba DC	ScaleUp Sat	15,651	2,071	1,656
Masasi DC	ScaleUp Sat	15,524	966	773
Bukoba DC	ScaleUp Sat	15,223	6,657	5,326
Songea DC	ScaleUp Sat	14,695	4,948	3,958
Kibondo DC	ScaleUp Sat	14,461	622	497
Busega DC	ScaleUp Sat	14,114	141	113
Arusha DC	ScaleUp Sat	13,790	2,542	2,034
Tunduru DC	ScaleUp Sat	13,195	2,016	1,613
Tunduma TC	ScaleUp Sat	13,195	1,847	1,478
Kibaha TC	ScaleUp Sat	13,080	8,411	6,729
Nyasa DC	ScaleUp Sat	12,376	1,043	834
Makete DC	ScaleUp Sat	12,141	5,949	4,759
Newala DC	ScaleUp Sat	12,121	850	680
Njombe DC	ScaleUp Sat	11,995	7,305	5,844
Meru DC	ScaleUp Sat	10,777	-	-
Missenyi DC	ScaleUp Sat	10,575	2,555	2,044
Muheza DC	Attained	10,398	-	-
Bukoba MC	ScaleUp Sat	9,618	-	-
Mpanda TC	ScaleUp Sat	8,541	2,330	1,864
Handeni TC	Attained	7,372	-	-
Mjini	ScaleUp Sat	6,175	680	544
Chake Chake	Attained	4,793	-	-
_Military Tanzania	Mil	-	1,680	1,344
Nsimbo DC	ScaleUp Sat	-	-	-
	Total	**2,239,917**	**807,913**	**646,331**

4.2 Priority Population Prevention

Activities addressing key and priority populations are implemented consistently regardless of whether a council is classified as Scale-Up, Sustained, or Attained. As noted above and described below, GOT policy shifts may impact these activities significantly. PEPFAR/T has set targets for key and priority populations in selected Attained and Sustained councils with known hotspots. These councils account for 17% of the KP_PREV targets in COP 2017. In Scale-Up Councils, PEPFAR/T targets key and priority populations, including sex workers (SW), men who have sex with men and transgender women (MSM/TG), persons who inject drugs (PWID), AGYW, and at-risk individuals in these sexual networks. To accelerate epidemic control, and informed by available data, PEPFAR/T will implement programs for key and vulnerable populations on HTS, condom provision and promotion, ART, PMTCT, and targeted community prevention interventions, including addressing gender norms and gender-based violence. Additionally, within the context of DREAMS, through structural interventions, social asset building, and economic strengthening, interventions are layered to ensure that vAGYW are reached with multiple and appropriate interventions to reduce their HIV risk.

Linkage and retention to ART remains the main area of focus for those identified as living with HIV, with the ultimate goal of achieving and sustaining viral suppression. Priority population prevention complements the PEPFAR/T clinical portfolio targeting hotspots with concentrations of key and priority populations to facilitate effective epidemic control in the country. The portfolio has set targets in select Scale-Up Councils where there are existing hotspots.

The policy environment for KP programming in Tanzania has been unstable since June 2016, with the GOT banning essential components of HIV prevention interventions, such as distribution of water-based lubricant and peer outreach for MSM. Concurrent raids on organizations suspected of promoting MSM and apprehending individuals suspected to be MSM or sex workers have driven many of KP into seclusion. Program data tracking quarterly performance trends have reflected this impact showing a dramatic drop in numbers of people reached, along with a corresponding decline in positive testing yield, which reflects failure to reach the highest risk individuals. The evolving situation is driven by socio-cultural, legal, and political factors against homosexuality. MOHCDGEC is responding by revising the national guidelines for health and HIV interventions among key and vulnerable populations. These are due for release in February 2017, though they have been delayed multiple times. Proposed targets for key and priority populations in COP 2017 were developed in consultation with stakeholders, including civil society, PEPFAR/T IPs, UN, GFATM, and the GOT, with the understanding that the revised guidelines will be grounded in evidence-based public health programming.

Project data from IPs indicate that 125,950 (168% of the target) KPs were reached with core intervention packages during FY 2016. For those KPs reached, 108,284 (86%) were tested for HIV during the implementation period, 7,153 (7%) were identified positive, and 3,870 (54%) were linked to ART. Recognizing the importance of identifying and linking KP living with HIV, PEPFAR/T worked with partners to improve positive testing yield to 12% in FY 2016 Q3; however, gains were reversed due to the aforementioned political issues and unfavorable policy environment. Interventions that have shown success in increasing yield among KP include: peer-

driven interventions, such as sexual and social network-based testing; incentivized referral and testing; as well as outreach services that include HTS and ART.

Given the FY 2016 performance, updated data on population estimates and information on hotspots, PEPFAR/T developed more ambitious targets in COP 2017 aiming for saturation and expansion to additional hotspots. This includes plans to rollout pre-exposure prophylaxis (PrEP) in 11 Scale-Up Councils, targeting female sex workers. PEPFAR/T will also explore the use of self-testing in demonstration projects to reach KPs, partners and other at-risk populations in selected geographic areas for key and priority populations in two locations. In addition to routine technical assistance as part of managing IMs and program engagement, PEPFAR/T will apply the new partner management model to monitor performance along the HIV prevention-treatment cascade each quarter at site, SNU, and IM levels, with immediate remediation where performance is below expectation.

PEPFAR/T will use enhanced strategic information (SI) methods to monitor coverage of services for key and priority populations through continuous mapping and enhanced monitoring and evaluation, which will provide localized population estimates and service data for sub-populations. The PEPFAR/T team is working with the GOT to safely roll out the national KP M&E system and unique identifier system that will facilitate case-based monitoring to allow confidential tracking of beneficiaries across the continuum of HIV prevention and care services without jeopardizing their anonymity and, ultimately, their safety. In COP 2017, PEPFAR/T will support the GOT to adopt the total market approach for condoms, including complementary support to meet the needs beyond GFATM support for the procurement of supplemental supply of male and female condoms, for both socially marketed and free public sector condoms. Support for condom programming will remain national in scope, yet condom promotion activities will be limited to Scale-Up Councils where targets are set for comprehensive prevention interventions.

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

The DREAMS program is also a large piece of PEPFAR/T's key and priority population portfolio. DREAMS delivers a comprehensive set of evidence-based biomedical, behavioral, and structural interventions which have been proven to reduce the risk of HIV amongst vulnerable adolescent girls and young women (vAGYW). The DREAMS Tanzania implementation model in Tanzania leverages the capacity of three key partner types; OVC, Community Prevention and Clinical/Facility to ensure young women are identified and supported across services between the community and facility within 3 regions and 7 priority councils (Temeke, Kahama TC, Shinyanga MC, Ushetu, Msalala, Kyela and Mbeya CC). This year, with the additive funds DREAMS will go deeper, by expanding coverage (wards) within the same SNUs to reach 80% coverage meaning that by the end of the implementation year, these councils will have fully saturated the target population. The primary beneficiaries for DREAMS Tanzania are split into 3 distinct age categories; 10-14 OVC in-school, 15-19 sexually active and 20-24 engaged in compensated sex. For COP 2017, DREAMS will continue to target

vAGYW and their sex partners, however also more broadly there will be enhanced focus on reaching and improving access to services for both men and women under 30.

The modality for identification of vAGYW is differentiated between the 10-14 and the 15-24 age-groups. For age 10-14, girls are identified through the OVC partner (8,000) and the schools that are reached are located in areas where there is a high OVC burden. While this is not the primary target for DREAMS they are a critical impact group if the goal is to change the trajectory of the epidemic. It is for this reason that for this sub-population, the DREAMS focus is on keeping OVC girls in school, accessing basic SRH education and providing their families with skills and links to support systems from the expanded OVC package which strengthen the family. In 2016, primary and secondary schools were mandated by law to be free and therefore the program shifted its focus to supporting the 'hidden' costs of education such as uniforms and testing fees which remain financial barriers.

The identification of vAGYW age 15-24 are supported through a variety of community based entry points (CBHTC, economic strengthening, vAGYW Resource Centers etc.). A locally developed Vulnerable Adolescent and Young Woman's index (vAGYW index) determines eligibility based on HIV risk behavior. In COP 2017, both prevention partners will be using this tool as it has been piloted and adapted. Once a girl completes the screening and if eligible is then enrolled into the program. The economic strengthening platform has been a key draw for sustained participation because young women are immediately connected with their peers centered on economic activity. This platform is also the vehicle to deliver the layering of programing including parenting education, financial literacy and entrepreneurial skills. In COP 2016 as per the initial DREAMS guidance, cash transfers were administered in select wards. In COP 2017, PEPFAR/T will place a stronger emphasis on economic empowerment through skills building, business assistance, and access to acceleration funds within the savings groups to facilitate sustained financial independence of the young women.

Also within the community, vAGYW are reached through targeted community-based HIV testing and counselling (routes based on hot spots), which includes FP provision and screening for STIs, TB and GBV. PEPFAR/T aims to ensure that of girls 100% (55,036) who receive BCC through Stepping Stones (PP_PREV) will also receive, at a minimum, two other interventions including HTC (HTC_TST) and gender norms change through SASA! (GEND_NORM).

At the facility, DREAMS works to improve adolescent friendly health services. Within each SNU, DREAMS facilities have been identified based upon a core set of criteria which included existing adolescent utilization data, the availability of comprehensive set of a range of relevant health services including (HIV, FP & GBV) and the presence of ACT to ensure the ease of the transition of HIV+ adolescents into care. A rapid assessment of adolescent-friendly health services (AFHS) within these facilities provided Partners and GOT counterparts with a baseline for improving the friendliness and quality of services. In addition to the provision of commodities and tools, clinic providers are trained on minimum standards for AFHS and GBV and to ensure quality and supportive supervision is conducted with Regional Health Management Teams (RHMT) and CHMTs. This year DREAMS AFHS facilities will also be supported to extend clinic hours to times that are convenient for young adults under 30 and men, as well as to have peer navigators within the facility to make services more 'friendly' to the target population.

In order to reach male sex partners, and more broadly men under 30, DREAMS leverages the testing and VMMC programs to deliver a tailored package composed of community based gender transformative education, targeted outreach through BCC SMS messages, and links to HTC, VMMC. The targeting is informed by the Characterization of Male Sex Partners Strategy which guides the testing and prevention partners how and where partners reach out to men.

The following tables below reflect the distinct core packages for the DREAMS target population. There are nuances in the 15-24 where while it may be the same intervention, the groups are distinct and separated by age.

Sub-Pop	Intervention
Age 10-14 (OVC in school)	Post-Violence Care
	School-Based HIV & Violence Prevention
	HTC (Clinic)
	Education Support
	Parenting/Caregiver Programs (targeting their parents)
	Social Asset Building

Sub-Pop	Intervention
Age 15-19 (Out of School) Age 20-24 (Transactional sex)	HIV Testing & Counseling (Community)
	HIV Testing & Counseling (Clinic)
	Condom Promotion & Provision
	Post-Violence Care (Clinic)
	Increase Contraceptive Method Mix
	Comm Mob & Norms Change- SBCC
	Comm. Mob & Norms Change- Community- SASA!
	Parenting/Caregiver Programs for parents of adolescents (15-19) & young mothers (15-24)
	Economic Strengthening (age specific)
	Characterization of Male Partners

DREAMS unit expenditures are based on a combined set of non-traditional additive interventions. It is for this reason that there are additive costs to the UE.

4.3 Voluntary Medical Male Circumcision (VMMC)

The male circumcision (MC) rate in Tanzania in 2011-2012 was 72% nationally, with regional estimates ranging from 30% to 99% (THMIS 2011/2012). The Tanzania National HIV Prevention Strategy (2009/2010) and the National Country Operational Plan for VMMC highlights VMMC as a priority intervention in key geographic locations to prevent new HIV

infections. Specifically, PEPFAR/T prioritizes VMMC in councils with low MC coverage and high HIV prevalence, including all DREAMS councils. Overall, it is anticipated that by the end of FY 2017, PEPFAR/T will have supported 2,732,041 VMMCs in the 10-29 year age band and that the cumulative number of VMMCs performed with PEPFAR support is expected to be 3,598,593 by October 2018.

While VMMC is capable of reducing HIV acquisition among males of all ages, results vary by age group in terms of immediacy and magnitude of HIV incidence reduction. PEPFAR-supported VMMC prioritizes age groups that yield both the highest magnitude and most immediate reduction in HIV incidence. Following an intensive modeling exercise in FY 2016, Tanzania data indicate that a focus on 10-29 year old males will obtain maximal impact for both short- and long-term impact. This focus was also supported by follow-up modeling that recommended three scenarios to optimize VMMC and ART in Scale-Up and Sustained Councils (Avenir Health, 2016).

The COP 2017 strategy is to maintain high coverage among 10-29 years in councils where circumcision coverage already exceeds 80% and achieve 80% coverage in councils where circumcision coverage is lower. In FY 2018, the program will expand into eight new councils (Iramba DC; Singida DC; Kilombero DC; Mvomero DC; Kibondo DC; Kigoma Ujiji MC; Tarime DC; and Musoma DC) for a target of 159,601 VMMCs. These are councils with low MC coverage that have migratory occupations, which attract young men and are known to be HIV transmission hotspots. Given substantial passive demand among males in the 10-19 year age cohort, all demand activities in COP 2017 will exclusively focus on reaching males aged 20-29. Overall, scale up of VMMC will continue in FY 2018 to reach and maintain saturation in all strategic councils (i.e. 2 Attained, 57 Scale-up to Saturation, and 19 Sustained), targeting 866,552 boys and men. These details are summarized in the table below.

Modeling indicates that PEPFAR/T has already reached VMMC coverage of ≥ 80% in the majority of councils across the priority age groups, and this will increase coverage of ≥ 80% to all councils by end of FY 2018. Based on the level of program maturity, plans for COP 2017 will also focus on the transition process towards sustainability. This will involve site-level capacity building, GOT engagement, and support for the implementation of VMMC sustainability models informed by in-country experience (Jhpiego, FY 2016), as well as expanding EIMC (COP 2017 target is 23,196 EIMCs). The COP 2017 VMMC budget is informed by the unit cost of $74.24, informed by following considerations: $47.00 for service delivery; $15.24 for commodities; $5.00 for demand creation and $2.00 to support waste management. In FY 2018, quality VMMC services will be ensured by a strategic partner management process that includes SIMS, quality improvement technical assistance, as well as ministry-led external quality assurance (EQA) assessments.

4.4 Preventing Mother-to-Child Transmission (PMTCT) of HIV

Implementation of PMTCT activities are consistent regardless of whether a council is categorized as Scale-Up, Attained, or Sustained. Tanzania has been implementing the PMTCT Option B+ approach by providing lifelong ART to HIV-positive pregnant and breastfeeding women since October 2013. Since the introduction of Option B+ there have been no recent policy changes that impact the program. As of APR 2016, 4.9% (48,479) of pregnant women

who were tested at ANC clinics were found to be HIV-positive. Through PMTCT, PEPFAR/T identified and reported 54,404 HIV-positive women receiving ART. Efforts are underway to investigate and document reasons for these findings.

Approximately 76% of HIV-exposed infants were tested through the EID program. Of these, 984 (2.7%) were identified as HIV-positive by the age of 12 months. Data from the Site Improvement and Monitoring System (SIMS) visits indicates low rates of linkage to HIV care and treatment of HIV-positive infants.

In order to achieve the UNAIDS goals of eliminating mother to child transmission (MTCT) and epidemic control in Tanzania, PEPFAR/T has set ambitious PMTCT targets for Scale-Up Councils in COP 2017, with the goal of reaching 95% of pregnant women with HTS and initiate 95% of HIV-positive women on ART. PEPFAR/T is working with MOHCDGEC to revise the testing policy and introduce verification tests for women who test HIV-positive. Also, the policy will introduce repeat HIV testing in the third trimester for all pregnant women who tested negative in first trimester.

The package for PMTCT will be the same for Scale-Up, Attained, and Sustained Councils. PEPFAR/T will continue to support the provision of care and treatment to a diminishing cohort of pregnant women currently enrolled on ART at PMTCT sites through FY 2018 as patients are treated in a PMTCT sites. The goal for early infant diagnosis (EID) is to reach 95% of HIV-exposed infants with HIV testing by 12 months. Among the infants tested by 12 months, 80% will be tested by 2 months of age. The goal is to initiate 100% of eligible infants on ART treatment.

In COP 2017, PEPFAR/T has allocated resources to continue supporting PMTCT services to sites with at least ten HIV-positive women receiving services in the last twelve months. PEPFAR/T IPs will support Option B+ in HIV-positive pregnant and breastfeeding women in all settings, including adolescents, sex workers, and 18-30 year olds. IPs will target Scale-Up Councils for increased community outreach to: encourage antenatal care and HIV testing and treatment; ensure quality assurance (QA) in rapid testing; rely on mentor mothers for pregnant and breastfeeding women identified as HIV-positive to encourage adherence to ART and retention in care; monitor retention of pregnant and lactating mothers at 3, 6, 12, 24 months of starting ART by mother child-pair cohort; and increase testing at delivery and during breastfeeding to identify women who acquire HIV infection during this period.

To improve monitoring of HIV-exposed infants, PEPFAR/T is supporting the national program to implement mother-child pair follow-up appointments until the child is 18 months of age. Strategies to improve follow-up and retention will also include scaling up m-Health and web based PMTCT and EID reporting and tracking of mother infant pairs, increasing and improving a hub and spoke specimen delivery system approach to support EID and receipt of timely results, and building on EID and VL platforms by using VL to track outcomes in HIV-positive pregnant women, breastfeeding women, and infants. The program will provide friendlier PMTCT services for AGYW and deploy the Partnership for HIV Free Survival (PHS) that uses quality improvement (QI) methodologies to improve retention. Further support will include provision of infant ARV prophylaxis, CTX prophylaxis, and Isoniazid preventative therapy (IPT), if indicated. Supporting routine infant care, such as monitoring of growth and development and

infant feeding counseling, will also be of focus with an emphasis on improving routine monitoring and using program data to improve PMTCT program and performance and quality.

4.5 HIV Testing Services (HTS)

According to the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS, 2012), approximately 47% of men and 62% of women in Tanzania had ever been tested for HIV. In APR 2016, PEPFAR/T supported testing for 6,259,167 individuals and diagnosed 270,169 PLHIV. The average testing yield in APR 2016 ranged from 4.3% for PITC and community based testing to 31.5% in TB clinics. The HIV testing yield result for community-based testing in FY 2016 was 3.7% and 5.2% in facilities. The HIV testing yield varied across different service delivery points, with the highest yield observed for index clients at care and treatment clinics (CTCs) at 40%, followed by those attending TB clinics at 33.5%, and the lowest at mobile outreach at 3%. The outpatient department contributed 48% of the total HIV-positive people identified and mobile testing approaches resulted in a yield of 4.5%.

Program data indicate gender and age disparities in accessing HTS services. Facility HTS remains poorly accessible to adolescents, men, and key and priority populations. In addition, PITC implementation is largely limited to outpatient, TB, and PMTCT clinics, with limited coverage in other service delivery points. Community testing strategies have struggled to reach high risk populations, achieving only 3.7% yield in APR 2016 results despite efforts to focus on key and priority populations.

To improve the efficiency of PEPFAR/T-supported HTS activities, PEPFAR/T aims to continue supporting both PITC and CBHTC through mobile and outreach activities targeting hotspots and high risk and harder to reach populations. The program will use evidence-based, high yield strategies to identify PLHIV and link them to care and treatment services.

PEPFAR/T will continue to support GOT to implement six high yield HIV testing approaches in COP 2017: 1) partner notification plus; 2) targeted PITC to TB suspects; 3) targeted PITC among STI clients; 4) incentivized peer network testing; 5) increasing friendly services for men; and targeted OVC testing.

PEPFAR/T Improved Testing Strategies

1. **Partner Notification Plus:** IP efforts will focus on the sexual partner(s) and family members of PLHIV in both key and priority populations. In FY 2017, PEPFAR/T will work with facility and community-based partners to implement this model in Scale-Up Councils. A dedicated case manager will be added to clinical teams to manage partner referrals, handle facilitated disclosure, as well as enhance HIV linkage efforts.
2. **Targeted PITC to TB Suspects:** PEPFAR/T will work in collaboration NACP and the National TB and Leprosy Program (NTLP) to intensify HIV diagnosis for TB suspects in both outpatient department (OPD) and inpatient department (IPD) settings. PEPFAR/T will assist MOHCDGEC and PORALG to monitor the implementation of a site-level standardized process for tracking testing for TB suspects and their integration into HIV treatment services. Facility-based partners will be engaged to implement these strategies.
3. **Targeted PITC Among STI Clients:** COP 2017 will implement routine HIV testing for all STI patients attending outpatient facilities or specialized STI clinics where they exist.
4. **Incentivized Peer Network Testing:** Peer network testing targeting KP has been conducted by some IPs. COP 2017 will use program data from these KP programs from FY 2016 to implement incentivized peer testing strategies among key and priority populations, including STI patients and their sexual networks.
5. **Increasing friendly HTS services for men:** These services include: extending testing hours to weekends and evenings hours; integrating mobile testing with other health services such as hypertension, diabetes, and prostate screening to incentivize and reduce stigma associated with HIV testing; using community mobilizers to promote testing where men congregate (e.g. work place and sporting events); and placing a CTC staff member such as a nurse or medical officer on the outreach testing team to fast track the enrollment of men identified as HIV-positive into HIV treatment services.
6. **Targeted OVC Testing:** In COP 2017, the OVC program will continue rolling out the HTC eligibility screening tool, building on successes from FY 2017. This will ensure prioritization of CLHIV, ALHIV children exposed to HIV, and children of PLHIV at both clinical and facility levels.

These targeted approaches to HTS will be applied in both facility and community settings with a focus on locations reporting high HIV prevalence rates and low rates of HTS and ART coverage, as well as in concentrated hotspots. PEPFAR/T will engage MOHCDGEC, PORALG, and IPs in the design, implementation, and monitoring of these strategies, developing council-specific plans to achieve increased yield. PEPFAR/T will work with teams to support and monitor the implementation of these strategies through the partner management model and joint supportive supervision.

PEPFAR/T will also focus HTS services toward most at risk OVC (including vAGYW) who will be identified through several channels including social service providers who cater to children and families already affected or at high risk of HIV. Social welfare officers, Most Vulnerable

Children's Committees (MVCC), post-rape care centers, children's homes and institutions, and programs for street children will serve as important conduits. FSW and AGYW who test HIV-positive will be encouraged to bring in their children for testing. vAGYW are also aggressively targeted for testing through DREAMS activities.

The national HTS reporting tools will be modified to include these new testing strategies so that data can be tracked and used to inform program management and improvement. PEPFAR/T, in collaboration with MOHCDGEC and PORALG, is anticipating that the roll out of these new reporting tools will start in mid-2017 and will be fully completed by 2018. In addition, PEPFAR/T will strengthen partner management efforts by conducting reviews with all IPs to track their progress towards meeting all targets, with a special focus on testing, yield, and new ART patient targets to support the national Test and Start policy. Performance plans will be developed for partners who are not on track to meet their targets. These plans will include strategies for better targeting of services to increase the yield and coverage of HTS.

PEPFAR/T will also provide support to the GOT to improve the overall quality of the HTS program. This includes providing TA on strengthening linkages from HTS to ART programs for individuals diagnosed as HIV-positive in support of the Test and Start policies, as well as linkage to male circumcision and other prevention services for individuals testing HIV-negative.

Finally, PEPFAR/T will support a number of above-site activities to improve HTS. This includes supporting the MOHCDGEC to develop a standardized and coordinated QA system for HTS, with a focus on improving quality control for HIV testing performed by health care providers and trained lay counselors. PEPFAR/T will also work with MOHCDGEC and other stakeholders to address policy barriers and create an enabling environment that will ensure PEPFAR/T support is fully aligned with national priorities and the 2015 WHO HTS recommendations.

Currently, HIV self-testing has not yet been incorporated into the HIV testing policy in Tanzania, and the age of consent for HIV testing is 18 years old. PEPFAR/T will engage MOHCDGEC, PORALG, TACAIDS, and other key stakeholders from ministries and lawmakers (via the Parliamentarians Against AIDS group) in a series of policy/advocacy dialogues around these two key policy issues with the goal of identifying concrete steps that can be taken to endorse the adoption of supportive policy frameworks including updating the National HTS guidelines. Specifically, PEPFAR/T will continue to advocate with GOT to lower the age of consent in order to increase HTS access among AGYW. Age of consent is part of the national HIV and AIDS law, and the MOHCDGEC wants to amend the entire law to address age of consent and other related issues. Building on implementing partner technical assistance provided in FY 2017, the law will be amended and PEPFAR/T will work to help ensure parliamentary approval.

Specific strategies for improving linkage to care will include:

- Co-locating services (HTS and ART provided in the same room or under the same roof);
- Intensified post-test counseling to emphasize the importance of seeking early treatment;
- Use of expert patients or peer navigators to physically escort newly diagnosed PLHIV to the CTC;

- Use of a mobile phone texting platform to provide additional post-test counseling messages to newly diagnosed PLHIV and remind them to enroll in care;
- Use of community health workers or appropriately trained lay counselors to follow up with clients who fail to self-enroll within 30 days of an HIV diagnosis;
- Introducing a QI strategy with all HTS partners to encourage them to use their program data to improve linkage to care rates;
- Supporting NACP to develop unique identification code to facilitate tracking of patients across health services; and
- Scaling-up best practices from operational research, including the Behavioral Combination Prevention Evaluation (BCPE) – Linkages and Case Management models that foster patient centered clinical management to improve linkages to care and retention.

4.6 Facility and Community-Based Care and Support

PEPFAR/T will support the implementation of evidence-based approaches to optimize linkage and adherence to ART to promote viral suppression. At the facility level, with a continued focus on Test and Start, PEPFAR/T will work with the GOT to ensure that all patients in care are initiated on treatment. PEPFAR/T will work with GOT to roll out differentiated service models to maximize efficiencies and to ensure alignment with the revised National Guidelines for the management of HIV. The new service delivery model will include: optimized ARV regimens geared toward early identification of patients who may need enhanced medication adherence counseling and/or optimized second line ARV regimens in order to achieve viral load suppression in pursuit of the third 90, decentralized ARV pick-ups at community dispensaries, multi-month prescriptions, and clinical visits every three to six months for stable patients.

These services will not differ between Attained, Scale-Up, and Sustained Councils and will include regular clinical and laboratory monitoring and VL monitoring as per the VL roll out strategy with gradual phase out of CD4 monitoring until roll out reaches all facilities. Other services include screening for active TB and provision of CTX prophylaxis for those who are eligible.[5] Additionally, in COP 2017, PEPFAR/T will continue to support cervical cancer services at the existing PEPFAR-supported health facilities. Through clinical implementing partners cervical cancer screening services will be maintained, and women in need of referrals for advanced investigations or management will be supported.

To increase access to quality, sustainable HIV service delivery, PEPFAR/T is leveraging the 2016 Task Sharing policy by increasing the use of PLHIV and peer support groups to better link clients to care and retain them on treatment. Focus will be given to strengthening the system to establish unique identifier codes (UIC) for all PLHIV to enable the program to track patients throughout the cascade. Support will be provided to organize clinics in a way that they can accommodate men's special needs in an effort to increase men's enrolment, *e.g.*, tailored clinic hours on evenings or weekends (while addressing concerns that may arise regarding clinic congestion), fast tracking men, and linking newly identified HIV-positive men with peer networks of expert HIV-positive men for immediate support and follow up. In addition,

[5] CTX procurement is planned to be supported by GOT through the essential medicines budget.

PEPFAR/T will increase efforts to provide tailored services to adolescents and young adults less than 30 years of age such as child- and adolescent-friendly clinics and mobile outreach to colleges in order to increase the reach of the program.

PEPFAR/T will also re-evaluate and re-allocate PEPFAR/T HRH investments to maximize meaningful support to highest burden councils and highest volume sites. The strategic shift to focus on evidence-based strategies in Scale-Up Councils, which includes strengthening bi-directional referrals and linkage for new clients and improving retention and adherence of existing clients in high volume sites, will continue in COP 2017.

Approaches in Scale-Up Councils will focus on community services and will roll out use of trained lay counselor testing at the community level to ensure access to quality, sustainable community based HIV services. IPs will train community support groups or volunteers to support adherence to ART and TB medication, identification and referral of PLHIV, TB suspects and GBV victims, commodities monitoring and management at the community level, and to strengthen social–economic support among other relevant services. To increase civil society participation in the national HIV response IPs will support quarterly CSO meetings at regional levels. In Scale-Up Councils PEPFAR/T will monitor this work through partner meetings, supportive supervision visits, quarterly data reviews, and close monitoring and remediation through SIMS. This work, however, could be affected by the pending KP guidelines and by how GOT follows through on efforts to limit community-based services.

For Scale-Up Councils in COP 2017, PEPFAR/T has reformed community care programming to focus primarily on the initial 12 months from when an individual has been identified positive to ensure that they are actively linked (ALTC) to treatment programs and retained on ART. For Attained and Sustained Councils, PEPFAR /T facility partners will implement community care interventions focused primarily on ensuring that all individuals who have been identified as HIV-positive are linked to treatment programs and retained on ART. Across all councils, with the continued roll out of Test and Start, all new HIV-positive patients will continue to immediately be initiated into ART programs. However, Test and Start alone cannot be relied upon to increase retention. To improve retention, PEPFAR/T will implement the evidenced-based approaches outlined in the table below:

	Scale-up	**Sustained & Attained**
Appointment and tracking registers with emphasis on early tracking of missed appointments, block appointments (through the Promise to Come Initiative);	X	X
Link all new patients to available CHW/HBC providers	X	
Use of mHealth (SMS reminders) to follow up clients	X	X
Promotion of patient peer support groups to enhance medication adherence, retention and disclosure	X	X
Roll out of family-centered care clinics and family days (same appointment for family)	X	X

Tailored adherence and retention activities for adolescents and young adults under 30 yrs, men, pregnant women and key populations	X	X
Community mobilization and empowerment activities that will ensure that ART services are available at the lowest level of health facility possible and increase health literacy to address stigma, discrimination, and violence.	X	
CHW/HBC provider to track and re-engage those lost to follow-up (LTFU)	X	

Implementation of interventions to strengthen effective retention will improve follow up of PLHIV health status, including VL or CD4 results. This will complement ongoing efforts to improve the central database of clients, which will enable the program to determine the number and percentage of patients who receive VL or CD4 count, and EID at national and subnational levels.

4.7 Tuberculosis (TB)/ HIV

TB/HIV activities are implemented consistently across scale-up, sustained, and attained councils. The TB program will continue to scale up TB/HIV collaboration to ensure HIV testing among TB patients and patients with suspected TB. PEPFAR/T will target HIV testing to patients with suspected TB found in outpatient and inpatient departments. Facility-based implementing partners will also work with MOHCDGEC to develop site-level standardized procedures to monitor and track testing of patients with suspected TB. The TB program will also update the M&E system to capture clients with chronic cough through a cough registry. Both baseline and follow-on data will be collected and analyzed. All those found to be co-infected with HIV and TB will be initiated on ART and TB treatment promptly. Additionally, the program will strengthen TB Infection Control measures in all facilities by paying attention to the practical, administrative, environmental, and personal protection activities to curb the spread of TB. This will include cough etiquette and use of N95 masks. In addition, special attention will be directed towards the suitability of the spaces used as TB and HIV clinics.

TB screening among PLHIV will continue to be implemented to the last mile of the diagnostic cascade and those found eligible for IPT will be initiated. In Tanzania, the policy that allows the provision of Isoniazid Preventive Therapy (IPT) to PLHIV was adopted in 2013. The policy recommends the use of Isoniazid as prophylaxis for six (6) months for all PLHIV (including children 12 months and older, or less than 12 months with a known TB contact) in whom active TB has been excluded. However, to date, IPT uptake has not been implemented to scale. Currently only 512 health facilities out of 1600 provide IPT, of which only 2% of the eligible PLHIV were put on IPT at the 512 facilities in 2015 (NACP Annual Report, 2015). Isoniazid is procured through the Global Fund. Barriers to scale up include procurement and logistics challenges. Ongoing efforts to address these barriers in FY 2017 include robust scale up of IPT to all eligible PLHIV and to all HF providing care services. PEPFAR/T will work with GOT and IPs to ensure the proper procurement and distribution in line with the ARV commodities.

Data for reporting on tuberculosis prevention will be collected in care settings using IPT registers and the CTC2 database to capture the regimen, duration, completion rate outcome, adverse events and associated test results. PEPFAR partners will provide additional training to staff expected to provide IPT and to support implementation and ensure adequate reporting. PEPFAR/T will monitor implementing partners quarterly for progress.

TB/HIV services have been scaled up in all regional and district hospitals and in a majority of lower facilities. PEPFAR/T will continue to support supportive supervision and mentoring to health care workers on HIV testing with a goal of 100% HIV testing among all patients diagnosed with TB. PEPFAR will also support HIV testing among presumptive TB patients as a high yield intervention, as well as support scale-up of integrated provision of ART in TB clinics to ensure 100% ART initiation among HIV-positive TB patients.

Tanzania has finalized TB guidelines which include the roll out and a sustainability plan for molecular technology; the Gene Xpert MTB/RIF which will enhance TB case diagnosis as well as detection of multidrug resistant (MTB/RIF) TB patients. In COP 2017, PEPFAR/T will continue to support the calibration of 15 Gene Xpert machines, replacement of modules when the need arises as well as the procurement of cartridges for the 50 Gene Xpert machines procured by PEPFAR/T implementing partners and other sources of funding, including the GFATM. Tanzania currently has a total of 73 machines. In COP 2017, PEPFAR will support MOHCDGEC and PORALG to strengthen and conduct quality assurance activities in TB clinics and to strengthen HIV testing.

4.8 Adult Treatment

In FY 2017, the PEPFAR/T adult ART program continues to realign its approach to support the attainment of the UNAIDS 90-90-90 targets. In COP 2017, PEPFAR/T will continue to focus its demand creation efforts in Scale-Up Councils with Attained and Sustained Councils focusing primarily on passive enrollment.

On October 1st 2016, the GOT issued a circular allowing heath care providers to implement Test and Start policy national-wide. The review of treatment guidelines to incorporate the Test and Start policy is underway. This will increase the number of clients who are eligible and in need of care and treatment services, hence providing wider ART coverage. PEPFAR implementing partners will focus on rapid adoption and implementation of the revised policy within all levels health care facilities. The current guidelines under revision will include several revised chapters including: (i) SDM; (ii) HIV testing; (iii) multi-month drug prescription; and (iv) optimized ARV regimens. These optimized regimens include introduction and use of newer, more efficacious regimens that include the 2nd generation NNRTIs (Etravirine –ETV), the 2ndgeneration PI (Duranavir-DRV) and integrase inhibitor (Dolutegravir-DTG, Raltegravir-RAL) especially as they become available as FDC. These measures are designed to mitigate health system challenges resulting from increased demand for services. In collaboration with MOHCDGEC and PORALG, the program is determined to continue to work with other stakeholders to adopt a model of service delivery where stable patients (i.e. on ART for >6 months with good adherence, no drug toxicities and no opportunistic infections) receive ARV

refills quarterly, and have clinical consultations twice per year. PEPFAR/T will support MOHCDGEC and implementing partners to roll out, monitor, and track its implementation. PEPFAR/T will continue to support the GOT in moving towards and scaling up same day ART initiation for newly diagnosed PLHIV through wide use of roving ART initiation teams.

The revised guidelines will also advise on the recommended number of clinic visits for stable, unstable, and new patients; drug refills; and clinical monitoring schedule. PEPFAR/T will continue to work with GOT to support ARV refill distribution points at designated village dispensaries, located in closer proximity to beneficiaries. PEPFAR/T plans to continue to explore promising models from other countries with GOT and other stakeholders. Adoption of differentiated SDM should allow the absorption of the expected patient increases and help to decongest high volume clinics. It is also expected to improve the quality of services provided.

PEPFAR/T expects to increase linkage and retention rates in COP 2017 from 72% (linkage) and 70% (for retention) to 85% for both. To increase linkage and retention PEPFAR/T will implement and track Test and Start and ART initiation through roving ART initiation teams, which has strong support from the MOHCDGEC. Additionally family centered care; identifying, documenting and sharing retention best implementation practices for scale up, standardization, and monitoring of SNU and IM-level retention cascade analyses by gender and age will also be implemented. PEPFAR/T will support expansion of web-based ECHO learning platform (Lab, TB, and HIV/TB) for clinical capacity building of health care providers in Scale-Up Councils.

In order to address low male enrolment (above 30 years difficult to reach men), IPs will support facilities to implement specialized Fast Track Services for men during regular clinics hours, which will include a case management model for men as well as flexible hours and a Saturday clinic, all the while addressing any issues related to potential clinic congestion. IPs will also use PMTCT clinics as ARV pick up points for men, peer support groups, and care and treatment outreach services for men (facility-HCW led) to increase coverage.

Additionally at the community level, IPs will use soccer and other sports- and youth-centered social events for advocacy for HIV testing, adherence to medication, and retention. The community programs will also adopt and implement programs to change harmful gender norms and provide male-friendly HIV services, such as the *Men as Partners program* conducted in South Africa. PEPFAR/T will also work with the MOHCDGEC and PORALG to spearhead a National Male Involvement Strategy.

PEPFAR/T will also employ strategies to increase enrollment of young adults (under 30 years) and adolescents. PEPFAR/T will collaborate with the Ministry of Education and TACAIDS to engage schools to implement strategies to facilitate ART adherence and retention for clients in this age group. IPs will use clinic hours that cater to children/adolescents in school, e.g. Saturday/evening hours (while still addressing any issues that may arise around clinic congestion) and will evaluate how children in boarding school currently access ART and what the challenges may be to adherence/retention. IPs will also strengthen AGYW specific activities at the facility by extending or allocating specific hours to attend PP (OVC and adolescents) and scaling up adolescent clubs and friendly services.

Widespread use of viral load testing and monitoring will help to improve adherence and better identify and serve stable patients. Therefore PEPFAR/T will strengthen clinical management and monitoring of PLHIV, and enhanced medication adherence counseling. PEPFAR/T will also increase the timeliness of VL testing and return of VL results to patients and their use by clinicians to improve client management. Moreover, effective community engagement, adherence to treatment, and quality of clinical care will be emphasized. These efforts will include new reporting systems, data quality improvement, and better use of data to improve programming at all levels and across the cascade using the continuous quality improvement approaches.

Successful implementation of these innovative and evidence-based approaches will enable PEPFAR/T to support GOT to initiate 360,030 new adults on ART and support a total of 1,245,251 patients currently on treatment by APR 2018. The targeted net new on ART in FY 2018 is 172,656 in Scale-Up Councils and 31,272 in Sustained Councils. All pre-ART adult patients are expected to be on ART following full adoption of Test and Start.

4.9 Pediatric Treatment

PEPFAR/T aims to initiate 22,601 new children on treatment (TX_NEW) in FY 2018, 17,655 (78%) will be from Scale-up SNUs, and 3,791 in Attained and Sustained councils. Active pediatric enrolment will contribute to a positive program growth. In total, PEPFAR/T aims at having 80,758 children on ART nationally, with 60,492; 17,965; and 2,301 clients in Scale-up, Attained and Sustained; and Military SNUs respectively.

PEPFAR/T strategic aim in COP 2017 is to maintain the high ART coverage in Attained councils and minimize demand creation activities for HTS, linkage, and enrollment in Sustained Councils. This will allow "passive" identification and enrolment of pediatrics into ART. The program will continue supporting the roll out the updated pediatric guidelines with Test and Start and innovative SDM. Tanzania is committed to ensuring ART treatment for children, with pediatric Test and Start being in place since May 2015. Since the introduction of the ACT Initiative in October 2014, the number of children on ART has increase from 38,848 to 50,891 (APR 2016), representing the ART coverage of 53% (vs the adult ART treatment coverage of 69%). PEPFAR/T's COP 2017 vision is to eliminate HIV treatment coverage disparities between adults and children to achieve universal pediatric ART.

In COP 2017, PEPFAR/Tanzania team will support service delivery packages in alignment with the national treatment guidelines to ensure quality. To accelerate the pediatric identification and enrollment, targeted and efficient case finding will utilize a mix of approaches including: 1) operationalization of the OPD HTC eligibility screening tool using a piloted screening tool for pediatric testing within the community setting; 2) demand creation for HTS and ART; 3) community HTS and case review for high-risk OVC in alignment with the risk assessment guidance; 4) active case finding will include targeting children of female sex workers and other key populations; and 5) active identification through both community and facility PITC/index/sibling testing, including HTS in TB/HIV, malnutrition, and in-patient wards. This will also include implementing targeted pediatric testing in private health facilities in which routine reporting will be strengthened to ensure active referral and ART for HIV-infected

children. The program will support the enhanced partner monitoring process with standard documentation and tracking of family index testing and an M&E system to ensure IPs reporting on HTS coverage and yield by entry point to ensure 100% coverage for index case testing and high yield entry points. These activities will be coupled with enhanced linkage and referral, including escorts and peer referrals. PEPFAR/T will also work with IPs and local government authorities (LGAs) to maximize availability of trained service providers through extended time and flexible service delivery shifts to accommodate in-school children, adolescents, and youth.

The pediatric service delivery model (in the to-be-finalized national Care and Treatment guidelines) includes a family-centered approach with same-day appointments, flexible hours, and weekend clinics to accommodate children and adolescents attending schools, with consideration for longer refills for children in boarding schools. When fully implemented the SDM policy will allow reaching more children and addressing the low pediatric retention. PEPFAR/T will also support the improved tracking and clinical monitoring of those on ART to include expanding the pediatric clinical mentoring to low-performing high volume sites, improved TB diagnosis and tracking of TB treatment outcomes for children on ART, and VL monitoring with clinical monitoring checklists and SOP.

Based on the program review, analysis of LTFU data indicated that of the children that were classified as LTFU, a majority (74%), were aging out, 14% were transferred out, 11% were true LTFU, and 0.1% had died. As part of enhanced partner management, PEPFAR/T will continue the systematic LTFU program review with IPs to document LTFU outcomes and roll-out SOPs to influence site-level practices and inform the "*Back-to-Care"* retention campaigns. Routine review is also being integrated into routine QI activities.

The current national ART guidelines recommend use of Lopinavir and Ritonavir (Lpv/R) oral pellet-based regimens as the first line regimen for children less than 3yrs. PEPFAR/T will work with MOHCDGEC to optimize the pediatric ARV formulary to increase the number of children using the Kaletra based regimen. Furthermore, the program will support enhanced mentorship to HCWs to accelerate use of the Kaletra based regimen to improve viral suppression.

In COP 2017, systems and activities supported through the ACT Initiative will be sustained with COP and additional ACT funds. ACT will also leverage DREAMS interventions to ensure linkage of HIV-infected AGYW. The program will also strengthen involvement of CSOs in supporting children, adolescents, and vulnerable children groups.

4.10 Orphans and Vulnerable Children (OVC)

Tanzania has an estimated 3,330,254 million OVC affected by HIV/AIDS (Measure Evaluation, 2016). Issuance of the National Action Plan to End Violence against Women and Children 2017-2022, progress on lowering the age of consent from 18 to 15 years, and implementation of shared confidentiality policy will have positive effects on OVC programming in Tanzania. In COP 2017, PEPFAR/T will serve 573,941 OVC under 18 years of age (17% of estimated OVC in the country) in Scale-Up Councils and will also reach 233,973 caregivers and adolescents above 18 years. PEPFAR/T OVC program will continue to support the GOT to implement the comprehensive OVC package in two of the seven Attained Councils. In those two Attained

Councils, the program will support 11,341 OVC ≤18 years, which represents 71.4% of the total OVC (15,877) in those councils.

PEPFAR/T will ensure that approximately 450,080 (80%) of OVC will report their HIV status to implementing partners. The status can be positive, negative, or unknown. This step is the starting point for the OVC HTC cascade. Those OVC who are known positive will not need an HIV test, but will be further reviewed with regards to treatment status and additional clinical actions will be taken as necessary. Those OVC who are HIV-negative, and have minimal HIV risks based on the use of the OVC HIV Risk Assessment tool,will not be referred for an HIV test. Those who are negative but are determined to have HIV risk, will be referred for a HIV test. For those whose HIV status is unknown, the IP will take necessary steps with OVC caregivers such as encouraging caregivers to know or disclose the HIV status of the OVC. Only those OVC who are at risk of HIV infection will receive an HIV test, which is consistent with the PEPFAR HTS approach to targeted HIV testing for those most at risk.

OVC targeting will prioritize CLHIV, ALHIV, children exposed to HIV, and children of PLHIV. PEPFAR/T will accomplish this through routine facility-based identification and assessment, in collaboration with clinical IPs. Community-based identification will prioritize orphans, children, and adolescents highly vulnerable to HIV infection. Service packages will be tailored according to OVC sub-population profile as well as their age and stage of development. In COP 2017, the program applied the UE of $47.86, compared to $41.27 in COP 2016 accounting for a comprehensive service package for children and their caregivers, delivered through individual case management.

To prevent new infections among the AGYW and improve the pediatric continuum of care, PEPFAR/T will ensure that OVC interventions continue to be integrated in ACT (clinical) and DREAMS (community) service delivery platforms. This will also include a strategy for linking HIV-positive children to treatment as well as to OVC services across KP, clinical, and OVC partners. Linkage strategies include: same day enrollment, bi-directional tracking, use of mHealth, escorted referrals, and collaborative QI initiatives. The program will ensure the implementation of Memoranda of Understanding between clinical and OVC IPs as a best practice that fosters coordination, accountability, and shared confidentiality for effective case management of CLHIV, ALHIV, and HIV-exposed children. The OVC program is starting to use the HIV risk assessment tool in FY 2017 and will continue to implement it in COP 2017. PEPFAR/T expects that these approaches will maximize human and financial resources and pediatric case finding through the OVC platform.

HIV-inclusive case management will improve the pediatric clinical cascade through the implementation of a bi-directional referral mechanism that increases health and social service access, improves linkages to care and treatment, and improves monitoring to reduce LTFU. Improving the care and development of CLHIV, ALHIV, and exposed children will be a program priority. PEPFAR/T will integrate early childhood development into HIV/PMTCT platforms (e.g. skills-building among mentor mother groups) in order to improve developmental milestone screening, monitoring, and early stimulation with the aim of reducing developmental delays of CLHIV and exposed children. Interventions to improve the retention of ALHIV will

include peer support/adherence clubs, adherence monitoring via case management, and collaboration with clinical IPs to increase access to ART via flexible clinic hours to improve retention among adolescents enrolled in school (while addressing concerns that may arise regarding clinic congestion). In addition, the Whole School Approach will improve HIV-friendly schools. Monthly HIV case conferencing by multi-sectoral teams will be facilitated by CTC focal points and case managers to address comprehensive barriers to adherence and increase access to holistic services.

The OVC program will also expand prevention activities targeting adolescent girls, age 10-17 years. Key interventions will include educational subsidies, HURU (sanitary) kits, positive parenting, sexual and gender-based violence prevention and response, comprehensive ASRH education, access to contraceptive methods, and condom promotion. The OVC implementing partners will collaborate with demand creation programs to increase uptake of HIV services among ALHIV. Caregiver strengthening will continue to be a critical component of the service package. Core interventions will include positive parenting (with a focus on skills-building in care and development of young children and adolescents), household economic strengthening (savings groups, financial education, and money management skills-building), preventing and responding to GBV, disclosure support (of caregiver and pediatric HIV status), and adherence monitoring for children, adolescents, and their parents/caregivers.

Other key COP 2017 OVC activities will include operationalizing the National Action Plan to End Violence against Women and Children (including training of community case managers, capacity strengthening of village and district protection committees, and positive parenting on violence prevention and response). PEPFAR/T will also support pre- and in-service training for community case managers for expanded implementation of HIV-inclusive case management. In addition program models that address HIV risk avoidance and reduction and strengthening the continuum of care for children living and working on the street and children in mining communities will be refined. This will include robust IP management, continuous program monitoring, quality assurance and improvement, learning, adaptation and operational research to advance the evidence base on HIV risk and reduction among these underserved OVC sub-populations.

4.11 Addressing COP 2017 Technical Considerations

Through addressing the COP 2017 Technical Considerations, PEPFAR/T will improve program implementation and impact. The four key technical considerations will be applied specifically to the Tanzanian context in pursuit of epidemic control.

Increased Focus on Prevention and Care Services for Under-30 Year Olds

To increase the identification of at-risk and HIV positive young people under 30 years of age, PEPFAR/T is supporting tailored outreach services, escorted linkage, and quality improvement at the point of care. PEPFAR/T recognizes that improved identification of young people at risk for contracting HIV in order to deliver targeted HIV prevention services requires greater involvement of youth serving organizations and young people. These partners and beneficiaries will be instrumental during COP 2017 implementation in program design for mobile outreach

services to colleges and training institutions, social network HIV testing, and in scaling up PrEP availability for young people in high-risk sub-populations.

Through the DREAMS program, PEPFAR/T will continue to employ the Population Council's Girl Roster and the Sauti program's Vulnerability Index to identify vulnerable AGYW to dramatically increase service coverage. Improvements in care and treatment services for young people under 30 similarly will require ongoing engagement with civil society. Some steps to improve services are well known and will continue to be implemented, such as increasing the flexibility of facilities in their hours of operation, sensitizing service providers to the unique needs of young people, and providing escorted referrals to services (e.g. post-GBV care, ART). In addition, PEPFAR/T will work with TACAIDS and the Ministry of Education and Vocational Training (MoEVT) to evaluate the particular challenges facing boarding school students in remaining adherent to treatment and in accessing clinical care services.

Increased Testing Yield and Improving Testing Modalities

To improve the modalities of HIV testing and increase the yield in identifying HIV positive clients, PEPFAR/T will continue to employ strategies from COP 2016, including the targeting and coverage of PITC, focusing on TB suspects in OPD and IPD settings, and on STI clients in OPD and in specialized STI clinic settings. In addition, PEPFAR/T and IPs will continue to work closely on developing council-specific plans to increase testing yield, based on the demographics of the HIV burden and the geography of HIV testing service availability.

In the context of counselling HIV positive clients, the PEPFAR/T strategy for COP 2017 also includes expansion of the Partner Notification Plus model, wherein dedicated case managers work with clients to provide referrals for testing to the sexual partners of ART clients. These case managers also facilitate the disclosure process and work to enhance the linkage into services. As a new intervention in COP 2017, Peace Corps volunteers will be involved in implementing evidence based, innovative testing modalities and linkage strategies, working within their communities and partnering with local organizations. In addition, COP 2017 includes expansion of the incentivized peer testing model, which collects referrals for key and vulnerable populations into testing services. Finally, COP 2017 will also employ a new approach working more closely with the families of key populations, particularly to refer their children into testing services.

Improved Retention and Viral Suppression

In COP 2017, PEPFAR/T will continue to monitor and improve patient retention in ART services, while scaling up routine viral load monitoring. In keeping with COP 2017's focus on improved cascade analysis using age and sex disaggregates, retention likewise will be monitored at 6, 12, and 24 months post-treatment initiation among these demographic groups. Retention will also be tracked by SNU and IM, as part of enhanced partner management.

While expanding access to VL services, PEPFAR/T will continue to evaluate the effectiveness of current initiatives aimed at AGYW in the DREAM program, at pediatric VL under ACT, and at creating conducive environments for improving retention among men, such as the use of PMTCT

clinics as ARV pick-up points for men and promoting ARV adherence at sports and social events. PEPFAR/T will also continue using the web-based VL dashboard to monitor Turn-Around-Time (TAT) of VL results and other data to take appropriate corrective actions.

Support a Sustainable, Quality Service Delivery Model

During the current implementation of COP 2016, PEPFAR/T is working closely with the GOT and partners to ensure that the approved SDM strategies are widely and effectively implemented. This includes reduced clinical visits for stable patients from monthly to 6-monthly and for ARV pick-ups from monthly to once per 2-3 months. The expansion of ARV pick-up sites to lower level dispensaries are also being planned for implementation in the current fiscal year. During COP 2017 implementation, the aggressive scale-up of these models to remaining sites and their support for effective work will be prioritized. Moving from adoption of these new models into routine quality monitoring will support the sustainability of these services over the long term.

4.12 Commodities

PEPFAR/T contributes to the total country needs for ART, RTK, EID, and VL commodities by providing commodities to the central medical stores for distribution. The GFATM and GOT also contribute to this total need. Products are distributed geographically based on historical consumption. Additionally, VMMC commodities will be fully supported through a combination of COP 2017 and Central funds and provided directly to IPs providing VMMC services.

The GFATM concept note is currently under development. PEPFAR/T assumed a minimum of $75 million to contribute to these commodities. Should this assumption hold true and given the COP 2017 planned investments no commodity shortage is expected for FY 2018.

4.13 Collaboration, Integration, and Monitoring

At the start of FY 2017, PEPFAR/T implementing agencies had completed the process of geographical alignment to ensure that one agency partner was responsible for the entire clinical cascade of services in each region of Tanzania. Within each region, transition plans are currently being implemented as PEPFAR/T withdraws support from low volume facilities to ensure that GOT assumes full responsibility for services and reporting. This process will have been completed before the implementation of COP 2017.

Alignment between PEPFAR/T and the GFATM with respect to the procurement of HIV commodities has been effective for several years and both PEPFAR/T and the GFATM work with the GOT from a common, national supply plan. With respect to the implementation of community services, including those targeting key populations, there has been a great deal of work to date in geographically aligning PEPFAR/T and GFATM supported partners. The HIV/TB funding request for the years 2018-2020 will be designed from the vantage of the COP 2017 community, priority and key population services plan to ensure that geographical alignment is built into the design from the outset.

For effective monitoring of IP performance, PEPFAR/T continues to monitor the clinical cascade by disaggregated population demographics, by SNU, and by IM. Remediation with IPs

performing below target expectations is increasing in frequency, particularly in high-burden areas. These intensified efforts are designed to ensure successful target achievements by APR 2017. IMs that fail to reach to expectations and to improve in response to remediation plans will be reevaluated during FY 2018, with budgetary consequences.

Cross cutting health systems interventions in COP 2017 continue to address policy implementation of Test and Start and rollout of SDM, as well as the sustainability barriers identified in the SID, including service delivery efficiency and quality, domestic resource mobilization, and laboratory capacity. Ongoing improvements in the rollout of the differentiated SDM will continue throughout the implementation of COP 2017, with the GOT, GFATM, and PEPFAR/T all reviewing the same disaggregated cascade analyses and agreeing on joint solutions to reach the UNAIDS Fast-Track Goals while realizing additional budget efficiencies.

To address human resource deficiencies, COP 2017 includes funding for HR mentors to be deployed in 13 targeted regions to boost recruitment and reach a target of 75% of HRH positions filled. Policy work to finalize the curriculum and SOPs for the Community Health Worker cadre will also help to alleviate the workload for outreach visits by facility-based staff.

Above-site level activities to strengthen laboratory services also include quality assurance for rapid testing at PMTCT sites and training of 212 laboratory staff and 20 trainer-or-trainers to reach a laboratory accreditation target of 80% for all PEPFAR/T supported labs.

Finally, PEPFAR/T will continue to work in a collaborative manner with MOHCDGEC and PORALG through the existing GOT platforms to ensure COP 2017 implementation reflects all relevant policies and guidelines regarding HIV/AIDS programming.

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

5.1 Targets for Attained and Sustained Locations and Populations

Attained Councils are SNUs that have achieved at least 80% coverage of ART among all PLHIV by the end of FY 2017. The emphasis for these Attained Councils is to sustain high coverage levels and increase viral load suppression rates to achieve at least 90% suppression rate in all PLHIV on treatment. Sustained Councils are those SNUs that have a lesser HIV burden and where fewer than 20% of all PLHIV reside. In COP 2017, treatment targets in Sustained and Attained Councils consider a passive growth of 19.4%.

PEPFAR/T calculated the expected volume of patients needing the standard package of services in these areas by council and overall (Table 5.1.1). PEPFAR/T derived the expected number tested through PMTCT sites based on the assumption that these sites would continue in FY 2018 to test 95% of pregnant women and link 95% of those identified HIV-positive to treatment, per standard of care and national guidelines; however, PEPFAR/T has discontinued support to testing in no- and low- yield sites. Further, these estimates assume a reduction in the number of women presenting to PEPFAR/T-supported sites, both due to discontinuation of active demand generation in these areas and transition of PMTCT services at antenatal clinic (ANC) sites to GOT support in FY 2018 due to PEPFAR/T's transition of support away from low volume sites.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Councils*

Attained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing (all populations)	HTS	140,054	189,723
HIV positives (all populations)	HTS_POS	5,346	16,063
Treatment new	TX_NEW	4,185	13,455
Current on ART	TX_CURR	40,314	49,722
OVC	OVC_SERV	14,248	15,877
Key populations	KP_PREV	1,588	3,841

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the Attained Councils. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage.

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Councils

Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites	PMTCT_STAT	478,927	325,676
HTS (only sustained ART sites in FY 2017)	HTC_TST/HTS_POS	23,884	54,415
Current on ART	TX_CURR	171,630	192,469
OVC	OVC_SERV	32,133	0

5.2 Establishing Service Packages to Meet Targets in Attained and Sustained Districts

In Attained Councils, aggressive demand creation will not be supported for the general population; however, in selected Attained and Sustained Councils, with key population hot spots, PEPFAR/T will provide targeted outreach, prevention, testing (including VL), and clinical

services for key populations since these populations may not have 80% ART coverage. In COP 2017, PEPFAR/T will work with IPs in Sustained Councils by employing facility-based, focused testing strategies; intensified PITC focusing on in-patient wards, STI, TB and presumptive TB clients; family testing in HIV clinics, ANC, and pediatrics; as well as family members of index clients.

To address linkage to care and treatment services, PEPFAR/T, in collaboration with the GOT, will implement strategies such as the use of expert patients or peer navigators to physically escort newly diagnosed PLHIV to the CTC; use a mobile phone texting platform to provide additional post-test counseling messages to newly diagnosed PLHIV to remind them to enroll in care; expanded weekend and evening hours (while addressing concerns that may arise regarding clinic congestion); and adolescent clubs for AGYW.

In clinical services and retention, PLHIV receiving care and treatment services in Attained and Sustained Councils will received the same standard of clinical care services package which is entitled to any PLHIV in Tanzania per the national guidelines. Such services include facility based PITC, linkage and ART initiation, retention in care, screening and management of opportunistic infections (OIs). PEPFAR/T support will implement a customized supportive ART retention service based on specific age, sex, and HIV risk factors related to the variable use of prevention and treatment services.

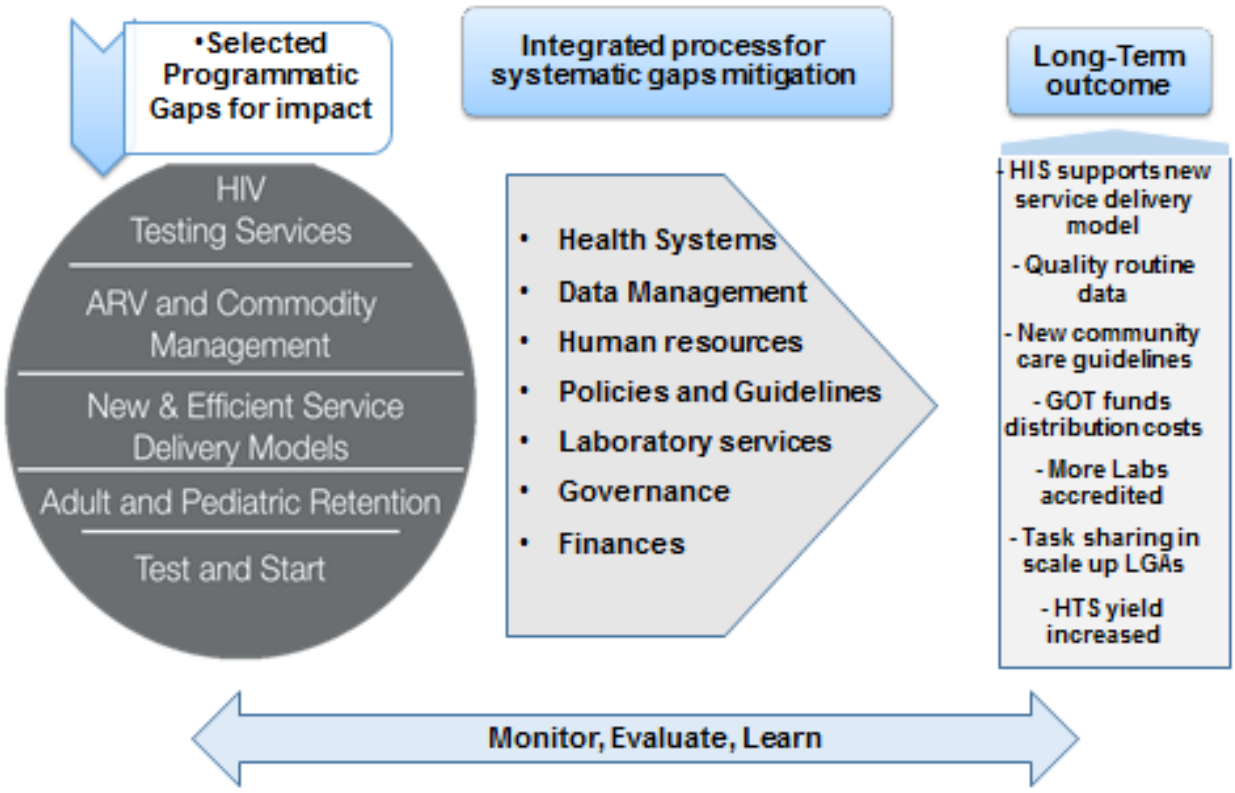
In surveillance, program monitoring, and laboratory systems, PEPFAR/T will continue to monitor viral load suppression and suspected treatment failure in Attained and Sustained Councils. PEPFAR/T will continue to support ongoing surveillance activities to monitor new and on-going HIV infection. Surveillance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

For VMMC, PEPFAR/T has already contributed to the VMMC coverage of greater than 80% in 34 Scale-Up and Sustained Councils and will transition to a maintenance phase that will include increased government ownership and roll out of Early Infant Male Circumcision (EIMC).

In FY 2016, the OVC program served 96,000 OVC and 32,000 OVC are expected to be reached in FY 2017. The 32,000 OVC in Sustained Councils will be transitioned by the end of FY 2017 and no OVC target is set in COP 2017. Effective IP engagement with council leaders and stakeholders as well as using the standardized transition tools and approaches are helping to ensure smooth and seamless transition out of the Sustained Councils.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Chart 6.1: PEPFAR Tanzania – COP 16 Programmatic framework



6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

As Tanzania moves towards a sustained epidemic control of new HIV infections, COP 2017 will focus on achievements made during COP 2016, and health systems barriers critical to address the remaining challenges of finding HIV-positive persons and linking them to treatment, retaining them into the treatment program, and guaranteeing that ARV and commodity supplies are reliable to assure quality of services across the cascade. All programmatic developments will need to be informed by and align with a long-term strategy for sustainable epidemic control. Thus, the key programmatic gaps addressed are:

a. Adult and Pediatric Retention
b. HIV Testing Services
c. ARV and Commodity Management

In order for long-term sustainability of the national HIV response to become a reality, service delivery must be delivered in an optimally efficient and effective manner. Therefore, during COP 2017 PEPFAR/T is prioritizing systems investments that will ensure the smooth roll out of Test and Start and the new SDM in Tanzania by building on the activities initiated during COP 2016. All the five gaps are relevant across the national, sub-national, and site levels and were based on system level investments deemed essential for reaching the 90-90-90 targets based on the red and yellow scores of Tanzania's COP 2016 SID results, and performance data from APR 2016 and partner management.

6.1.1 Adult and Pediatric Retention

Adult and pediatric retention is relevant to the achievement of the second and third 90s, as well as reaching the ACT targets for pediatrics. In general, retention data shows that crude retention for both adults and children has been declining over the years. Further analysis on LTFU notes that major reasons for low pediatric retention include children aging out of the indicators, re-testers, transfer outs, and true defaulters especially in high volume sites.

Programmatic Barriers

The PEPFAR/T team identified four critical programmatic barriers in adult and pediatric retention, which needs Above Site investments to support the GOT to meet its annual programmatic targets. The system barriers that were identified in COP 2016 remain relevant and will constitute the focus on interventions for the Above Site level. They include:

a. Low quality of data and evidence from evaluations and surveillance, which is not sufficiently identifying retention issues leading to insufficient information for addressing retention challenges.
b. Shortfalls in the existing and relevant guidelines, which limits the abilities to support ART retention and adherence interventions.
c. Weaknesses in functionality of the patient level data systems, which hinders improved support at various service levels.
d. Follow up on retention and quality of routine data and linkages across service delivery points.

The last gap identifies as a barrier to retention is the shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up in all Scale-Up Councils.

3 Year Outcomes

The PEPFAR/T team developed and prioritized outcomes requiring systemic and programmatic interventions to address the above barriers. Ten measurable outcomes have been proposed and are linked to specific activities while addressing the retention barriers over a three year period. All outcome measures have been set while considering the programmatic target-linked retention challenges particularly in the Scale-Up Councils, and the systems and policy challenges in meeting the 90-90-90 targets by 2018/19.

The outcome measures defined as part of the COP 2016 process will continue to guide implementation of COP 2017. The key outcomes include a functioning case based surveillance system that consists of testing data, care and treatment sentinel events, and facility-based HIV mortality data. The outcomes also include having annual quality evaluations to inform service delivery retention interventions. PEPFAR/T has produced a coordinated investment plan to achieve data quality through an end to end approach that recognizes all partners and all organizations have a role in ensuring data is complete, timely, accurate and relevant. To achieve this, TA partners are working with various national level government departments to ensure they fulfill their separate mandates in relation to data quality. This includes updated M&E tools to ensure data collected is relevant and aligned with information needs, data verification systems are in place to ensure data is accurate, and reporting processes are streamlined and automated to improve timeliness.

Similarly, implementing partners at regional and district levels are responsible for supporting stakeholders to help implement national systems and strategies at district and regional levels. All data quality activities are linked to the premise that data use is the primary driver for data quality and all PEPFAR/T funded partners are tasked with improving their own data use and supporting relevant government departments to understand, review, challenge, and use data for evidence based decision making. For instance, PEPFAR/T will seek to improve data quality that is triangulated with results from SIMS assessment visits, including having 90% of the Scale-Up Councils able to include results of HIV data triangulation within their annual plans.

PEPFAR/T will work with the GOT on a community data reporting system for non-facility indicators, home based care, and OVC served. PEPFAR/T will also work to track and link patients across HIV services via electronic systems for 60% of HIV positives identified and 90% of clients on treatment in Scale-Up Councils. PEPFAR/T will work with the GOT to develop and implement a strategy for identifiers and systems that support anonymously linked services.

To improve HRH, PEPFAR/T has made some significant achievements in collaboration with the GOT including finalization of the Curriculum and Scopes of Practice for Community Health workers in support of the Task Sharing policy, while also deploying HR mentors to 13 target regions- that will facilitate workforce retention. PEPFAR/T will work towards meeting 75% of approved HR permits filled in Scale-Up Councils and have 95% of all sites use a QM/QI system, with routine monitoring of processes and quality of services and involvement of patient, community and council management stakeholders. PEPFAR/T will also work to update Community Care guidelines to strengthen retention through improved use of QI approaches in community services.

Activities

As part of COP 2017, the PEPFAR/T team will work with IPs and the GOT to define yearly benchmarks through the annual planning process based on progress and achievements of the previous reporting period. Above site level activities proposed in COP 2016 will have continued relevance for COP 2017, because initial achievements are used to inform and build on additional work. Where specific accomplishments have been attained, these activities were removed. New

activities are included that will continue to address LTFU through a combination of activities that focus on tracking and retaining patients across different sites and service programs.

Through COP 2017 PEPFAR/T will consolidate gains and continue to strengthen the national Health Information System infrastructure to support integrated service delivery across different sites and services. Linkages between HIV-related electronic medical record systems will be supported along with the national health client register across Scale-Up Councils to link services across sites, councils, and programs.

PEPFAR/T will support health care workers to monitor and follow up on retention and support decision makers monitoring of the HIV cascade. In particular, HRH interventions will support the deployment and distribution of critical workforce and support local government authorities (LGAs) to implement HR retention packages in Scale-Up Councils. To increase pediatric retention, PEPFAR/T will strengthen tracking system for children, adolescents, and vulnerable children. For overall retention, PEPFAR/T will strengthen the use of appointment and tracking registers, with special emphasis on early tracking of missed appointments. PEPFAR/T will use mobile technology by setting up text message reminders to follow up clients and electronic self-triaging systems, family centered clinic appointments. Targeted "back to treatment" campaigns will encourage LTFU patients to return. All of these efforts will improve tracking and retention of patients in care.

6.1.2 HIV Testing Services

Programmatic Barriers

In the HIV Testing Services Gap, PEPFAR/T has prioritized three system barriers to be addressed during COP 2016 and subsequent years to achieve the first 90 by 2018/19. The system barriers include:

- Challenges in consistency of routine data quality and survey evidence being used to inform efforts to target HTS, increase yield, and identify program challenges and facilitators.
- A limited HTS intervention due to inadequacies in the current policy guidelines and operating procedures on self-testing, age of consent, CHW testing, repeat testing, certification of testers/sites and anonymous HTS to maximize yield.
- Challenges in quality of the HIV rapid testing according to WHO guidelines (new, repeat, retest and documented annual certification).

3 Year Outcomes

The PEPFAR/T team has developed eleven outcomes to be measured while addressing the HIV Testing Services barriers over a three years period. The outcome measures have considered the HIV testing services programmatic challenges in meeting the 90-90-90 targets by 2018/19. PEPFAR/T will update the Monitoring and Evaluation paper tools and routine reporting to track initial, repeat, and confirmatory tests to offer high quality data for decision making. Tanzania will use PMTCT data for HIV prevalence at SNU level to target HTS interventions. Tanzania

completed the development and approval of Hot Spot surveillance (TISINI) and Zanzibar KP surveillance under COP 2016.

In COP 2017, PEPFAR/T will also complete and disseminate findings from the Integrated Bio-Behavioral Survey in Scale-Up Councils to improve HTS. PEPFAR/T is working on a number of policy initiatives related to the WHO release of the new HTS guidelines and updated mandates on HTS, including new initiatives such as self-testing. PEPFAR/T will work with the GOT to advocate for lowering the age of consent than the current 18 year by supporting efforts to amend the national HIV and AIDS law and ensure this gets parliamentary approval, establish anonymous HTS, and introduces disclosure policy. Draft guidelines have already been developed under these areas with COP 2016 funding and implementation will continue through COP 2017. Tanzania will disseminate the updated HTS SOPs within 18 months of the release of new WHO testing guidelines. PEPFAR/T will also deploy HIV rapid test quality assurance systems. Lastly, PEPFAR/T will strengthen the laboratory management and accreditation system and will increase yield for all HTS tests from 5% to 7% by 2019.

Activities

PEPFAR/T will work with the GOT and IPs to ensure that 90% of people who are infected with HIV in the Scale-Up Councils know their status, and are then linked to ART treatment services. In COP 2016, PEPFAR/T revised national M&E tools and systems to facilitate the identification and linkages of PLHIV to care and treatment. COP 2017 will provide additional emphasis on KP data and include new variables such as unique identifiers. The revised tools will be printed and disseminated to the regions and councils. Other priority activities include advocacy work from the demonstration project to inform the self-testing approach, increased access of HTS for KP and AGYW using appropriate testing modalities.

PEPFAR/T will also scale up access to HTS in areas of high prevalence and in hot spots. PEPFAR/T will create a standardized and coordinated Quality Assurance (QA) system for HTS, with a focus on QA for demonstration projects on self-testing, counseling, and quality control for HIV testing performed by health care providers and trained lay counselors. Integrate partner referral plus and testing within the facilities, communities, and resource centers will be initiated, focusing on individuals (key, vulnerable, and members of the general population) in established relationships such as husbands and wives as well as cohabitating partners.

PEPFAR/T will also focus on most at risk OVC who will be identified through KP focused social services initiatives. Likewise, HIV-positive FSW and AGWY will also be encouraged to bring in their children for testing. PEPFAR/T will work closely with the MOHCDGEC, PORALG, and other stakeholders to address policy barriers to HTS services including lowering of the age of consent for HTS which hinders youth access to services below the age of 18 years. In this area, PEPFAR/T will continue policy work around the Law of Marriage Act (1971), which allows for marriage at the age of 15 and contributes to challenges for girls to access testing services.

PEPFAR/T will support HIV rapid test quality improvement to ensure accuracy of HIV rapid tests for diagnosis by integration with quality improvement teams, use of standardized HIV Log

books, certification of testers and testing sites, and implementation of proficiency testing/EQA programs. In COP 2016, work was initiated to provide QA, mentorship, and coaching to all zonal centers on certification to Africa Society for Blood Transfusion (AfSBT) international standards. COP 2017 resources will continue to support these efforts and use of this platform for expanding quality HTS services. PEPFAR/T will also collaborate with the GOT to increase demand for HTS, targeting community-level demand creation by focusing on individuals who know their HIV status through "back to treatment campaigns."

6.1.3 ARV and Other Commodity Management

The availability and accessibility of life-saving commodities are the cornerstones of epidemic control and achieving the 90-90-90 goals. Tanzania is set to adopt the new Test and Start policies and new SDM in the treatment, which is expected to increase the number of clients and demand more ARVs and commodities. PEPFAR/T is committed to working with the GOT to meet the projected commodity demands and address the barriers to ARV and commodity availability. PEPFAR/T is planning to support ARV refill distribution points outside the clinics using trained community health workers, and to decentralize ARV pick up at designated village dispensaries.

Programmatic Barriers

During COP 2016, two barriers have been prioritized to address ARV and commodities, including:

- Ensuring ARV and viral load needs are met and are coordinated between the GOT, PEPFAR/T, and GFATM;
- Inefficient distribution of commodities under the new SDM platform.

3 Year Outcomes

The PEPFAR/T team has developed four measurable outcomes while addressing the barriers associated with ARV and commodity management by 2018/19. PEPFAR/T will develop and implement a coordinated procurement plan for commodities on an annual basis with sufficient domestic and external financing for HIV commodities defined in that procurement plan. PEPFAR/T will also work with the GOT to ensure they fund the full amount of in-country distribution costs for all donated products including HIV-related donated products. PEPFAR/T will also work with GOT to reduce the average in-country distribution costs for health commodities from 20% to 15%.

Activities

The PEPFAR/T team will work with the GOT to ensure that procurement of ARVs is covered by PEPFAR/T and GFATM, and that the GOT allocates funds to mitigate challenges associated with ARV and commodity distribution. The developed activities expected to be carried out to achieve the three year outcomes include to assist the GOT be able to cover the in-country supply chain distribution costs, including the continuing repayment of outstanding debts to Medical

Stores Department. Through advocacy from PEPFAR/T and its implementing partners, the GOT has made payments to this outstanding balance.

It will also include supporting the GOT to reduce inefficiencies and inconsistencies in domestic funding for clearance and distribution of donated commodities and address the distribution system for commodities under the new service delivery platform. A holistic review of the supply chain has begun with engagement from PEPFAR/T, IPs, and NACP. From this, PEPFAR/T will strengthen supply chain performance management in all facilities in Scale-Up Councils providing HIV services, as well as national level institutions through the monitoring of key performance indicators.

PEPFAR/T will also strengthen national capabilities in forecasting, budgeting, and product availability through improved supply chain management, planning, and accountability to improve treatment adherence by ensuring that products are available to patients and clinicians when needed. PEPFAR/T will target support to improve processes for distribution of IPT and lab supplies are new activities for FY 2018, as is ongoing support to assist with monitoring site level commodity availability as Tanzania scales up multi-month scripting.

Please see Appendix C for Tables 6.1.1, 6.1.2, and 6.1.3.

6.2 Critical Systems Investments for Achieving Priority Policies

During the preparations for COP 2016, OGAC identified two priority policy and programmatic gaps (Test and Start; and New and efficient SDM) for Tanzania as critical. The two programmatic gaps were also described in the WHO Guidelines and the PEPFAR/T Technical Considerations and both are relevant across the national, sub-national, and site levels while also aligning with PEPFAR/T's objectives of developing system level investments essential for reaching 90-90-90 targets and on addressing Tanzania's 2016 SID results. PEPFAR/T continues with these two critical gaps in COP 2017.

6.2.1 Test and Start

In 2016, the GOT has undertaken substantial policy revisions that will allow for the achievement of the UNAIDS 90-90-90 goals by 2018/19 and move Tanzania closer to the epidemic control, which included adopting Test and Start nationwide as of October 2016. PEPFAR/T will continue to support the roll out of Test and Start and ensure quality and monitoring of services.

Programmatic Barriers

Five system barriers have been identified to mitigate the gaps toward Test and Start implementation during COP 2016. These include commodities, human resource quantity, accessibility, retention, and the need for guidelines and other monitoring tools. PEPFAR/T will continue with these five programmatic gaps in COP 2017 by continuing/ revising activities initiated in COP 2016 and initiating new activities in COP 2017. Adopting the Test and Start policy was a barrier during COP 2016, which has since been addressed. In 2016 PEPFAR/T successfully worked with the GOT to develop and roll out Test and Start policy guidelines. In

COP 2017, PEPFAR/T will continue to support the roll out and strengthen supportive supervision structures established in COP 2016.

3 Year Outcomes

The PEPFAR/T team has developed thirteen measurable outcomes that address the barriers associated with the implementation of Test and Start by 2018/19. PEPFAR/T successfully worked with GOT to develop and roll out Test and Start policy guidelines in October 2016. Related SOPs and supportive supervision structures are currently under development and implementation. Supervision and assessment of Test and Start will be coordinated between MOHCDGEC and PO-RALG. Information, Education and Communication continues to be developed for awareness and understanding of Test and Start policy, benefits of early treatment, and promoting service uptake amongst KP and PP. COP 2017 will see the inclusion of demonstration projects in self-testing for targeted populations in raising the awareness and understanding.

PEPFAR/T continues to develop and utilize M&E tools and systems for Test and Start for program monitoring and resource allocation. Test and Start interventions are informed by quality evaluation findings. The national HIS infrastructure will support integrated service delivery. To increase linkages between programs, PEPFAR/T is developing a national electronic system for referrals. Service providers continue to adjust personnel and functions according to the new Task Sharing policy. COP 2016 activities resulted in a revised policy for nurses that enables dispensing of ARVs, although, an operational plan is still required in order to effectively roll out such activities. By the end of FY 19, at least 90% of Scale-Up Councils will have systems that facilitate use of multi-sectoral profile data for decision making with 100% of GOT funds allocated to health and HIV being spent for intended purposes.

Activities

PEPFAR/T will work closely with the GOT to continue to roll out Test and Start in COP 2017. Policy guidelines have been updated and supportive supervision structures are in place to monitor the implementation of Test and Start. In COP 2017, PEPFAR/T continues to support CHMTs in translating Test and Start policy guidelines into annual operational plans, and provides continuous monitoring support for efficient implementation. In COP 2016, PEPFAR/T worked closely with PO-RALG to roll out tools that promoted accountability at the LGA level, and recruited financial mentors across 26 councils to strengthen governance and financial management. In COP 2017, PEPFAR/T continues to improve effective governance at the council and regional level to effectively implement Test and Start.

In COP 2016, PEPFAR/T worked closely with the GOT to develop and roll out an implementation plan for task sharing and revise the Scopes of Practice (SOP) for nurses and other mid-level cadres that practice task sharing. In COP 2017, PEPFAR/T will address the shortages of adequately skilled health workers in Scale-Up Councils to provide HIV testing and treatment services by revising the HRH recruitment and allocation process to be based on disease burden, and supporting the implementation of task sharing through strengthening professional councils and regulatory bodies.

In COP 2016, PEPFAR/T worked with the GOT to develop HIV drug resistance surveillance protocols, which will be implemented in COP 2017. In addition, PEPFAR/T achieved successful integration of the Health Facility Registry (HFR) with DHIS2, providing better understanding and accountability for facility reporting. In COP 2017, PEPFAR/T will continue to maximize program impact by improving data collection practices, systems, data quality and data analysis, and describe the drivers of the epidemic in Tanzania.

In COP 2017, PEPFAR/T will continue to provide TA on capacity-building, shared information strategies, country ownership strategies, data quality, and evidenced-based programming in a coordinated approach with other donors, and ensure the M&E and health information systems (HIS) for patient referral, tracking, and results follow-up are in place. PEPFAR/T continues to support quality data and systems to inform decisions regarding monitor systems to implement Test and Start. These SI activities leverage other resources and collaborate with other donors to ensure investments in the collection of quality data. PEPFAR/T continues to provide support for the Health Management Information Systems (HMIS) and HIS system, and surveys and surveillance activities to aligned and integrated with the GOT.

6.2.2 New and Efficient Service Delivery Models

PEPFAR/T is working with the GOT to accommodate a more streamlined and standard SDM aiming to decongest clinics, improve quality of care, support ARV distribution points to decentralize ARV pick up at designated village dispensaries that are closer to beneficiaries in their communities. Adoption of the new SDM will help to decongest clinics even as they absorb the expected patient increases with the adoption of Test and Start. The new SDM will also improve the quality of services provided.

Programmatic barriers

PEPFAR/T identified five barriers in COP 2016 to address the challenges expected during implementation of the new SDM by 2018/19. These included improving the GOT human resource systems in place to successfully implement new SDM, and strengthening data quality and systems to inform decisions regarding new SDM. It also included strengthening the laboratory sample referral system for accurate and timely diagnosis, improving patient tracking, and strengthening financial management systems to ensure efficient disbursement and management of funds across all levels of government.

3 Year Outcomes

The PEPFAR/T team has developed fifteen measurable outcomes that address barriers associated with the implementation of the new SDM by 2018/19. New national treatment guidelines will be implemented including alternate SDM. PEPFAR/T is working with the GOT to ensure that 100% of Scale-Up Councils will have QA/QI structures in place to ensure quality of HIV/AIDS services provided by health workers and retention of individuals on treatment.

Nursing, clinical officer, pharmacy, and CHW cadres will provide high quality services per the Task Sharing policy in 100% of Scale-Up Councils and the GOT will deploy at least one CHW

to each village within Scale-Up Councils. In COP 2016, PEPFAR/T strengthened the practice of task sharing by developing regulatory mechanisms to improve quality of shared tasks, and developing a draft continuous professional development (CPD) framework for nurses that enables the practice of task sharing. In addition, COP 2016 activities led to the development of CHW training packages and Scopes of Practice (SOP). Recruitment of CHWs has been delayed due to a GOT hiring freeze that impacts health care workers across all cadres.

In COP 2016, PEPFAR/T completed the synchronization of the current on treatment indicator between GOT and PEPFAR/T data sets. COP 2017 will see continued synchronization of PEPFAR/T and GOT HIV-related data systems with remaining indicators. Data used by PEPFAR/T and GOT will be used to evaluate and scale up sustainable service delivery platforms for prevention and treatment of HIV/AIDS in Scale-Up Councils. At least 90% of CHMTs in Scale-Up Councils will implement data-driven planning and accountability approaches when developing Comprehensive Council Health Plans and monitoring their implementation. COP 2016 achievements include the development of data dashboards that will be used by CHMTs for planning during the upcoming fiscal year.

In COP 2017, PEPFAR/T will make further advances to the three year goal of ensuring timely and accurate laboratory results for patients in 100% of Scale-Up Councils by strengthening monitoring of lab results through a centralized laboratory database. PEPFAR/T will continue to increase the percentage of labs confirmed to meet SIMS EQA and accreditation Core Essential Element (CEE) and will strengthen pre-service lab training programs.

COP 2016 activities resulted in expansion of mHealth, which enabled targeted messaging and increased demand for services. In COP 2017, PEPFAR/T will continue to increase the number of clients registered within patient level data systems for alternative refill sites to encourage less frequent clinic visits.

In COP 2016, PEPFAR/T rolled out an improved community health fund action plan across 50 councils for better financial management. In addition, PEPFAR/T rolled out an efficient algorithm to disburse health basket funds that enables CHMTs to better manage their resources. Programs will continue to seek to increase the proportion of facility-own revenue in Scale-Up Councils are deposited in facility bank accounts and expended, and facilities in Scale-Up Councils will receive timely disbursements of funds from the central level. In COP 2016 PEPFAR/T rolled out financial management toolkits to 26 councils and will scale up in COP 2017. Scale-Up Councils will receive an increased allocation of domestic funds for HIV services by 10% in CCHP and the budget execution rate should increase to 80% in Scale-Up Councils by 2019.

Activities

The PEPFAR/T team is working with the GOT and IPs to ensure the implementation of the new SDM is achieved by 2018/19. Programs will ensure that Health Care Workers (HCW) are available and well equipped with the essential skills to provide quality treatment in the new service delivery model. In COP 2016 PEPFAR/T led an innovative and successful approach to

redesign the HRH recruitment, deployment, and retention process using evidence-based methods, which enabled better recruitment and deployment strategies based on disease burden.

PEPFAR/T will continue to support activities that align with the PEPFAR/T Human Resources for Health (HRH) Strategy, with enhanced focus on four of the five objectives mentioned in the strategy: improving recruitment, deployment and retention; establishing sustainable financing of HRH; improving HRH performance through appropriate skills building in both public and private sectors; and implementation of task sharing policy to efficiently utilize the available mid and lower level cadres (i.e. nurses and community HCWs), especially in remote and high volume sites.

COP 2017 will see continued support to mid and lower-level cadres practicing task sharing in the form of continuous professional development, strengthened monitoring and supportive supervision, and strengthening of professional councils to regulate the quality of task sharing. In addition, PEPFAR/T will track the practice of task sharing to inform future strategy on HRH investments. Using APR 16 data, PEPFAR/T is working closely with the GOT on a transition plan to shift salary support for HCWs to allow for PEPFAR/T to support target-based activities.

Building on gains from COP 2016, PEPFAR/T will continue to address gaps in surveillance and surveys including, IBBS, SABER study, key population size estimations, mortality, pediatric, case-based surveillance, ANC/PMTCT comparison, HIV incidence, and hot spot and HIV drug resistance surveillance. PEPFAR/T will continue supporting automated aggregate reporting from facility level systems to the HMIS/DHIS2 and continuous improvements in quality and use of electronic medical records to support the full HIV cascade.

In COP 2016 PEPFAR/T rolled out Laboratory Information System (LIS) across 3 zones for real time program performance management. In addition, PEPFAR/T procured 68 GeneXpert machines to scale up lab capacity. In COP 2017, PEPFAR/T will continue to scale up HIV viral load for routine monitoring and EID services that include access, uptake, results return, and documentation of final diagnosis. Sample transport networks and results return system will be bolstered using a hub and spoke system to transport the samples from facilities to testing labs.

In COP 2016, PEPFAR/T supported 10 training institutions with training materials and training equipment. In COP 2017, PEPFAR/T will continue to provide technical assistance on laboratory quality management systems (LQMS) and laboratory in-service training, mentoring, and supportive supervision. Technical assistance will also address the laboratory logistics (commodities) and information management systems (LMIS and LIMS), as well as TB detection and monitoring and other OIs.

Please see Appendix C for tables 6.2.1 and 6.2.2.

6.3 Proposed System Investments Outside of Programmatic Gaps and Priority Policies

During COP 2017, PEPFAR/T identified eight system investments, which are considered important in the contribution towards the achievement of the UNAIDS 90-90-90 goals by

2018/19, but which fell outside of the five programmatic gaps and priority policies narrated in section 6.1 and 6.2 above. Four of the eight system investments are continuing from COP 2016.

In COP 2016, PEPFAR/T developed and rolled out communication plans aimed at GBV and launched a costed plan for violence against women and children. In COP 2017, PEPFAR/T partners will provide TA to relevant ministries, including MOHCDGEC and PORALG, to develop communication strategies aimed at AGYW, and revise VMMC guidelines to incorporate EIMC. In addition, PEPFAR/T will support the integration of the component of Active Linkage to care (ALTC) to establish tracking structures and reporting database.

PEPFAR/T will continue to support community M&E systems to track violence against children and linkage and retention into HIV care. The Ambassador Self Help Grants will continue to engage civil society in addressing the epidemic, and PEPFAR/T will support the transition of Tanzania Marketing and Communications (T-MARC) from NGO to a commercial entity that is able to create a business sales network and market for those able and willing to pay for condoms. A program evaluation will be conducted at the end of year 3 to determine the continued level of support for T-MARC. In COP 2017, PEPFAR/T will continue supporting the implementation of information, education, and communication services for GBV including integration of messaging into existing mHealth channels and services to reach wider audiences with specific service and support information for victims of GBV.

Please see Appendix C for table 6.3.

7.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals

PEPFAR/T used the staffing tools for COP 2017 to identify needs for new or repurposed PEPFAR/T staff across the interagency team. An interagency management team reviewed the tools and determined that no immediate staffing shifts are required aside from one additional position requested by Department of Defense. The team determined that the overall funding allocation by budget code and the budget code attribution by FTE are well aligned.

There are currently 15 vacancies spread across the agencies. Many of these positions have gone through the recruitment process and will be extended offers of employment pending the removal of the USG 2017 hiring freeze. We anticipate all of these positions to be filled by mid-2017.

Each implementing agency in PEPFAR/T also conducted an internal staffing review to ensure that staff time is aligned with core programmatic, population, and geographic priorities. Agencies continuously assess the most important needs when vacancies occur and repurpose appropriately. Overall, the management and staffing budget increased from COP 2016 due to the increased cost of LES health insurance, salary increases for LES, ICASS, and Capital Security Cost Sharing requirements.

The implementation of SIMS will continue in FY 2017. PEPFAR/T estimates that the planning levels from COP 2016 will be maintained in COP 2017 and are sufficient to cover the scale up of SIMS visits. The SIMS contribution to management and operations budget takes into account all funding requirements from the SIMS Action Planner.

PEPFAR/T is not requesting any new positions within COP 2017. Several positions have been repurposed. For USAID the two Fellow positions have been repurposed to USPSC positions at the request of the Embassy Front Office. The name of two other positions has also changed. CDC is repurposing three positions and DOD and Peace Corps are not repurposing any positions. The PEPFAR Coordinator has been shifted from HHS to a State Limited-term Non-career Appointment. The Global Fund Liaison position is shifting from CDC to the PEPFAR Coordination Office.

In 2015, PEPFAR/T also reviewed the interagency technical team structure to better correspond with the technical organization of activities within the cascade of services and support being provided. The streamlined structure reduced the number of technical working groups from 14 to seven operating within three clusters: Services Cascade Cluster, Populations Focus Cluster, and Program Support Cluster.

APPENDIX A

SNU Prioritization

Table A.1 Treatment Coverage

SNU	COP 15 Prioritization	APR 16 Achievement	COP 16 Prioritization	Expected Achievement by APR 17	COP 17 Prioritization	COP17 Target (APR 18)
_Military Tanzania	Military	0%	Military	0%	Military	80%
Arusha City Council	ScaleUp Sat	59.4%	ScaleUp Sat	78%	ScaleUp Sat	89%
Arusha DC	Sustained	17.9%	ScaleUp Agg	59%	ScaleUp Sat	81%
Babati DC	Sustained	4.8%	Sustained	47%	Sustained	57%
Babati TC	Sustained	>100%	Sustained	68%	Sustained	82%
Bagamoyo DC	Sustained	56.3%	ScaleUp Agg	68%	ScaleUp Sat	84%
Bahi DC	Sustained	23.2%	Sustained	33%	Sustained	40%
Bariadi DC	Sustained	3.6%	Sustained	45%	Sustained	53%
Bariadi TC	Sustained	0.6%	Sustained	65%	Sustained	78%
Biharamulo DC	Sustained	53.8%	Sustained	59%	Sustained	70%
Buhigwe DC	Sustained	20.3%	Sustained	51%	Sustained	60%
Bukoba DC	ScaleUp Agg	35.2%	ScaleUp Agg	67%	ScaleUp Sat	82%
Bukoba MC	Sustained	80.3%	ScaleUp Sat	98%	ScaleUp Sat	100%
Bukombe DC	Sustained	2.3%	ScaleUp Sat	71%	ScaleUp Sat	81%
Bumbuli DC	NOT APPLICABLE	51.8%	Sustained	52%	Sustained	62%
Bunda DC	Sustained	60.9%	ScaleUp Sat	72%	ScaleUp Sat	98%
Busega DC	Sustained	1.0%	ScaleUp Agg	61%	ScaleUp Sat	81%
Busokelo DC	Sustained	8.3%	Sustained	94%	Sustained	112%
Butiama DC	Sustained	17.4%	Sustained	34%	Sustained	41%
Chake Chake	Sustained	0.0%	Sustained	160%	Attained	191%
Chamwino DC	Sustained	67.8%	Sustained	60%	Sustained	71%
Chato DC	Sustained	0.0%	ScaleUp Agg	63%	ScaleUp Sat	81%
Chemba DC	Sustained	1.1%	Sustained	21%	Sustained	25%
Chunya DC	Scale up Saturation	75.5%	ScaleUp Sat	84%	ScaleUp Sat	97%
Dodoma MC	ScaleUp Sat	66.8%	ScaleUp Sat	69%	ScaleUp Sat	85%
Gairo DC	Sustained	0.0%	Sustained	42%	Sustained	50%
Geita DC	ScaleUp Sat	1.1%	ScaleUp Sat	82%	ScaleUp Sat	89%
Geita TC	Sustained	8.5%	Sustained	145%	Sustained	174%
Hai DC	Sustained	65.3%	Sustained	43%	Sustained	52%
Hanang DC	Sustained	60.6%	Sustained	51%	Sustained	61%
Handeni DC	Sustained	71.9%	Sustained	43%	Sustained	51%

Handeni TC	Sustained	2.5%	Sustained	163%	Attained	195%
Igunga DC	ScaleUp Sat	70.3%	ScaleUp Sat	63%	ScaleUp Sat	81%
Ikungi DC	Sustained	0.0%	Sustained	33%	Sustained	40%
Ilala MC	ScaleUp Sat	65.1%	ScaleUp Sat	88%	ScaleUp Sat	97%
Ileje DC	Sustained	70.3%	Sustained	68%	Sustained	81%
Ilemela MC	Sustained	>100%	ScaleUp Agg	30%	ScaleUp Sat	89%
Iramba DC	Sustained	41.5%	ScaleUp Agg	64%	ScaleUp Sat	81%
Iringa DC	Sustained	70.7%	ScaleUp Agg	70%	ScaleUp Sat	81%
Iringa MC	ScaleUp Sat	>100%	ScaleUp Sat	117%	ScaleUp Sat	119%
Itilima DC	Sustained	3.2%	Sustained	75%	Sustained	90%
Kahama DC	ScaleUp Agg		NOT DEFINED	0%	NOT DEFINED	
Kahama TC	ScaleUp Sat	79.8%	ScaleUp Sat	93%	ScaleUp Sat	103%
Kakonko DC	Sustained	21.0%	Sustained	32%	Sustained	38%
Kalambo DC	Sustained	36.4%	Sustained	51%	Sustained	61%
Kaliua DC	Sustained	3.3%	ScaleUp Agg	60%	ScaleUp Sat	81%
Karagwe DC	Sustained	76.3%	ScaleUp Agg	66%	ScaleUp Sat	81%
Karatu DC	Sustained	42.3%	Sustained	37%	Sustained	44%
Kaskazini A	Sustained	0.0%	Sustained	648%	Sustained	774%
Kaskazini B	Sustained	0.0%	Sustained	0%	Sustained	0%
Kasulu DC	Sustained	26.8%	Sustained	31%	Sustained	37%
Kasulu TC	Sustained	42.3%	Sustained	26%	Sustained	31%
Kati	Sustained	0.0%	Sustained	0%	Sustained	0%
Kibaha DC	Sustained	58.3%	Sustained	69%	Sustained	82%
Kibaha TC	Sustained	82.3%	ScaleUp Sat	72%	ScaleUp Sat	88%
Kibondo DC	Sustained	29.7%	ScaleUp Agg	64%	ScaleUp Sat	81%
Kigoma DC	Sustained	5.1%	Sustained	10%	Sustained	12%
Kigoma Ujiji MC	ScaleUp Agg	21.7%	ScaleUp Agg	61%	ScaleUp Sat	81%
Kilindi DC	Sustained	66.6%	Sustained	75%	Sustained	90%
Kilolo DC	Sustained	50.7%	ScaleUp Agg	66%	ScaleUp Sat	81%
Kilombero DC	Sustained	78.3%	ScaleUp Sat	76%	ScaleUp Sat	86%
Kilosa DC	Sustained	83.3%	ScaleUp Agg	67%	ScaleUp Sat	83%
Kilwa DC	Sustained	85.6%	Sustained	85%	Sustained	101%
Kinondoni MC	ScaleUp Agg	35.5%	ScaleUp Sat	79%	ScaleUp Sat	92%
Kisarawe DC	Sustained	93.3%	Sustained	74%	Sustained	88%
Kishapu DC	Sustained	97.8%	ScaleUp Sat	77%	Attained	91%
Kieto DC	Sustained	57.9%	Sustained	52%	Sustained	62%
Kondoa DC	Sustained	67.7%	Sustained	51%	Sustained	61%
Kongwa DC	Sustained	40.2%	Sustained	44%	Sustained	53%
Korogwe DC	Sustained	>100%	Sustained	107%	Sustained	127%
Korogwe TC	ScaleUp Sat	89.4%	Sustained	93%	Sustained	111%

Kusini	Sustained	0.0%	Sustained	0%	Sustained	0%
Kwimba DC	Sustained	48.9%	ScaleUp Agg	74%	ScaleUp Sat	86%
Kyela DC	Scale up Saturation	48.6%	ScaleUp Sat	84%	ScaleUp Sat	92%
Kyerwa DC	Sustained	1.3%	Sustained	64%	Sustained	76%
Lindi DC	Sustained	82.3%	Sustained	90%	Sustained	108%
Lindi MC	ScaleUp Sat	>100%	Sustained	103%	Sustained	123%
Liwale DC	Sustained	93.7%	Sustained	65%	Sustained	77%
Longido DC	Sustained	54.7%	Sustained	34%	Sustained	40%
Ludewa DC	Sustained	4.9%	ScaleUp Agg	59%	ScaleUp Sat	81%
Lushoto DC	Sustained	>100%	Sustained	142%	Attained	170%
Mafia DC	Sustained	53.7%	Sustained	65%	Sustained	78%
Mafinga TC	Sustained	95.6%	Sustained	118%	Sustained	141%
Magharibi	ScaleUp Agg	0.0%	Sustained	2%	Sustained	2%
Magu DC	Sustained	>100%	ScaleUp Sat	85%	ScaleUp Sat	94%
Makambako TC	Sustained	30.5%	ScaleUp Sat	65%	ScaleUp Sat	81%
Makete DC	Sustained	2.7%	ScaleUp Sat	69%	ScaleUp Sat	81%
Manyoni DC	Sustained	54.2%	ScaleUp Agg	62%	ScaleUp Sat	81%
Masasi DC	Sustained	>100%	ScaleUp Sat	71%	ScaleUp Sat	85%
Masasi TC	Sustained	0.1%	Sustained	69%	Sustained	82%
Maswa DC	Sustained	78.9%	ScaleUp Sat	87%	ScaleUp Sat	90%
Mbarali DC	ScaleUp Agg	61.2%	ScaleUp Sat	73%	ScaleUp Sat	91%
Mbeya CC	Scale up Saturation	90.3%	ScaleUp Sat	87%	ScaleUp Sat	96%
Mbeya DC	ScaleUp Sat	87.6%	ScaleUp Sat	51%	ScaleUp Sat	81%
Mbinga DC	ScaleUp Agg	59.5%	ScaleUp Agg	60%	ScaleUp Sat	81%
Mbongwe DC	Sustained	7.0%	Sustained	72%	Sustained	86%
Mbozi DC	ScaleUp Sat	85.3%	ScaleUp Sat	69%	ScaleUp Sat	81%
Mbulu DC	Sustained	51.3%	Sustained	49%	Sustained	58%
Meatu DC	Sustained	67.8%	Sustained	84%	Sustained	100%
Meru DC	Sustained	42.9%	ScaleUp Agg	56%	ScaleUp Sat	81%
Micheweni	Sustained	0.0%	Sustained	0%	Sustained	0%
Missenyi DC	Sustained	47.4%	ScaleUp Agg	63%	ScaleUp Sat	81%
Misungwi DC	Sustained	73.1%	ScaleUp Agg	62%	ScaleUp Sat	95%
Mjini	ScaleUp Agg	0.0%	ScaleUp Agg	116%	ScaleUp Sat	117%
Mkalama DC	Sustained	0.3%	Sustained	39%	Sustained	46%
Mkinga DC	Sustained	74.2%	Sustained	69%	Sustained	83%
Mkoani	Sustained	0.0%	Sustained	0%	Sustained	0%
Mkuranga DC	Sustained	55.6%	ScaleUp Agg	69%	ScaleUp Sat	86%
Mlele DC	Sustained	82.1%	Sustained	237%	Sustained	283%
Momba DC	Sustained	17.1%	ScaleUp Agg	28%	ScaleUp Sat	81%
Monduli DC	Sustained	60.3%	Sustained	44%	Sustained	53%

Morogoro DC	Sustained	86.8%	Sustained	38%	Sustained	45%
Morogoro MC	ScaleUp Sat	64.4%	ScaleUp Sat	59%	ScaleUp Sat	81%
Moshi DC	ScaleUp Agg	28.9%	ScaleUp Agg	66%	ScaleUp Sat	81%
Moshi MC	Sustained	>100%	ScaleUp Sat	101%	Attained	121%
Mpanda DC	Sustained	6.7%	Sustained	89%	Sustained	107%
Mpanda TC	Sustained	7.7%	ScaleUp Agg	64%	ScaleUp Sat	81%
Mpwapwa DC	Sustained	>100%	Sustained	81%	Sustained	96%
Msalala DC	NOT APPLICABLE	41.8%	ScaleUp Agg	80%	ScaleUp Sat	90%
Mtwara DC	Sustained	78.6%	Sustained	60%	Sustained	71%
Mtwara Mikindani MC	Sustained	80.6%	Sustained	96%	Sustained	115%
Mufindi DC	ScaleUp Sat	>100%	ScaleUp Sat	78%	ScaleUp Sat	84%
Muheza DC	ScaleUp Sat	>100%	Sustained	113%	Attained	135%
Muleba DC	ScaleUp Sat	52.1%	ScaleUp Sat	77%	ScaleUp Sat	84%
Musoma DC	Sustained	>100%	Sustained	36%	Sustained	43%
Musoma MC	ScaleUp Sat	>100%	Sustained	153%	Sustained	183%
Mvomero DC	Sustained	71.9%	ScaleUp Agg	60%	ScaleUp Sat	81%
Mwanga DC	Sustained	>100%	Sustained	49%	Sustained	58%
Nachingwea DC	Sustained	79.9%	Sustained	79%	Sustained	95%
Namtumbo DC	Sustained	43.3%	Sustained	46%	Sustained	55%
Nanyumba TC	NOT APPLICABLE	0.0%	Sustained	40%	Sustained	48%
Nanyumbu DC	Sustained	47.7%	Sustained	56%	Sustained	66%
Newala DC	Sustained	13.9%	ScaleUp Agg	64%	ScaleUp Sat	83%
Ngara DC	Sustained	52.2%	Sustained	55%	Sustained	66%
Ngorongoro DC	Sustained	>100%	Sustained	43%	Sustained	51%
Njombe DC	Sustained	17.6%	ScaleUp Agg	68%	ScaleUp Sat	81%
Njombe TC	ScaleUp Sat	5.2%	ScaleUp Sat	66%	ScaleUp Sat	81%
Nkasi DC	Sustained	49.2%	ScaleUp Agg	64%	ScaleUp Sat	81%
Nsimbo DC	NOT APPLICABLE	11.9%	ScaleUp Agg	65%	ScaleUp Sat	81%
Nyamagana MC	ScaleUp Sat	>100%	ScaleUp Sat	143%	Attained	171%
Nyang'hwale DC	Sustained	17.0%	Sustained	51%	Sustained	61%
Nyasa DC	Sustained	9.0%	ScaleUp Agg	61%	ScaleUp Sat	81%
Nzega DC	ScaleUp Sat	69.2%	ScaleUp Sat	74%	ScaleUp Sat	83%
Nzega TC	NOT APPLICABLE	21.7%	Sustained	23%	Sustained	28%
Pangani DC	Sustained	82.9%	Sustained	72%	Sustained	86%
Rombo DC	Sustained	55.9%	Sustained	51%	Sustained	61%
Rorya DC	ScaleUp Sat	24.1%	ScaleUp Sat	81%	ScaleUp Sat	149%

Ruangwa DC	Sustained	74.2%	Sustained	76%	Sustained	90%
Rufiji DC	Sustained	71.1%	ScaleUp Sat	79%	ScaleUp Sat	91%
Rungwe DC	ScaleUp Agg	99.5%	ScaleUp Sat	77%	ScaleUp Sat	83%
Same DC	Sustained	58.1%	Sustained	59%	Sustained	71%
Sengerema DC	ScaleUp Agg	76.5%	ScaleUp Agg	86%	ScaleUp Sat	95%
Serengeti DC	Sustained	65.1%	Sustained	63%	Sustained	75%
Shinyanga DC	Sustained	66.7%	ScaleUp Agg	61%	ScaleUp Sat	81%
Shinyanga MC	ScaleUp Sat	68.7%	ScaleUp Sat	83%	ScaleUp Sat	94%
Siha DC	Sustained	31.4%	Sustained	76%	Sustained	91%
Sikonge DC	Sustained	48.2%	Sustained	48%	Sustained	58%
Simanjiro DC	Sustained	48.2%	Sustained	32%	Sustained	39%
Singida DC	Sustained	59.8%	Sustained	26%	Sustained	31%
Singida MC	Sustained	72.3%	Sustained	62%	Sustained	74%
Songea DC	Sustained	71.8%	ScaleUp Agg	67%	ScaleUp Sat	81%
Songea MC	ScaleUp Sat	52.9%	ScaleUp Sat	59%	ScaleUp Sat	81%
Sumbawanga DC	ScaleUp Agg	56.9%	ScaleUp Agg	67%	ScaleUp Sat	81%
Sumbawanga MC	ScaleUp Sat	46.5%	ScaleUp Sat	73%	ScaleUp Sat	83%
Tabora MC	ScaleUp Agg	73.4%	ScaleUp Agg	46%	ScaleUp Sat	81%
Tandahimba DC	Sustained	41.3%	Sustained	56%	Sustained	67%
Tanga City Council	ScaleUp Sat	>100%	ScaleUp Sat	112%	ScaleUp Sat	117%
Tarime DC	Sustained	26.9%	Sustained	71%	Sustained	85%
Tarime TC	NOT APPLICABLE	>100%	Sustained	26%	Sustained	31%
Temeke MC	ScaleUp Agg	49.6%	ScaleUp Sat	81%	ScaleUp Sat	99%
Tunduma TC	NOT APPLICABLE	51.9%	ScaleUp Agg	71%	ScaleUp Sat	84%
Tunduru DC	Sustained	28.6%	ScaleUp Agg	60%	ScaleUp Sat	81%
Ukerewe DC	Sustained	72.8%	Sustained	69%	Sustained	82%
Ulanga DC	Sustained	58.6%	Sustained	62%	Sustained	74%
Urambo DC	Sustained	>100%	Sustained	45%	Sustained	54%
Ushetu DC	NOT APPLICABLE	47.4%	ScaleUp Agg	83%	ScaleUp Sat	99%
Uvinza DC	Sustained	11.3%	ScaleUp Agg	63%	ScaleUp Sat	82%
Uyui DC	Sustained	75.3%	ScaleUp Agg	57%	ScaleUp Sat	81%
Wanging'ombe DC	ScaleUp Agg	5.9%	ScaleUp Agg	60%	ScaleUp Sat	81%
Wete	Sustained	0.0%	Sustained	129%	Sustained	154%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART	Additional patients required for 80% ART	Target current on ART	Newly initiated (APR FY	ART Coverage (APR 18)

		(APR FY 2017)	coverage	(APR FY 2018) TX_CURR	2018) TX_NEW	
Attained	35,773	41,644	8,079	49,722	13,455	139%
Scale-Up Saturation	1,085,648	795,496	172,656	968,152	278,104	89%
Scale-Up Aggressive	N/A	N/A	N/A	N/A	N/A	N/A
Sustained	264,364	161,194	31,272	192,469	52,083	73%
Central Support	N/A	N/A	N/A	N/A	N/A	N/A
Military	N/A	22,624	12,284	39,908	16,389	N/A
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A	N/A
Total	1,385,785	1,020,958	224,291	1,250,251	360,031	90%

APPENDIX B

B.1 Planned Spending in COP 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	**New Funding**	**Total Spend**
$99,549,400	**$383,310,544**	**$482,859,944**

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
CIRC	Male Circumcision	$19,842,188
HBHC	Adult Care and Support	$11,577,381
HKID	Orphans and Vulnerable Children	$15,331,510
HLAB	Lab	$4,510,535
HTXS	Adult Treatment	$111,207,671
HTXD	ARV Drugs	$70,275,766
HVCT	Counseling and Testing	$46,028,461
HVMS	Management & Operations	$16,020,760
HVOP	Other Sexual Prevention	$23,194,069
HVSI	Strategic Information	$6,151,675
HVTB	TB/HIV Care	$15,758,021
IDUP	Injecting and Non-Injecting Drug Use	$2,303,329
MTCT	Mother to Child Transmission	$15,556,826
OHSS	Health Systems Strengthening	$9,728,596
PDCS	Pediatric Care and Support	$1,248,708
PDTX	Pediatric Treatment	$10,803,053
HMBL	Blood Safety	$838,064
HMIN	Injection Safety	$15,557
HVAB	Abstinence and Be Faithful	$2,918,374
TOTAL		$383,310,544

B.2 Resource Projections

PEPFAR/T used the Expenditure Analysis (EA) data throughout the COP process to inform planning and for budgeting purposes. In the early phases of COP development, Technical Working Groups (TWG) reviewed UEs to identify outliers. Reported FY 2016 UEs across program areas were utilized as a starting point for arriving to COP 2017 applied UE. In consultation with the EA Advisor, adjustments to these UEs were made based on assumptions taking into account the program and partner context.

All target driven TWGs used the adjusted applied UEs in the PBAC tool to project the national level budget. IP budgets utilized IM SNU UE. The IM SNU UEs were recalculated and used to set partner budgets after removing outliers. Low outlier IM SNU UEs were pushed up to the low UE threshold determined by taking a cutoff point of the average IM SNU UE divided by five. Highest IM SNU UEs were pushed down to upper IM SNU UE threshold determined by taking a cutoff of 5 times the average IM SNU UE.

Testing indicators used adjusted national UE to set partner budgets due to reported achievement issues in EA 2016. Budget code amounts were derived in PBAC after budgeting for targets by SNU categorization. In an effort to maximize efficiency, given the rationalized landscape by IP and SNU and programmatic context, PEPFAR/T used the IM SNU UE for COP 2017 IP budget setting. Adjustments were made on lowest UE and highest UE by pushing them to nearest within the range UE. PEPFAR/T will implement routine monitoring strategy from the start of FY 2018 to ensure partners are able to implement programs effectively and stay on track to achieve the targets with the budgets assigned to them.

PEPFAR/T budgeted for all HIV commodities, Program Management (PM) and Strategic Information (SI) separately through the PBAC's commodity calculator and PM and SI tab. Thus, the cost of all commodities (ARVs, non-ARV drugs/reagents, HIV test kits, and condoms), PM and SI was removed from the relevant program area unit expenditure with the exception male circumcision since the MC surgical kit already included an HIV rapid test. To budget for commodities, PEPFAR/T calculated the additional number of patients to be served above the estimated Global Fund procurements. Unit costs (calculated using the current cost of the product and increased by 20% to account for Procurement and Supply Management costs) were applied to each target served to approximate the budget for commodity category. Additionally, CD4 tests and viral load tests were also budgeted in the PBAC commodities calculator.

Program Management and Strategic Information budget were allocated by taking out the portion of PM and SI from the applied UEs.

The Program Support Cluster (PSC), which includes Health Systems SI, and Lab TWGs did extensive analysis of EA data. After filtering for target driven partners, PEPFAR/T was able to provide information to each TWG on the expenditures for each TWG on above-site health systems activities. TWGs used this information to inform budget allocations for non-target (or non-unit expenditure) driven activities. The HSS TWG used the COP 2016 budget as a starting point in review of activities and budgets as part of the strategic alignment (SBOR) process.

Activities that were completed in Year One were deleted and the remaining activities were reviewed by respective TWGs to ensure relevance and fit within the programmatic gaps. Three year outcomes were validated during this review process and yearly benchmarks developed. Savings found during this review process are used towards new activities that are deemed critical for epidemic control and vetted at the TWG and inter-agency level. The end result is a reduction in above site level investment amount compared to COP 2016. The above site level activity investment in COP 2017 is 9% of the total budget – a reduction from 13% of total budget in the previous two COP cycles.

HTS

Facility-based testing (FBTC), largely PITC, will be supported by clinical partners who receive HTXS funding. The unit cost of $2.73 was applied to FBTC in Scale-Up Councils, Attained, and Sustained Councils. The UE excludes costs for RTKs, which were budgeted in the PBAC commodities calculator.

For community-based HTC, the unit expenditure of $12.35 (excluding RTKs) in all SNUs was used. Funding was increased to from $9.65 to $12.35 for coordination of support, travel and transport to facilitate client's escorting, and other recurrent expenditures increased to support communications.

Care and Treatment

PEPFAR/T used FY 2016 UEs as a starting point and made adjustments on cost categories. Some cost categories were fixed and others variable. The clinical TWG considered the UE in four categories: (a) service delivery, (b) associated lab component, (c) commodities, (d) program support (PM and SI).

The applied UEs were average national unit expenditure to allocate resource across all councils. This was done under a consideration that there is no major difference in the package of services at facility level between Scale-Up, Attained, and Sustained Councils. UEs adjustment were made by adjusting cost categories which the TWG agreed to not increase (i.e., fixed) as the targets increase. Construction and renovation, vehicles and equipment, and furniture were zeroed out, while in-service training, other investment expenditures, building rental and utilities, PM, and SI were fixed. Personnel and travel and transport increased to supportive patients tracking and follow up and partners to do weekly supportive supervision. The lab component of the ART UE was evaluated separately and necessary adjustments were made. The UEs used excluded ARVs, Non-ARV Drugs/Reagents, HIV test kits and condoms (budgeted separately in the commodities calculator). The IM SNU UE was used to allocate councils' IM level budgets. A product of council's targets and unit expenditures was summed up to come up with individual IM budget for all councils supported by the respective mechanism. IMs with low or higher outliers pushed to nearest UE threshold.

No Pre-ART UEs were used for budgeting since there are no associated targets in COP 2017.

Below are the adjusted applied national unit expenditures used:

Adult ART (incl. lab, PM, and SI, excl. commodities)	$105.49
Pediatrics ART (incl. lab, PM, and SI, excl. commodities)	$120.91

For community-based care, treatment, and support, the UE was calculated using reported FY 2016 CBCTS expenditures divide by COP 15 targets as the EA 2016 have not reported CBCTS UEs due to SI reporting issues. The estimated UE of $ 64.01 was used as a base line to estimate the unit budget. After adjustment, the applied UE for CBCTS is $70.27.

PMTCT

For PMTCT, PEPFAR/T used the COP 2016 UEs except for PMTCT on treatment. The UEs excluded expenditures for ARVs, Non-ARVS, HIV test kits and condoms and applied them to the respective council targets to reach the epidemic control for four PMTCT indicators:

1) # of pregnant women tested and received results
2) # of women receiving ART as Option B+ (PMTCT_ARV disaggregate Life-long ART (Option B+))
3) # of infants tested (PMTCT_EID Numerator)
4) # infants receiving care (PMTCT_STAT_POS)

PEPFAR/T used the following methodology for the PMTCT indicators:

	Methodology
# of pregnant women tested and received results (PMTCT_STAT) UEs	COP 2016 UE was used. Scale-Up, Attained, and Sustained have the same UE. UE excludes HIV test kits and condoms. The applied COP 2017 UE is $4.47 including COP 2016 site level lump sum.
# of women receiving ART as Option B+ (PMTCT_ARV disaggregate Life-long ART (Option B+)	EA16 Adult ART UE was used as a baseline to estimate PMTCT ART UE. The applied UE is $93.07 and B+ Lab is $12.42.
# of infants tested (PMTCT_EID Numerator)	COP 2016 UE was used. The UE used for COP 2017 is $61.19 and for EID_Lab is $26.21
# infants receiving care (PMTCT_STAT_POS)	COP 2016 UE was used The UE used for COP 2017 is $26.62 Note that PEPFAR/T is aware that the TX_CURR (<1 year old) indicator may not be fully reflective for whom the resources are used as the actual beneficiaries extend well beyond those infants already on treatment i.e., all exposed infants.

VMMC

VMMC TWG created a total service delivery budget to saturate VMMC using a UE of $58.65. The UE excludes costs for VMMC Kits and RTKs, which were budgeted in the PBAC commodities calculator.

Key Population and AGYW Prevention

The TWG conducted a literature search on unit cost of individual components of a minimum package of services for KP and AGYW. In addition, the team also looked at the various components budgeted through the DREAMS program. There was consensus to utilize the COP 2016 UEs for COP 2017 for all prevention targets (PP-PREV, MSM/TG, FSW, PWID, and MAT). The UEs used for COP 2017 are PP-PREV- $36, MSM/TG-$82, FSW-$60, PWID-$90 and MAT $470.28

OVC

UEs for Scale-Up and Attained Councils were based off of COP 2016 UE for scale-up of $47.86. Cluster agreed to keep UEs the same as COP 2016 but adding up COP 2016 site lump sum. There was no Sustained UE as there was no sustained target.

All UEs included PM and SI during TWG discussion, however the National Projected Budget excluded the PM and SI portion and having two separate budget for PM and SI and TBB.

APPENDIX C

Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control

Systems Investments for Section 6.0:

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HR Requests and retention plans at LGA levels, POPSM's HRH permit allocation process, POPSM's HR information systems, LGAs HRH data systems, Community HRH systems, Task sharing rollout HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	Scholarships and tuition support for students
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities; sitting fees for health workers participating in stakeholders meetings
Governance	
Develop community care guidelines, Technical area-specific guidelines, tools, and policy; general policy on Test and Start, Age of Consent, Patient Categorization and other governance; Development of National strategic behavior change messaging, Review HTS policy guidelines, SOPs, protocols, TOTs, curriculum and M&E system, Human rights advocacy and other governance activities not classified as above	Sitting fees for health workers participating in stakeholders meetings. Conference packages at hotels.
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; commodity distribution and support for commodity domestic Funding Plans other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS), LGA performance monitoring systems; National and LGA dashboards and data warehouse, CHW management systems, DHIS2 system, laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	

Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	Sitting fees for health workers participating in stakeholders meetings. Conference packages at hotels.
Strategic Information	
Monitoring and evaluation systems, Service statistics (DHIS) and logistics data (eLMIS) dashboard; surveys; operations research; geographic mapping, National and LGA dashboards,; surveillance; multi-sectoral geographical hierarchy registry other strategic information activities not classified above	N/A
Laboratory	
Quality management and bio-safety systems; implementation and evaluation of diagnostics (VL monitoring); capacity building, EQA, Viral Load, and EID systems, laboratory information and data management systems including basic laboratory information (BLISS) system; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included