

**TANZANIA**

**Country Operational Plan**

**(COP) 2016**

**Strategic Direction Summary**

August 5, 2016

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## Goal Statement

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Working collaboratively across U.S. Government agencies, the Government 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 84 councils with the highest HIV burden, out of a total of 178 councils in Tanzania. Based on a review of new council boundaries, updated epidemiologic data and the results and data from FY2015, the interagency team expanded from the 42 priority councils included in COP 2015 to a focus on 84 councils.

For COP 2016, the 84 Scale-Up Councils are home to approximately 80% of the 1.4 million persons living with HIV (PLHIV) in Tanzania. They include 40 Scale-Up to Saturation Councils and 44 Aggressive Scale-Up Councils. The goal in the Scale-Up to Saturation Councils is to reach 80% coverage of all PLHIV on antiretroviral therapy (ART) by 2017. The goal in the Aggressive Scale-Up Councils, where ART coverage is currently lower, is to reach 80% coverage by 2018 or 2019. One key population hotspot council is also included in the Aggressive Scale-Up Councils. The Scale-Up to Saturation Councils also include councils in Dar es Salaam that were upgraded from the Aggressive Scale-Up Council category, to reach saturation more quickly. The remaining 94 Sustained Councils will continue to be supported by PEPFAR through passive enrollment of clients only.

Within the Scale-Up Councils, IPs will focus implementation and site level targets in areas of highest HIV burden. 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. Interventions include partner notification and treatment, social networks through incentivized peer referrals, increased condom use, targeted testing of TB suspects and patients with sexually transmitted infection (STI) to optimize identification of PLHIV, linkages to services, uptake of ART, retention, and adherence. PEPFAR/T will continue supporting a standard package of prevention, care, treatment, and support for beneficiaries in care and treatment, including PMTCT, in all council types, with greater focus of demand creation for services in Scale-Up Councils. PEPFAR/T will also continue to support core services for orphans and vulnerable children (OVC) in Scale-Up Councils while transitioning out of Sustained Councils by September 2017.

In 2016, the GOT is undertaking substantial policy revisions to achieve the UNAIDS 90-90-90 goals by 2020 and move Tanzania closer to epidemic control. In January 2016, the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) adopted the 2013 World Health Organization (WHO) recommendations for ART initiation of patients with a CD4 count of less than 500. After review of the 2015 WHO guidelines and available funding, MOHCDGEC indicated that it will adopt Test and Start nationwide as of October 2016. In addition, the service delivery package will be revised and adjusted to standardize the length of time between visits and access to medications in the community for stable patients, which may help decongest clinics and allow more patients to be placed on treatment. In March 2016, MOHCDGEC signed the Task Sharing policy allowing nurses to prescribe anti-retroviral (ARV) drugs and community health care workers to perform rapid testing. PEPFAR/T continues to

work closely with MOHCDGEC to scale up viral load testing as a routine service throughout the country and to also discuss other efficiencies, such as community ARV delivery.

PEPFAR/T will work with the GOT to determine the best schedule to implement these important policy revisions. The discussions will complement continued consultations and advocacy for increased Domestic Resource Mobilization (DRM) from both public and private sector sources, including adequate funding of the AIDS Trust Fund (ATF). In particular, 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 the Global Fund to Fight AIDS, Tuberculosis, and Malaria (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 beyond 2017. PEPFAR/T will also continue to work with the GOT to plan for a phased and increasing proportion of government to government activities and salary support across all mechanisms to transition to GOT financial support.

PEPFAR/T will work with the GOT in 2016 to transition out of PEPFAR service delivery support provided to all sites serving fewer than 10 ART or PMTCT patients on treatment per year. There were 2,788 sites below this 10 patient threshold out of a total of 5,322 PEPFAR-supported sites during COP 2015 implementation. As of March 2016, these low volume sites were seeing less than 10,000 patients combined. PEPFAR will work with the GOT at the national and local levels to conduct an inventory review of training, human resources, lab support, and assets in order to transition these low volume sites in a phased manner beginning in October 2016.

## 1.0 Epidemic, Response, and Program Context

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### 1.1 Summary statistics, disease burden and country or regional profile

According to UNAIDS,<sup>1</sup> 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)<sup>2</sup>. UNAIDS estimates a total of 1.4 million Tanzanians living with HIV in 2015, out of a total population of 48,667,310. 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 and incidence, but more geographic and population-focused interventions and improving universal access to ART in priority areas will be required to attain epidemic control. This includes shifting resources towards higher volume and higher yield sites in higher burden councils, aligning partners for better program efficiency, and reviewing partner

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<sup>1</sup> <http://aidsinfo.unaids.org/>

<sup>2</sup> Tanzania 2011-12 HIV/AIDS Malaria Indicator Survey

work plans and budgets to identify savings from unnecessary travel and unsupported staff salaries.

The country grapples with weak health infrastructure, poor quality data, shortages of health and social workers, high levels of 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 other relevant national strategic documents, 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 focusing on core, evidence-based interventions.

In December 2014, the National Bureau of Statistics announced a revision of its national accounts in which they rebased economic indicators to 2007 prices. This revision produced an estimated 31.9% increase of the 2013 Gross Domestic Product and an updated per capita Gross Domestic Income of \$977. The new estimate brings the country closer to the World Bank threshold of \$1,046 to qualify for lower middle income status. Qualification as lower middle income status would have significant implications for GOT counterpart financing requirements for the GFATM (raising it from 5% to 15%) as well as other health-related and development financing platforms. Although the Parliament of Tanzania approved the creation of the ATF in 2015, the funding level last year was set at only \$1.5 million. To date, the ATF is not yet functional. PEPFAR/T is working with the GOT as the ATF is established to ensure that activities are well prioritized. TACAIDS, with support from UNAIDS, is also launching an Investment Case in April 2016 that will help to identify resource gaps and assist the country to prioritize activities.

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	48,667,310	100	10,681,562	22	10,685,184	22	14,296,029	29	13,004,535	27	National Bureau of Statistics Estimation, 2014
Prevalence (%) (15-49)		4.69 (2015)					6.37		4.30		UNAIDS Spectrum Estimates, 2015
AIDS Deaths	35,659 (2015)	NA	5,105 (both male and female)			14	9,450	38	15,304	62	UNAIDS Spectrum Estimates, 2015
PLHIV	1,385,779 (2015)	NA	91,353 (both male and female)			7	776,355	60	518,071	40	UNAIDS Spectrum Estimates, 2015
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	26,127	58	18,997	42	UNAIDS Spectrum Estimates, 2015
Annual births	1,911,313	NA			NA				NA		UNAIDS Spectrum

											Estimates, 2015
% >= 1 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
TB cases	63,151 (2014) TB prevalence 295/100.000										NTLF Annual Report, 2014  TB Prevalence survey report Sept 2013
TB/HIV Co-infection	19,890										NTLF Annual Report, 2014
Males Circumcised	612,557		NA		278,701	45	NA		333,856	56	PEPFAR Tanzania Annual Program Results (APR) for FY 2014
Key Populations	235,150										Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Total 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
Total 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

Total 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 <sup>2</sup>	4,782,006	2.74			NA					NA	Calculations based on NBS (2014) projections and THMIS (2012)
Military Community <sup>4</sup>	61,632										Calculations based PEPFAR program data and partner information, FY 2013

			<b>HIV Treatment and Viral Suppression</b>				<b>HIV Testing and Linkage to ART</b>			
	<b>Total Population Size Estimate</b>	<b>HIV Prev (15-49 years)</b>	<b>Total PLHIV</b>	<b>On ART</b>	<b>Retained on ART 12 Months</b>	<b>Viral Suppression 12 Months</b>	<b>Tested for HIV</b>	<b>Diagnosed HIV Positive</b>	<b>Initiated on ART</b>	
	(#)	(%)	(#)	(#)	(#)		(#)	(#)	(#)	
<b>Total population</b>	48,667,310 <sup>1</sup>	4.7 <sup>2</sup>	1,400,000 <sup>2</sup>	740,078 <sup>2</sup>	Not available	Not available	Not available	Not available	Not available	
<b>Population less than 15 years</b>	21,366,746 <sup>1</sup>	Not available	91,000 <sup>2</sup>	51,474 <sup>2</sup>	Not available	Not available	Not available	Not available	Not available	
<b>Pregnant Women</b>	1,928,533 <sup>5</sup>	5.6 <sup>4</sup>	86,000 <sup>2</sup>	74,190 <sup>2</sup>	56,501 <sup>6</sup>	Not available	1,588,234 <sup>4</sup>	47,487 <sup>4</sup>	37,870 <sup>4</sup>	
<b>MSM</b>	49,700 <sup>7</sup>	25 <sup>7</sup>	Not available	Not available	Not available	Not available	Not available	Not available	Not available	
<b>FSW</b>	155,450 <sup>7</sup>	26 <sup>7</sup>	Not available	Not available	Not available	Not available	Not available	Not available	Not available	
<b>PWID</b>	30,000 <sup>7</sup>	36 <sup>7</sup>	Not available	Not available	Not available	Not available	Not available	Not available	Not available	
<b>Priority Pop (AGYW)</b>	4,782,006 <sup>8</sup>	2.74 <sup>8</sup>	131,027 <sup>8</sup>	Not available	Not available	Not available	Not available	Not available	Not available	

<sup>1</sup> National Bureau of Statistics Estimation, 2016.

<sup>2</sup> UNAIDS 2015 Spectrum Estimates for 2015

<sup>3</sup> National AIDS Control Program

<sup>3</sup> PEPFAR Program Data, 2015

<sup>4</sup> ANC, 2011

<sup>5</sup>  $PMTCT\_STAT$  denominator, FY 2015 / % of pregnant women who attended ANC, TDHS 2010 =  $1928533 / 0.959 = 2010983$

<sup>6</sup> 75% of PW on ART<sup>7</sup>

<sup>7</sup> Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.

<sup>8</sup> Calculations based PEPFAR program data and partner information, FY 2013

There are differences in the prevalence between urban (7.2%) and rural (4.3%) areas. Gender disparities are also significant between male prevalence (3.8%) and the nearly double female prevalence (6.2%), with girls acquiring HIV at a younger age. The PEPFAR-funded 2016-2017 Tanzania HIV Impact Survey (THIS) will take place in 2016 and 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 the 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 the HIV prevalence is 36% among people who inject drugs, 26% among sex workers, and 25% for men who have sex with men.<sup>3</sup>

## **1.2 Investment Profile**

Tanzania's national HIV program is heavily donor dependent. PEPFAR and the GFATM are the two largest donors, contributing 98.8% of all financing, according to the 2013-2014 Public Expenditure Review (2015) for HIV and AIDS. Moreover, the share of health sector (all areas of health) spending by the GOT from its own resources has significantly declined from 13% in 2006/7 to approximately 6% in 2013/14. 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 2017.

The GFATM approved the HIV/TB Concept Note submitted in October 2014 for mainland Tanzania including \$230 million within the country's pre-set funding allocation, \$78.6 million in additional incentive funding, and also registered \$285.7 million as Unfunded Quality Demand, the majority of which was for medicines and health commodities. Within this funding envelope, the HIV grant to the Ministry of Finance was scheduled to end in December 2016 with a capped ART patient number of 656,794 PLHIV. In July 2016, this grant was approved for an additional \$109 million and extended through the end of December 2017, and the ART patient cap was removed. GFATM support for HIV/TB in Zanzibar for the current funding period (2015-17) totals approximately \$10 million and includes funding for HIV care, treatment, and support, as well as prevention programs for the general population and key populations, PMTCT, health information systems, and treatment for HIV/TB co-infection.

PEPFAR/T plans to increase the funding portfolio for COP 2016, with an additional \$37,391,603 in Treatment Impact Funds, and continues to utilize central funding for DREAMS and the Accelerating Children on Treatment (ACT) initiatives, voluntary medical male circumcision (VMMC) and Viral Load (VL) Scale-Up. PEPFAR/T is also adopting a streamlined service delivery package, revised care package, and prioritized core interventions to achieve epidemic control, all of which have allowed PEPFAR with the GFATM to identify funding to cover the full funding needs for commodity procurement through FY 2017, complemented by continued advocacy for the GOT to adequately finance the cost of logistics in country.

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

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<sup>3</sup> *Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014.*

followed the UNAIDS investment approach which prioritizes particular activities and geographies for maximum impact. The NMSF III prioritizes investments by intervention category, the GFATM HIV/TB Concept Note prioritizes priority population prevention and key population activities in the top ten high prevalence regions, and PEPFAR support prioritizes high-impact service delivery in the 84 Scale-Up Councils (most of which are aligned with the ten regions in the GFATM concept note). 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 and GFATM to determine resource needs based on this scale-up plan.

**Table 1.2.1 Investment Profile by Program Area**

Program Area	Total Expenditure	% PEPFAR	% GFATM	% GOT	% Other
Clinical care, treatment and support	\$209,720,870	61.52%	37.70%	0.11%	0.67%
Community-based care	\$21,592,836	100%	0%	0%	0%
PMTCT	\$44,313,994	99.86%	0.14%	0%	0%
HTC	\$24,015,109	88.22%	11.78%	0%	0%
VMMC	\$24,547,531	100%	0%	0%	0%
General Population Prevention	\$36,917,655	50.53%	5.7%	0%	43.77%
Priority population prevention	\$5,558,332	100%	0%	0%	0%
Key population prevention	\$9,863,178	71.41%	28.59%	0%	0%
OVC	\$44,764,286	49.49%	0%	0%	50.51%
Laboratory	\$24,460,221	100%	0%	0%	0%
SI, Surveys and Surveillance	\$11,299,816	88.89%	11.11%	0%	0%
HSS	\$36,811,216	7.36%	15.24%	14.27%	63.13%
<b>Total</b>	<b>\$493,865,044</b>	<b>67.07%</b>	<b>18.98%</b>	<b>1.66%</b>	<b>12.84%</b>

Source: PER HIV/AIDS FY 2013/14 (2015); PEPFAR EA 2014; GF EA; PER Private Sector HIV/AIDS (2015)  
 Program Area breakdowns for GOT and Other Donors estimated from % breakdowns in the PER HIV/AIDS

**Table 1.2.2 Procurement Profile for Key Commodities in FY 2017**

Commodity Category	Total Budget	PEPFAR	GF	Host Country	Other
ARVs	\$183,110,582	\$94,222,572	\$83,106,128	\$5,781,882	-
Rapid test kits	\$8,385,992	\$2,722,259	\$5,268,875	\$394,858	-
Other drugs	-	-	-	-	-
Lab reagents	\$33,425,503	\$2,550,885	\$29,174,015	\$1,700,603	-
Condoms	\$1,006,557	\$1,006,557	-	-	-
Viral Load commodities	\$24,474,031	\$15,856,465	\$7,949,785	\$667,781	-
VMMC kits	\$7,869,735	\$7,869,735	-	-	-
MAT	\$189,119	\$189,119	-	-	-
Other commodities	-	-	-	-	-
<b>Total</b>	<b>\$258,461,519</b>	<b>\$124,417,592</b>	<b>\$125,498,803</b>	<b>\$8,545,124</b>	<b>-</b>

Commodity costs include associated storage and distribution expenditures

**Table 1.2.3 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	\$12,819,319	\$11,767,319	7	\$21,090,000	Maternal and Child Health
USAID TB	\$4,806,282	\$2,450,000	7	\$27,541,821	TB control
USAID Malaria	\$44,722,885	\$23,870,185	9	\$28,540,000	Malaria control
Family Planning	\$24,050,022	\$20,050,022	11	\$33,058,282	Family planning

NIH	0	0	0		110 various studies in Tanzania Global Health Security, Malaria, FELTP Community health
CDC	\$5,200,000	0	0		
Peace Corps	\$2,980,000	\$2,980,000	1	\$213,010	
<b>Total</b>	<b>\$94,578,508</b>	<b>\$61,117,526</b>	<b>35</b>	<b>\$110,443,113</b>	

**Table 1.2.4 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
ACT	\$12,075,000	\$5,000,000	\$12,075,000	3		Double Pediatric ART Coverage
DREAMS	\$16,326,356		\$16,326,356	9		
DREAMS Innovation	TBD					
DREAMS Test & Start-Men	\$2,368,337		\$2,368,337	1		Increase Male ART coverage
VMMC	\$24,190,348		\$24,190,348	6		Increase VMMC
Viral Load	\$1,553,000		\$1,553,000	0		Increase Viral Load
Other PEPFAR Central Initiatives	\$2,500,000		\$2,500,000	1		PEPFAR/MCC Data Initiative
Other Public Private Partnership				0		Various
<b>Total</b>	<b>\$59,013,041</b>	<b>\$5,000,000</b>	<b>\$59,013,041</b>			

### 1.3 National Sustainability Profile

The Sustainability Index and Dashboard (SID) for 2016 was completed through a combination of desk reviews, individual consultations with MOHCDGEC and Tanzania AIDS Commission (TACAIDS) staff, MOHCDGEC technical working group meetings, the Joint UN HIV Programme Working Group, and civil society engagement meetings during the period from 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 in order to address the sustainability weaknesses identified. The sustainability domains scoring in the red category range included Service Delivery, Laboratory, Domestic Resource Mobilization (DRM), and Technical/Allocative Efficiencies.

To address the weaknesses in service delivery, PEPFAR/T is supporting the implementation of the recently approved Task Sharing Policy, in conjunction with a differentiated HIV service delivery model, to help decongest facilities and improve the quality of HIV clinical services. COP 2016 supports the realization of greater technical and allocative efficiencies in the existing HIV services delivery model, through implementation of 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 to implement new service delivery models in which stable patients will no longer be required to visit facilities on a monthly basis. In these types of new service delivery models, ARV medicines may be available for pick-up in quantities of two or three months and clinical

evaluations may be reduced to once every three to six months. In addition, ARV pick-up locations may be decentralized to be available closer to patients at dispensaries or other 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 and AIDS response, PEPFAR will work with the GOT to plan a phased transition of salary support for PEPFAR funded positions to the GOT. A Health Worker Salary Inventory was conducted at the end of 2015 showing PEPFAR/T supported 28,265 clinical, managerial, and community health workers through one or a combination of different benefits, including salaries/stipends, financial benefits (*e.g.*, social security fund, insurance, annual leave, and other fringe benefits as well as allowances), non-financial benefits (*e.g.*, mobile phones, airtime, internet), and professional development. During COP 2016 implementation, PEPFAR/T will develop an HRH transition plan, in consultation with government counterparts, to begin sustainably shifting these costs to the government budget, particularly in the 2,788 low volume sites that will transition to GOT.

The availability and accessibility of life-saving anti-retroviral drugs (ARVs) are the cornerstones of epidemic control. While the GFATM and PEPFAR/T collectively procure commodities, PEPFAR/T also provide technical assistance (TA) to strengthening supply chain performance management in facilities providing HIV services, as well as national level institutions. Prior support has produced a significant increase in the availability of products at MSD, councils, and facilities to date. Moving forward, through recommendations of a recent assessment of MSD, PEPFAR will support restructuring the supply chain system design that will enhance supply chain data analytics to both improve performance and streamline distribution. PEPFAR will also assist the Pharmaceutical Services Unit to develop performance metrics, to be used to hold MSD and facilities accountable to a minimum standard of service.

To improve the sustainability of the laboratory program, PEPFAR/T has fully mapped and piloted an Early Infant Diagnosis (EID) and viral load specimen transport system, which will be rolled out nationally during the implementation of COP 2016. Two web-based dashboards for real time viral load and EID monitoring will additionally inform the effective implementation of diagnostic services for HIV. COP 2016 also allocates resources for improving the selection of courier systems for sample transport and for training Council Health Management Teams (CHMT) to increase the demand for viral load diagnostic services.

Recognizing the need to scale-up access to HIV/AIDS care and treatment as well as the dependency on PEPFAR and the GFATM to finance the national response, the GOT has taken steps to promote DRM and financial sustainability. Specifically, the GOT established the ATF in 2015 and developed a Health Financing Strategy (HFS) through an Inter-Ministerial Steering Committee. 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 continues to advocate that the GOT allocate sufficient funds to ensure future debts to the Medical Stores Department are not incurred.

PEPFAR/T was selected for PEPFAR's Sustainable Financing Initiative and has also prioritized DRM activities in COP 2016. 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 including members of Parliament, media, national thought leaders, visiting congressional delegations, and 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 will work together to address the policy, infrastructure and human resources challenges with fully adopting these guidelines. Once fully adopted, the guidelines will serve to significantly decongest clinics and optimize the efficient delivery of HIV services.

Since the beginning of PEPFAR, the program has worked to strengthen the government institutions which are required for a sustained epidemic response. Initiated in COP 2015 and continued in COP 2016, PEPFAR/T is implementing a phased transition to reduce direct funding of GOT agencies, and require the GOT to support their own governmental functions and strengthen sustainability within host country programming.

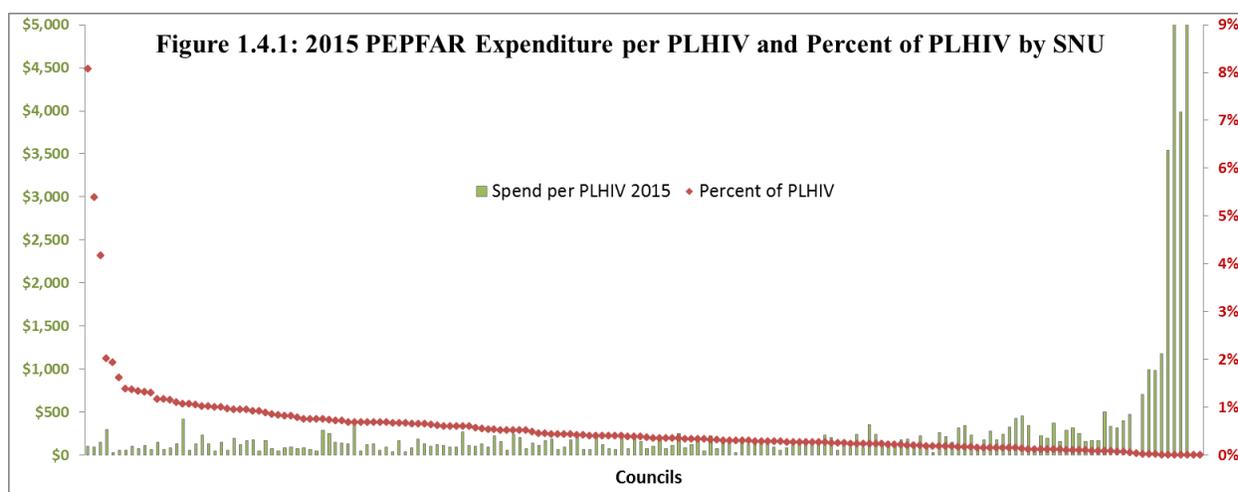
#### **1.4 Alignment of PEPFAR investments geographically to disease burden**

At the start of FY 2016, Tanzania has 178 Councils or Sub-National Administrative Units (SNUs). The 2015 PEPFAR 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 \$26 to \$8,457, with an average of \$194 per PLHIV. Some of this extreme variation can be explained by the variance in the size of the programs. Eight out of ten SNUs with 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 \$236 per PLHIV in Magharibi council up to \$8,457 in Kaskazini A. Excluding Zanzibar, spending in the councils varied from \$26 to \$500 per PLHIV. The FY 2015 expenditure data does reflect the COP 2015 geographic prioritization and program pivot.

To further facilitate understanding of PEPFAR investments, alignment with HIV burden, and program efficiencies by SNU, PEPFAR/T completed a detailed outlier analysis process and developed mitigation strategies to be implemented through quarterly program monitoring and partner management. By identifying high cost drivers for outlier implementing mechanisms the team will actively work with partners to derive efficiency gains through reduced spending where appropriate. Additional information on the outlier mitigation plan is included in Appendix B.

In an effort to maximize efficiency, given the rationalized landscape by partner and SNU and programmatic context, PEPFAR/T used the same adjusted, applied national unit expenditures (UEs) for partners to budget in COP 2016. Minor adjustments were also made to account for program context, *e.g.*, various environmental factors in the councils where partners operate, where necessary. In addition, as noted above, since FY 2015 expenditure data were not

reflective of the COP 2015 pivot or the adoption of the new guidelines for differentiated models of service delivery and Test and Start, adjustments to the applied UEs were based on assumptions to incorporate these changes. PEPFAR/T will also implement a routine monitoring strategy to ensure partners are able to implement programs effectively to achieve targets within their budget allocation.



senior and technical leadership about the overall program, its current strategic direction, targets, and planned interventions.

Although the initial meetings succeeded in addressing a number of important concerns about implementation of the PEPFAR/T program, they did not include a large number of (particularly non-PEPFAR funded) stakeholders from outside of Dar es Salaam. For this reason, PEPFAR/T supported an additional dedicated meeting for over one hundred (100) organizations to discuss COP 2016 planning in March 2016, out of which over fifty (50) organizations based outside of Dar es Salaam were provided financial support to attend. This meeting also selected the two CSO representatives to attend the COP review meeting in Johannesburg, as well as receive and provide ongoing feedback from the larger external stakeholders group through the COP 2016 process. A final meeting to represent the senior leadership from all stakeholder groups (GOT, DPs, and CSOs) was held in April to review the all draft materials for the final COP submission.

## 2.0 Core, Near-Core and Non-Core Activities

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PEPFAR/T defined core, near-core, and non-core activities for program implementation in COP 2015 through consideration of several factors: activities required to achieve sustained epidemic control; the current country investment portfolio, with special attention to the GFATM Concept Note; and opportunities for engagement highlighted in the SID. After careful review, PEPFAR/T will continue to use the same core, near-core, and non-core definitions in COP 2016 with a few minor updates to account for implementing new test and start guidelines, differentiated service delivery models, and revision of the care package. Core activities accelerate an already intensive combination prevention approach to addressing the epidemic that focuses on adult and pediatric ART, PMTCT, VMMC, and condom promotion as well as targeted testing and demand creation in Scale-Up Councils. Although PEPFAR/T is the major financial contributor to the HIV/AIDS response in Tanzania, the country team has articulated non-core activities that PEPFAR will no longer support. Appendix A contains more details on the elements classified as core, near-core, and non-core, as well as updated transition plans.

## 3.0 Geographic and Population Prioritization

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The 84 Scale-Up Councils represent 80% of the national HIV burden. PEPFAR/T is currently operational in all 178 councils in the country, with a passive enrollment approach in Sustained Councils. PEPFAR/T has realigned its investments to better correspond with the epidemiology, and prioritized investments to increase ART coverage and 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 prioritizes diagnosis and ART initiation for HIV+ pregnant women.

COP 2016 builds on the pivot planned in COP 2015, where efforts were focused on the highest-burden councils to get maximum impact per dollar. The three council types established in COP

2015 included: Saturation: 80% ART coverage by end of FY2017; Aggressive: 80% ART coverage by end of FY2018-2019; and Sustained characterized by passive enrollment. PEPFAR/T identified with MOHCDGEC the 84 Scale-Up Councils based on PLHIV estimates that were derived from national Spectrum 2015 figures disaggregated to lower subnational units using PMTCT program, survey, and census population data.

	Scale-up Saturation				Scale-up Aggressive		
	Councils	HIV Prev	PLHIV		Councils	HIV Prev	PLHIV
	Arusha CC	4.2%	13,960		Arusha DC	2.9%	6,560
	Bukoba MC	8.7%	7,960		Bagamoyo DC	4.4%	9,040
	Bukombe DC	5.2%	7,083		Bukoba DC	6.9%	12,672
	Bunda DC	4.3%	8,576		Busega DC	6.8%	8,202
	Chunya DC	7.8%	14,656		Chato DC	4.4%	9,610
	Dodoma MC	5.3%	15,155		Ilemela MC	4.7%	11,563
	Geita DC	4.4%	18,645		Iramba DC	4.3%	6,245
	Igunga DC	5.5%	13,267		Iringa DC	6.2%	10,338
	Ilala MC	6.5%	67,833		Kaliua DC	3.3%	7,588
	Iringa MC	8.3%	9,336		Karagwe DC	3.8%	7,857
	Kahama TC	7.5%	12,203		Kibondo DC	3.9%	6,016
	Kibaha TC	7.5%	6,873		Kigoma Ujiji MC	9.2%	13,206
	Kilombero DC	3.8%	10,709		Kilolo DC	7.3%	10,473
	Kinondoni MC	6.7%	104,438		Kilosa DC	3.9%	11,525
	Kishapu DC	4.7%	7,955		Kwimba DC	3.5%	8,709
	Kyela DC	14.5%	22,313		Ludewa DC	14.4%	12,279
	Magu DC	5.0%	9,383		Manyoni DC	3.5%	6,221
	Makambako TC	10.2%	6,309		Mbinga DC	6.4%	14,739
	Makete DC	15.6%	10,384		Meru DC	3.8%	7,621
	Masasi DC	4.4%	7,080		Missenyi DC	6.8%	8,901
	Maswa DC	2.9%	5,909		Misungwi DC	4.2%	9,234
	Mbarali DC	11.1%	22,318		Mjini	1.6%	2,871
	Mbeya CC	10.2%	29,165		Mkuranga DC	6.4%	9,158
	Mbeya DC	6.9%	14,247		Momba DC	6.1%	7,251
	Mbozi DC	6.3%	18,438		Moshi DC	3.6%	11,372
	Morogoro MC	5.9%	14,148		Mpanda TC	12.6%	8,746
	Moshi MC	5.7%	7,566		Msalala DC	7.4%	11,140
	Mufindi DC	11.1%	19,101		Mvomero DC	2.9%	6,134
	Muleba DC	4.7%	15,886		Newala DC	4.2%	5,777
	Njombe TC	16.9%	15,071		Njombe DC	13.2%	7,220
	Nyamagana MC	5.2%	13,626		Nkasi DC	5.3%	8,844
	Nzega DC	4.8%	12,349		Nsimbo DC	4.1%	5,809
	Rorya DC	8.4%	13,067		Nyasa DC	6.6%	6,224
	Rufiji DC	4.8%	6,436		Sengerema DC	3.2%	13,379
	Rungwe DC	5.9%	11,188		Shinyanga DC	6.2%	12,621
	Shinyanga MC	9.6%	10,990		Songea DC	7.4%	8,637
	Songea MC	10.4%	14,753		Sumbawanga DC	5.4%	9,867
	Sumbawanga MC	9.8%	13,389		Tabora MC	6.6%	10,440
	Tanga CC	4.7%	9,211		Tunduma TC	10.2%	6,871
	Temeke MC	6.2%	72,289		Tunduru DC	5.4%	10,608
	<b>Total</b>		<b>713,265</b>		Ushetu DC	7.1%	11,623
					Uvinza DC	3.4%	7,937
					Uyui DC	3.2%	7,404
					Wanging'ombe DC	12.4%	13,000
					<b>Total</b>		<b>401,532</b>

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

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### 4.1 Targets for scale-up locations and populations

Based on initial geographic and population prioritization decisions for COP 2016, PEPFAR/T used the Data Pack to set the FY 2017 treatment targets. Using council level PLHIV estimates based on PMTCT program data, PEPFAR/T selected councils with the largest HIV burden (83) or significant key population HIV burden (1) in which to focus attention to reach epidemic control. Of these 84 councils, 40 Scale-Up to Saturation Councils were identified that had sufficient coverage to reach 80% ART coverage by FY 2017, taking into account expected loss to follow up (LTFU) for newly initiating ART patients. For those 44 councils of high burden where it was not feasible to scale to 80% coverage by 2017, PEPFAR/T set targets to reach 80% saturation by 2018 or 2019. PEPFAR/T maximized the targets in these Aggressive Councils in order to accelerate the timeline to saturation, limited predominantly by absorptive capacity and structural barriers outlined in Section 6. For the remaining 94 Sustained Councils, PEPFAR/T set targets with a passive enrollment that incorporates an increase to account for immediate transition of a portion of pre-ART patients who would qualify for ART when Test and Start guidelines are released by the GOT.

In FY 2017, PEPFAR/T aims to enroll 252,738 new patients on treatment in the 84 Scale-Up (Scale-Up to Saturation and Aggressive Scale-Up) Councils, with the goal of supporting 831,223 patients on ART by APR 2017. This represents an increase in national coverage from 58% to 71% (Table 4.1.1). Based on these targets, the prioritized Scale-Up to Saturation Councils should reach 80% coverage of PLHIV by APR 2017 (387,900/479,696).

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+ individuals and effectively link them to care and treatment (Table 4.1.2). 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, the country team 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 incentivized 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 (HIV+) pregnant women and lactating mothers. The goal in FY 2016 is to continue the COP 2015 plan to test 95% of pregnant women in all regions and enroll 95% of those testing HIV+ into ART programs for Scale-Up Councils. In COP 2015 PEPFAR/T planned to enroll 90% in Sustained Councils and in COP 2016 PEPFAR/T is targeting 95% enrollment. These strategies are expected to yield an additional 33,083 newly initiated pregnant and lactating women on ART. PEPFAR/T will identify the remaining patients required to meet the target for PLHIV newly initiated on ART in

Scale-Up Councils and link them to treatment via provider-initiated, voluntary, and mobile counseling and testing models targeted to key and priority populations (Section 4.5). PEPFAR/T expects to enroll 80% of those diagnosed HIV+ through these HTC platforms into ART.

#### **4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-Up Councils (FY 2017)**

HIV testing targets for COP20 16 were set using a cascade analysis that will allow Scale-Up Councils to reach 80% treatment coverage by the end of FY 2017. Programmatic data and trends were used to estimate the volume of HIV tests needed per testing approach. In addition, testing volume was aligned with additional demands created through implementation of new testing approaches. These approaches include supporting MOHCDGEC to scale-up provider initiated testing and counseling (PITC), in inpatient (IPD), and outpatient (OPD) departments for:

- TB suspects;
- Individuals with a sign or symptom of a sexually transmitted infection (STI);
- Sexual partners and family members of PLHIV;
- Orphans and vulnerable children (OVC); and
- Individuals presenting with a possible opportunistic infection.

In addition, community-based HIV testing services (HTS) will be used to target key and priority populations, including the partners and family members of PLHIV, using home-based and mobile testing approaches. These approaches will increase both the volume of tests conducted as well as the number of HIV-positive (HIV+) identified. HIV testing in Sustained Councils will be limited to clinically sick individuals and those who request an HIV test in IPD, OPD, or TB settings, but will not include community-based testing.

HIV prevalence and SAPR data was used to set council level targets for number of PLHIV identified for each testing approach. For Scale-Up Councils, the testing positivity rate was assumed to be equal to or greater than the council's estimated prevalence. Where SAPR16 data indicated a higher yield than the council's estimated HIV prevalence, the positivity target was set using the rate observed from programmatic data. In councils where SAPR data indicated a lower yield than the council's estimated HIV prevalence, the COP 2016 positivity target was set to match the council's estimated HIV prevalence. Expected testing yields were adjusted to reflect more aggressive rates than currently found in program data. This decision was informed by improved SNU HIV prevalence estimates and the expected increase in HIV testing volume and yield based on new programmatic approaches to HIV testing (see section 4.5).

Based on the different testing approaches, PEPFAR/T estimates that 6,607,626 individuals will need to be tested during FY 2017 to achieve the goal of initiating 320,349 HIV+ clients on anti-retroviral treatment. These numbers reflect both COP 2016 targets as well as additional targets set for the seven DREAMS Councils. A breakdown of ART entry streams is presented in Table 4.1.2. These entry streams include: clinical care patients not on ART (pre-ART); sexual partners and family members of PLHIV; individuals co-infected with TB-HIV as well as HIV+ TB suspects; HIV+ pregnant women and lactating mothers; HIV+ individuals co-infected with another sexually transmitted infection (STI); and HIV+ individuals identified among priority and key populations in facility and community settings.

**Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control**

Prioritization	SNU	Total PLHIV	Expected current on ART (APR FY 2016)	Additional patients required for 80% ART coverage	Target current on ART (APR FY 2017) TX_CURR	Newly initiated (APR FY 2017) TX_NEW	ART Coverage (APR 17), using PEPFAR targets	Estimated PLHIV on ART in FY 2017	Estimated ART coverage
Scale-up Saturation	Arusha CC	13,960	13,432	-2,264	10,907	1,091	78%	13,432	96%
	Bukoba MC	7,960	7,338	-970	8,538	1,856	107%	8,570	108%
	Bukombe DC	7,083	5,329	337	5,117	814	72%	5,666	80%
	Bunda DC	8,576	5,816	1,045	6,474	1,584	75%	6,861	80%
	Chunya DC	14,656	13,525	-1,800	12,260	1,487	84%	13,816	94%
	Dodoma MC	15,155	10,683	1,441	10,979	2,390	72%	12,124	80%
	Geita DC	18,645	6,500	8,416	14,861	8,900	80%	14,916	80%
	Igunga DC	13,267	9,580	1,033	8,954	1,822	67%	10,614	80%
	Ilala MC	67,833	49,799	4,467	49,394	8,945	73%	54,266	80%
	Iringa MC	9,336	13,027	-5,558	11,253	1,125	121%	13,027	140%
	Kahama TC	12,203	10,419	-657	12,132	2,637	99%	12,177	100%
	Kibaha TC	6,873	5,491	8	5,052	647	74%	5,649	82%
	Kilombero DC	10,709	8,585	-17	8,307	1,249	78%	9,051	85%
	Kinondoni MC	104,438	45,011	38,539	81,728	42,728	78%	83,550	80%
	Kishapu DC	7,955	5,538	826	6,810	1,480	86%	6,836	86%
	Kyela DC	22,313	13,109	4,741	16,225	5,874	73%	17,851	80%
	Magu DC	9,383	5,348	2,158	8,110	1,763	86%	8,141	87%
	Makambako TC	6,309	4,459	588	6,125	1,331	97%	6,148	97%
	Makete DC	10,384	8,740	-433	7,186	719	69%	8,740	84%
	Masasi DC	7,080	5,020	644	5,105	1,088	72%	5,664	80%
	Maswa DC	5,909	5,462	-735	5,464	899	92%	5,855	99%
	Mbarali DC	22,318	14,609	3,246	16,597	4,570	74%	17,855	80%
	Mbeya CC	29,165	24,510	-1,178	22,689	2,970	78%	25,292	87%
	Mbeya DC	14,247	6,903	4,495	11,355	2,461	80%	11,398	80%
	Mbozi DC	18,438	14,724	27	12,540	1,278	68%	14,751	80%
	Morogoro MC	14,148	9,943	5,439	10,697	2,303	76%	11,318	80%
	Moshi MC	7,566	9,878	-3,825	7,638	764	101%	9,878	131%
	Mufindi DC	19,101	18,356	-3,075	14,970	1,497	78%	18,356	96%
	Muleba DC	15,886	8,372	4,336	12,661	4,592	80%	12,709	80%
	Njombe TC	15,071	11,188	869	10,153	1,794	67%	12,057	80%
	Nyamagana MC	13,626	20,961	-10,060	18,190	1,834	133%	20,978	154%
	Nzega DC	12,349	10,741	-862	9,134	913	74%	10,741	87%
Rorya DC	13,067	6,452	4,002	10,415	4,388	80%	10,454	80%	
Rufiji DC	6,436	3,917	1,232	5,130	1,599	80%	5,149	80%	

Scale-up Aggressive	Rungwe DC	11,188	10,035	-1,085	8,588	859	77%	10,035	90%
	Shinyanga MC	10,990	8,702	90	8,475	1,299	77%	9,205	84%
	Songea MC	14,753	9,820	1,982	11,758	2,681	80%	11,802	80%
	Sumbawanga MC	13,389	7,231	3,480	9,905	4,111	74%	10,711	80%
	Tanga CC	9,211	13,352	-5,983	10,761	1,076	117%	13,352	145%
	Temeke MC	72,289	45,623	12,208	51,611	16,107	71%	57,831	80%
	Arusha DC	6,560	1,656	3,592	4,112	2,725	63%	4,264	65%
	Bagamoyo DC	9,040	6,493	739	6,366	1,292	70%	7,232	80%
	Bukoba DC	12,672	4,699	5,439	8,745	4,149	69%	8,871	70%
	Busega DC	8,202	4,148	2,414	5,660	1,737	69%	5,742	70%
	Chato DC	9,610	5,006	2,682	6,041	2,131	63%	6,727	70%
	Ilemela MC	11,563	3,488	5,762	7,409	4,137	64%	7,516	65%
	Iramba DC	6,245	2,862	2,135	4,085	1,748	65%	4,372	70%
	Iringa DC	10,338	6,954	1,316	7,535	1,921	73%	8,270	80%
	Kaliua DC	7,588	3,444	2,627	5,037	2,161	66%	5,312	70%
	Karagwe DC	7,857	3,996	2,290	5,302	1,865	67%	5,500	70%
	Kibondo DC	6,016	1,247	3,566	3,855	2,609	64%	3,910	65%
	Kigoma Ujiji MC	13,206	3,518	7,047	8,031	5,298	61%	8,584	65%
	Kilolo DC	10,473	5,673	2,706	6,818	2,153	65%	7,331	70%
	Kilosa DC	11,525	4,432	4,788	7,953	3,535	69%	8,067	70%
	Kwimba DC	8,709	5,217	1,750	6,518	2,205	75%	6,967	80%
	Ludewa DC	12,279	6,906	2,917	7,597	2,259	62%	8,595	70%
	Manyoni DC	6,221	3,358	1,619	4,256	1,310	68%	4,355	70%
	Mbinga DC	14,739	8,001	3,790	9,317	2,986	63%	10,317	70%
	Meru DC	7,621	4,202	1,894	4,507	1,455	59%	5,335	70%
	Missenyi DC	8,901	4,933	2,188	5,921	1,744	67%	6,231	70%
	Misungwi DC	9,234	5,368	2,019	5,848	1,557	63%	6,464	96%
	Mjini	2,871	4,158	-1,861	3,370	361	117%	4,158	145%
	Mkuranga DC	9,158	5,585	1,741	6,719	2,217	73%	7,326	80%
	Momba DC	7,251	6,287	-486	2,053	205	28%	6,287	87%
	Moshi DC	11,372	4,251	4,847	7,734	4,065	68%	7,960	70%
	Mpanda TC	8,746	3,371	3,626	5,929	3,034	68%	6,122	70%
	Msalala DC	11,140	5,389	3,523	7,687	2,680	63%	7,798	70%
	Mvomero DC	6,134	3,305	1,602	3,836	1,261	63%	4,294	70%
Newala DC	5,777	3,028	1,594	3,651	1,266	63%	4,044	70%	
Njombe DC	7,220	3,401	2,375	4,842	1,951	67%	5,054	70%	
Nkasi DC	8,844	3,894	3,181	5,761	2,614	65%	6,191	70%	
Nsimbo DC	5,809	990	3,657	3,722	2,833	64%	3,776	65%	
Nyasa DC	6,224	3,104	1,875	4,092	1,520	66%	4,357	70%	
Sengerema DC	13,379	7,893	2,810	10,548	3,548	79%	10,703	80%	
Shinyanga DC	12,621	6,268	3,829	8,504	3,127	67%	8,834	70%	
Songea DC	8,637	5,526	1,383	6,123	1,840	71%	6,910	80%	
Sumbawanga DC	9,867	4,616	3,277	6,809	2,423	69%	6,907	70%	

Tabora MC	10,440	5,552	2,800	7,204	2,175	69%	7,308	70%
Tunduma TC	6,871	175	5,321	4,741	1,677	69%	4,810	70%
Tunduru DC	10,608	3,633	4,854	6,448	3,539	61%	6,896	65%
Ushetu DC	11,623	5,512	3,786	8,020	2,924	69%	8,136	70%
Uvinza DC	7,937	1,300	5,050	5,085	3,933	64%	5,159	65%
Uyui DC	7,404	3,559	2,364	5,109	1,799	69%	5,183	70%
Wanging'ombe DC	13,001	6,358	4,043	8,073	3,241	62%	9,101	70%
<b>Total</b>	<b>1,114,797</b>	<b>700,281</b>	<b>195,620</b>	<b>831,223</b>	<b>252,738</b>	<b>75%</b>	<b>904,097</b>	<b>81%</b>

**Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-Up Councils (FY 2017)**

<b>Entry Streams for ART Enrollment</b>	<b>Tested for HIV HTC_TST</b>	<b>Identified Positive HTC_TST_POS</b>	<b>Newly initiated TX_NEW</b>
<b>Facility Testing: Adults-based testing</b>			
HIV Care and Treatment	89,218	12,097	11,492
Inpatient Departments	174,020*	24,829*	23,590*
Outpatient Departments	1,869,066	85,921	81,635
PMTCT/ANC	1,458,617	45,771	43,486
TB Clinics	43,963	13,858	13,167
VMMC	348,221	5,986	5,387
STI Clinics	60,253*	6,816*	6,475*
<b>Facility Testing: Pediatrics (&lt;15 years)</b>			
Pediatric Department	907,307	19,264	18,302
PMTCT/ANC	62,783	1,516	1,295
VMMC	348,221	1,496	1,346
<b>Total Facility Testing</b>	<b>5,363,610*</b>	<b>217,558*</b>	<b>206,175*</b>
<b>Community Testing: Adults</b>			
Home-Based Testing	185,794	30,239	27,667
Community Testing	637,010	40,318	36,739
<b>Community Testing: Pediatrics (&lt;15 years)</b>			
Home-Based Testing	157,703	3,291	2,962
Community Testing	262,224*	6,368*	5,731*
<b>Total Community Testing</b>	<b>1,242,731*</b>	<b>80,216*</b>	<b>73,099*</b>
<b>Pre-ART Patients</b>	--	--	<b>41,075</b>
<b>Total All Modalities and Entry Streams</b>	<b>6,606,341*</b>	<b>297,768*</b>	<b>320,349*</b>

\*Includes COP16 targets plus additional DREAMS targets. All other targets reflect COP16 targets only.

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, the country team has committed to increasing the number of TB/HIV co-infected patients on ART in the next year. To identify individuals co-infected with TB and HIV, PEPFAR/T will continue testing all PLHIV attending TB clinics as well offering routine HIV testing for TB suspects in outpatient and inpatient departments.

PEPFAR/T is continuing to prioritize diagnosis and ART initiation for HIV+ pregnant women and lactating mothers to accelerate the elimination of mother-to-child transmission of HIV and attain sustained epidemic control in Scale-Up Councils. The goal in COP 2016 is to continue the COP15 plan to test 95% of pregnant women in all regions and enroll 95% of HIV+ pregnant women into ART programs in Scale-Up Councils.

Based on current PMTCT data, an estimated 62,783 infants born to HIV+ mothers will be tested during FY 2017. Of these infants, 2.4% are expected to be HIV+, leading to approximately 1,295 children initiated on ART. In addition, PITC will be instituted within pediatric departments to diagnose children presenting with conditions for which HIV is the underlying cause. An additional 18,302 children are expected to be enrolled on ART using this testing approach. Finally, 1,346 male children are expected to be enrolled on ART through EIMC testing programs.

PEPFAR/T will identify the remaining PLHIV required to meet the target for newly initiated on ART through a variety of HTS modalities including increased PITC in outpatient and inpatient departments within health facilities and community testing targeted to key and priority populations (see Section 4.5). PEPFAR/T also expects to enroll 41,075 pre-ART patients on ART during FY 2017.

**Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Councils**

Council	Categorization	Total male population age 10-29	FY 2016 Expected VMMC_CIRC age 10-29	FY 2017 target VMMC_CIRC (COP16 + central)	FY 2016 Expected Coverage, age 10-29	FY 2017 target coverage, 10-29, COP16 + central
Chunya DC	ScaleUp Sat	59,860	5,657	10,444	64%	81%
Geita DC	ScaleUp Sat	147,117	20,263	19,758	57%	70%
Igunga DC	ScaleUp Sat	79,824	7,639	22,575	77%	105%
Iringa MC	ScaleUp Sat	36,647	1,957	5,182	94%	108%
Kahama TC	ScaleUp Sat	52,112	4,123	18,547	68%	104%
Kishapu DC	ScaleUp Sat	55,812	-	20,205	71%	107%
Kyela DC	ScaleUp Sat	46,046	4,331	22,983	59%	109%
Magu DC	ScaleUp Sat	60,666	-	6,943	83%	95%
Makambako TC	ScaleUp Sat	20,454	-	11,479	58%	114%
Maswa DC	ScaleUp Sat	70,459	-	25,756	76%	113%
Mbarali DC	ScaleUp Sat	59,916	5,798	15,158	50%	75%
Mbeya CC	ScaleUp Sat	89,729	8,715	36,090	59%	100%
Mbozi DC	ScaleUp Sat	95,193	8,752	16,343	66%	83%
Muleba DC	ScaleUp Sat	110,306	16,543	12,617	92%	104%
Njombe TC	ScaleUp Sat	29,132	2,350	7,147	83%	107%
Nyamagana MC	ScaleUp Sat	81,736	7,993	11,118	63%	76%
Nzega DC	ScaleUp Sat	83,716	9,720	21,766	84%	110%
Rungwe DC	ScaleUp Sat	55,227	6,289	9,997	66%	84%
Shinyanga MC	ScaleUp Sat	36,064	2,772	4,536	96%	109%

Songea MC	ScaleUp Sat	44,383	9,765	10,347		
Sumbawanga MC	ScaleUp Sat	46,674	7,032	7,418	65%	81%
Bukoba DC	ScaleUp Agg	57,642	8,728	21,687	49%	87%
Busega DC	ScaleUp Agg	41,156	-	15,574	69%	107%
Chato DC	ScaleUp Agg	75,156	-	21,442	82%	111%
Ilemela MC	ScaleUp Agg	75,719	-	18,253	60%	84%
Iringa DC	ScaleUp Agg	52,589	416	6,350	106%	118%
Kaliua DC	ScaleUp Agg	82,111	-	27,421	69%	102%
Karagwe DC	ScaleUp Agg	69,236	-	13,906	51%	71%
Kilolo DC	ScaleUp Agg	45,729	608	4,931	95%	106%
Kwimba DC	ScaleUp Agg	81,571	-	22,732	69%	97%
Mbinga DC	ScaleUp Agg	74,838	22,961	2,302		
Missenyi DC	ScaleUp Agg	42,103	-	9,233	47%	69%
Misungwi DC	ScaleUp Agg	70,979	-	16,785	77%	100%
Mpanda TC	ScaleUp Agg	21,910	-	3,858	59%	76%
Msalala DC	ScaleUp Agg	51,497	2,644	20,000		
Nkasi DC	ScaleUp Agg	54,974	-	9,899	61%	79%
Sengerema DC	ScaleUp Agg	137,373	13,711	9,078	97%	104%
Shinyanga DC	ScaleUp Agg	66,626	-	20,325	60%	91%
Songea DC	ScaleUp Agg	35,726	-	13,483		
Sumbawanga DC	ScaleUp Agg	59,663	7,483	19,957	85%	118%
Tabora MC	ScaleUp Agg	51,510	4,834	14,820	71%	99%
Tunduma TC	ScaleUp Agg	21,240	-	5,398	48%	73%
Tunduru DC	ScaleUp Agg	57,800	17,937	12,029		
Ushetu DC	ScaleUp Agg	55,788	3,735	17,455		
Uyui DC	ScaleUp Agg	81,008	-	28,897	68%	103%
Wanging'ombe DC	ScaleUp Agg	32,650	2,350	13,165	61%	101%
Mafinga TC	Sustained	27,216	877	11,054	55%	139%
Total		2,884,883	215,983	696,442		

**Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate	Coverage Goal	FY 2017
	(scale-up SNU's)	(in FY 2017)	Target
<b>AGYW</b>	163,410	72%	110,438
<b>MSM</b>	17,654	58%	10,222
<b>FSW</b>	72,346	85%	62,075
<b>PWID</b>	6,864	85%	5,835

**Table 4.1.5 Targets for OVC and Linkages to HIV Services**

Prioritization	SNU	Estimated # of	Target # of active OVC (FY 2017
		Orphans and Vulnerable Children	Target) OVC_SERV
Scale-up Saturation	Arusha CC	22,955	4,591
	Chunya DC	28,566	5,713
	Dodoma MC	24,464	4,893
	Geita DC	79,171	15,834
	Igunga DC	38,013	7,603
	Ilala MC	94,486	18,897
	Iringa MC	22,574	4,515
	Kahama TC	23,932	4,786
	Korogwe TC	4,970	994
	Kyela DC	20,817	4,163
	Lindi MC	6,733	1,347
	Masasi DC	15,524	3,105

	Mbeya CC	47,725	9,545
	Mbeya DC	28,656	5,731
	Mbozi DC	43,002	8,600
	Meatu DC	20,507	4,101
	Morogoro MC	30,139	6,028
	Mufindi DC	30,051	6,010
	Muheza DC	10,398	2,080
	Muleba DC	28,705	5,741
	Musoma MC	17,850	3,570
	Njombe TC	20,664	4,133
	Nyamagana MC	28,269	5,654
	Nzega DC	23,391	4,678
	Rorya DC	24,083	4,817
	Rungwe DC	29,632	5,926
	Shinyanga MC	16,965	3,393
	Songea MC	26,020	5,204
	Sumbawanga MC	17,990	3,598
	Tanga CC	19,282	3,856
	Bukoba DC	15,223	3,045
	Ilemela MC	27,038	5,408
	Kigoma Ujiji MC	16,618	3,324
	Kinondoni MC	129,071	25,814
	Magharibi	10,724	2,145
	Mbarali DC	29,719	5,944
	Mbinga DC	31,039	6,208
	Mjini	6,175	1,235
	Moshi DC	28,713	5,743
	Msalala DC	24,831	4,966
	Nzega TC	23,391	4,678
	Sengerema DC	39,436	7,887
	Shinyanga DC	30,177	6,035
	Sumbawanga DC	22,036	4,407
	Tabora MC	25,357	5,071
	Temeke MC	108,607	21,721
	Ushetu DC	19,061	3,812
	Wanging'ombe DC	21,287	4,257
	<b>Total</b>	<b>1,454,036</b>	<b>290,807</b>
<b>Scale-up Aggressive</b>			

### 4.1.3 Saturating Dar es Salaam Councils

Despite currently low coverage in some councils within Dar es Salaam, PEPFAR/T will seek to reach saturation in all by September 2017. PEPFAR/T continues to engage GOT at the national, regional, and council levels as well as stakeholders from different sectors such as Prime Minister's Office, TACAIDS, NACP, UNAIDS, WHO, Council Health Teams as well as implementing partners, CSOs and OGAC/HQ to identify program shifts, strategies and resources needed to saturate Dar es Salaam. Preliminary strategies include increasing rapid test kit availability, improving and documenting linkages from testing to treatment and enhancing retention during the first year.

Rapid assessment to identify needs, barriers and existing opportunities for saturation at all levels such as supply chain reliability, HR coverage, SI, infrastructure capacity to accommodate additional clients. PEPFAR/T is also working with FELTP to conduct flash assessments to understand patient and site level factors associated with poor retention to identify effective mitigation strategies. Efforts include intensifying monitoring efforts to saturate Dar as well as programmatic monitoring and evaluation. This includes creating a dashboard for key indicators that will cascade down to the site level through councils.

#### **4.2 Key Populations and Adolescent Girls and Young Women (AGYW)**

PEPFAR/T key populations (KPs) include: sex workers (SW), men who have sex with men and transgender (MSM/TG), and persons who inject drugs (PWID). Priority population programs are focused on adolescent girls and young women (AGYW). Based on data about KPs and AGYW, the national context, the core, near-core, and non-core analysis, and evaluation findings, PEPFAR/T proposes to invest in the following core prevention interventions to accelerate epidemic control: HTS, condom provision and promotion, PMTCT, and targeted community prevention interventions for key populations and AGYW including addressing gender norms and gender-based violence. Linkage and retention will be the main area of focus for HIV identified KPs for Test and Start. The community prevention scope will continue to support the Scale-Up Councils.

Project data from IPs indicate that 26,548 (35%) KPs have been reached with core intervention packages during the first quarter of FY 2016. For those KPs reached, 24,448 (92%) were tested for HIV, 1,695 (6.9%) were identified positive, and 1,162 (69%) were linked into HIV care and treatment. Recognizing that the yield for KPs is relatively low, PEPFAR/T will pinpoint and further scale promising and innovative interventions for identifying positives among KPs and linking them to services. Interventions that have shown success in increasing HIV positivity yields in other countries include peer-driven interventions, such as sexual and social network-based testing, incentivized referral and testing as well as evening outreach activities that include HTS.

In alignment with the GOT's increased focus on achieving epidemic control for KPs, PEPFAR/T will continue to work with the GOT to implement the National Guidelines for the Comprehensive Package of HIV Interventions for Key Populations through its rollout of the KP National Curriculum, which has been piloted by several partners. The goal of the curriculum is to increase access to a comprehensive package of quality, evidence-based health and social services to KPs. By increasing the coverage of the National Curriculum, PEPFAR/T will significantly minimize the transmission of HIV and reduce HIV-related mortality, morbidity, stigma, and discrimination among KPs. In January 2016, the GOT rolled out new care and treatment guidelines that allowed providers to offer Test and Start for KP and pediatric patients. Subsequently, the GOT has agreed to adopt Test and Start country-wide by October 2016.

In COP 2016, PEPFAR/T will provide KPs and AGYW with comprehensive packages of interventions that incorporate the continuum of services in HIV prevention, care, and treatment. Interventions will include improving access to condoms and lubricants, GBV, STI screening and treatment, targeted demand creation for services, HIV testing and counseling, and linkage to HIV care and treatment through intensified mobile outreach services to ensure KP HIV cascade.

Implementation will continue to target identified KP hot spots in Scale-Up to Saturation and Aggressive Scale-Up Councils. In coordination with stakeholders, including CSOs and GOT, PEPFAR/T will scale up Test and Start, streamline service delivery, and implement the task shifting policy to raise awareness, create demand, and immediately initiate PLHIV on ART. In order to understand better the type of men who influence the sexual behaviors of young girls, the PEPFAR/T team will work with IPs on characterizing of male sexual partners with the already available tools. IPs will continue to implement DREAMS intervention package in the selected Scale Up Councils.

PEPFAR/T will use enhanced SI methods to monitor coverage of services for KPs and AGYW through regular mapping and enhanced monitoring and evaluation, which will provide localized population estimates and service data for the identified sub-populations. The PEPFAR/T team is working with the GOT to finalize and disseminate a KP National Monitoring Tool and Unique Identifier Code system including KP tracking tools between community and facilities. In COP 2016, PEPFAR/T will continue technical assistance for a total market approach for condoms, including complementary support to meet the needs beyond GFATM support for the procurement of more than 32,000,000 male and female condoms, for both socially-marketed and free condoms. Support for condom programming will remain national in scope, yet condom promotion activities will be limited to Scale-Up Councils.

### **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% (highest in Tanga, Mtwara and Lindi regions: 99%; lowest in Simiyu and Shinyanga regions: 30%).<sup>4</sup> VMMC is highlighted as a priority program in targeted geographic locations in the Tanzania National HIV Prevention Strategy which aims to bring to scale proven HIV prevention interventions for a Tanzania with no new HIV infections.

PEPFAR/T prioritizes VMMC in councils with low MC coverage and high HIV prevalence. Overall, PEPFAR/T has supported 1,840,622 VMMCs through the end of FY 2015 with 33% of these in FY 2015 alone. The cumulative VMMCs performed by October 2016 with PEPFAR support is expected to be 2,389,086. Scale up of VMMC will continue in FY2017, targeting 696,442 boys and men in 47 Councils.

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 2015, Tanzania data indicate that a focus on 15-29 year old males will obtain maximal impact for both short- and long-term impact. This was also supported by the follow-up modeling that recommended three scenarios to optimize VMMC and ART in Scale-Up and Sustained Councils.

Given substantial passive demand among the 10-14 age cohort, all demand creation activities in COP 2016 will exclusively target 15-29 year olds, while still providing services to men 30 years

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<sup>4</sup> Tanzania HIV/AIDS Malaria Indicator Survey (THMIS) 2011/2012

old and above. PEPFAR/T has already contributed to the VMMC coverage of  $\geq 80\%$  in 34 Scale-Up and Sustained Councils. This will increase to 61 Councils in total by October 2017. Ten Councils which have saturation  $\geq 100\%$  coverage will transition after FY 2016 and have no targets in COP 2016. Councils that have achieved more than 80% coverage by APR 2017 will also transition out of PEPFAR direct support. These VMMC-saturated Councils will transition to GOT in phases to support a sustainability process while PEPFAR continues to provide technical assistance. Based on council level UEs, VMMC TWG created a total service delivery budget to saturate VMMC in Scale-Up Councils. The TWG agreed to use the COP 2016 applied UE of \$66.74 for both COP and Central initiatives funds, where \$51.74 was used for service delivery and \$15.00 for commodities.

#### **4.4 Preventing mother-to-child transmission (PMTCT)**

Tanzania has been implementing the PMTCT Option B+ strategy by providing lifelong ART to pregnant and breastfeeding women since October 2013. As of APR 2015, 3.6% of pregnant women tested at antenatal care (ANC) clinics were found to be HIV+. Through PMTCT, PEPFAR/T reported 59,940 HIV+ women identified and 73,896 were reported as receiving ART. This apparent discrepancy between number of HIV+ and those on ARV is due to under-reporting of HIV+ pregnant women who were known to be HIV+ at entry into PMTCT service. Approximately 75% of the HIV-exposed infants were tested through the EID program. Of these, 1,514 (3.7%) were identified as HIV+. Data from the Site Improvement and Monitoring System (SIMS) visits indicates low rates of linkage to HIV care and treatment of HIV+ infants. In COP 2016, PEPFAR/T has allocated resources to continue supporting PMTCT services to sites with at least 10 HIV+ women receiving services in the last twelve months.

In order to achieve the goals of MTCT elimination and epidemic control in Tanzania, the interagency team set targets for Scale-Up Councils in COP 2016 for PMTCT to reach 95% of pregnant women with HTC and initiate 95% of HIV+ women identified on ART. 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 2017 as patients are referred and integrated into existing ART sites. The goal for EID is to reach 95% of HIV exposed infants with HIV testing by age of 12 months.

COP 2016 also targets Scale-Up Councils for increased community outreach to encourage antenatal care and HIV testing; training and quality assurance (QA) in rapid testing; education, support groups, and mentoring of mothers for pregnant and breastfeeding women identified as HIV+ to encourage adherence to ART and retention in care; increased testing at delivery and during breastfeeding to identify women who acquire HIV infection during this period; and improved EID and linkage of HIV+ children to care. In order to improve monitoring of HIV-exposed infants, PEPFAR/T is supporting the national program to implement longitudinal birth cohort reporting to follow HIV-exposed infants through the end of the breastfeeding period.

Additional resources through the Accelerating Children's Treatment (ACT) Initiative will support the national EID monitoring system to better track functioning of the EID cascade. An additional effort in this area is the use of the hub and spoke system to facilitate specimen transport and results provision from sites to the testing labs and vice versa. Improvements in family planning (FP) availability are reflected in the increase from 36% (APR 2014) to 52%

(APR 2015) in the number of ART sites providing FP services. The program will continue support for FP integration to increase coverage.

#### **4.5 HIV Testing and Counseling Services (HTS)**

According to the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS, 2012), approximately 47% of men and 62% of women in Tanzania have ever been tested for HIV. In APR 2015, PEPFAR/T supported testing for 5,981,418 individuals and diagnosed 257,201 PLHIV. The average testing yield in APR 2015 was 4.3%, ranging from 2% in VMMC programs to 30% in TB clinics.

Program data indicate gender and age disparities in access to HTS services. Facility HTS remains poorly accessible to adolescents, men, and key populations. In addition, PITC implementation has been largely limited to TB and PMTCT clinics, with limited coverage in other service delivery points. Community testing strategies have struggled to reach high risk populations, achieving only a 4% positivity rate despite efforts to focus on KP and PP.

To address these challenges and improve the efficiency of PEPFAR-supported HTS programs, PEPFAR/T will support GOT to implement four new high yield HIV testing approaches in COP 2016. 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 “hot spots”. PEPFAR/T will engage MOHCDGEC and implementing partners in the design, implementation, and monitoring of these new strategies, developing council-specific plans to achieve increased yield.

These four new strategies include:

1. **Partner notification plus:** IP “efforts will focus on the sexual partner(s) and family members of PLHIV in both key and priority populations. Findings from a pilot study of a referral “plus” partner notification approach conducted in Iringa was found to be acceptable, feasible, and effective in identifying persons living with HIV and linking them to care. 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 with the National AIDS Control Program and the National TB and Leprosy Program (NTLP) to intensify HIV diagnosis for TB suspects in both OPD and IPD settings. PEPFAR/T will assist the MOHCDGEC to develop a site-level standardized process for monitoring and tracking testing for TB suspects and their integration into HIV treatment services. Facility-based partners will also be engaged to implement these strategies.
3. **Targeted PITC among STI clients:** Program data indicate many undiagnosed PLHIV present at health facilities with STI signs or symptoms. Yet not all clients presenting with an STI sign or symptom receive an HIV test. COP 2016 will implement routine HIV testing for all STI patients attending OPDs or specialized STI clinics (where they exist).

4. **Incentivized peer network testing:** Peer network testing targeting KP has been conducted by some IPs; however, it has not been incentivized. COP 2016 will use program data from these KP programs, as well as global best practices from Vietnam, Thailand, and other countries to implement incentivized peer testing strategies among key and at-risk priority populations. An evaluation component will be included with this approach to monitor the acceptability and feasibility of this approach with different populations including STI patients and their sexual networks as well as KP and PP.

In addition to the above strategies, specific strategies will be implemented to increase the number of men reached with HTS services. These include:

- Extending testing hours to weekend and evening hours;
- Integrating mobile testing with other health services such as hypertension, diabetes and prostate screening to incentivize and reduce stigma associated with HIV testing;
- Utilizing community mobilizers to promote testing where men congregate (e.g. work place and sporting events); and
- Placing a Care and Treatment Center (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+ into HIV treatment services.

PEPFAR/T will also focus HTS services toward most at risk OVC 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.

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 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 and new ART patient targets. 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 technical assistance on strengthening linkages from HTS to ART programs for individuals diagnosed as HIV+ in support of new 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 HIV Testing Services. This includes supporting the MOHCDGEC to develop a standardized and coordinated Quality Assurance (QA) system for HTS, with a focus on improving quality control for HIV testing performed by health care providers and trained lay counselors. In addition, PEPFAR/T

will 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 the age of consent for HIV testing in Tanzania is 18 years. PEPFAR/T will engage the MOHCDGEC, TACAIDS and other key players from ministries and lawmakers (via the Parliamentarians Against AIDS group) in a series of policy/advocacy dialogues around these 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. PEPFAR/T will continue to advocate with GOT to lower the age of consent in order to increase HTS access among AGYW.

Specific strategies for improving linkage to care include:

- Co-location of 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/peer navigators to physically escort newly diagnosed PLHIV to the CTC;
- Utilization 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/lay counselors to follow-up with clients who fail to self-enroll within 30 days of an HIV diagnosis;
- Introduction of a quality improvement strategy with all HTS partners to encourage them to use their program data to improve linkage to care rates; and
- Supporting NACP to develop unique identification code to facilitate tracking of patients across health services.

#### **4.6 Facility and community-based care and support**

PEPFAR/T will support implementation of evidence-based approaches to optimize linkage and adherence to ART to promote viral suppression. At the facility, PEPFAR/T will work with GOT to adopt Test and Start and ensure that all patients in care are initiated on treatment. PEPFAR /T will work with GOT to adapt differentiated service models to maximize efficiencies. The new service delivery model will include: decentralize ARV pick-ups, two or three month refills, and clinical visits every three to six months for stable patients. These services will not differ between Scale-Up and Sustained Councils and will include regular clinical and laboratory monitoring, WHO staging, baseline CD4 count, viral load (VL) monitoring per the roll-out/CD4 monitoring until roll out reaches that facility, screening for active TB, and provision of cotrimoxazole (CTX) prophylaxis<sup>5</sup> for those who are eligible.

To address barriers to enrollment in care, PEPFAR/T is leveraging the new Task Sharing policy by increasing the use of PLHIV and peer support to better link clients to care. Focus will be given to strengthening the system to establish unique identifier codes (UIC) for all PLHIV to

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<sup>5</sup> CTX procurement is planned to be supported by GOT through the essential medicines budget.

enable the program to track specific 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 their enrolment e.g. tailored clinic hours such as evening or weekend clinics, fast tracking men, linking newly identified HIV positive men with peer networks of expert HIV positive men for immediate support and follow up. PEPFAR/T will also re-evaluate and re-allocate PEPFAR HRH investments to maximize meaningful support to highest burden councils and highest volume sites. For COP 2016, there is a strategic shift to focus on evidence-based strategies in Scale-Up Councils. Which include strengthening bi-directional referrals and linkage for new clients and improving retention and adherence of existing clients in high volume sites.

Community services will support adaptation of community ART provision and roll out of lay counselor testing at the community level. IPs will train community support groups/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.

In COP 2016, 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 linked to treatment programs and retained on ART. With the adoption of Test and Start all new HIV+ patients can immediately be initiated into ART programs, but Test and Start alone cannot be relied upon to increase retention. At Q1 2016, 28% of first year patients in care services were LTFU. To improve retention PEPFAR/T will implement evidenced-based approaches such as:

- Appointment and tracking registers with emphasis on early tracking of missed appointments, block appointments (through the Promise to Come Initiative);
- Link all new patients to available CHW/HBC providers;
- Use of mHealth (SMS reminders) to follow up clients;
- Promotion of patient clubs to enhance retention and disclosure;
- Roll out of family-centered care clinics and family days (same appointment for family);
- Back to treatment campaigns to bring LTFU.

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

The interagency team will support the core package of care and support services, outlined in Appendix A. Additionally, PEPFAR/T will invest in piloting innovative models for linkage and retention and in extending care and support services to populations who report difficulty in accessing traditional clinical platforms, especially KP, PP, children under five years, and men.

The human resource challenges facing the health sector constrain its ability to deliver quality services. SBOR activities outlined in Section 6 consequently focus on supporting human resources for health (HRH) at the facility and community level.

#### **4.7 TB**

The TB program will ensure HIV testing among TB patients and suspects. PEPFAR/T will target testing to TB suspects found in OPD and IPD. Facility-based partners will also work with MOHCDGEC to develop site-level standardized processes for monitoring and tracking testing for TB suspects. The TB program will also update the M&E system to capture coughers' baseline data. Those found to be infected with HIV or TB will be initiated ART or TB treatment respectively. Additionally, the program will strengthen TB Infection Control (TB IC) in all facilities by paying attention to the practical, administrative, environmental, and personal protection activities to curb the spread of TB. Special attention will be paid to the suitability of the spaces used as TB 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. 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 the importance of HIV testing, TB screening and initiation of ART and TB treatment in co-infected patients, increasing TB case detection, especially for PLHIV and children.

Tanzania has finalized the guideline which includes a roll out and 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 2016, the PEPFAR/T supports the calibration of 15 Gene Xpert machines that were donated by PEPFAR, 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 67 machines. Additionally quality assurance in TB clinics for HIV testing will be strengthened.

#### **4.8 Adult Treatment**

In FY 2017, the PEPFAR/T adult ART program is continuing to realign to support the attainment of the UNAIDS targets of 90/90/90 by ensuring that out of 90% PLHIV who know their status, 90% of them (80% of PLHIV) are receiving ART by 2020. In COP 2016, PEPFAR/T will continue to focus on Scale-Up Councils.

The GOT is revising the ART treatment guidance to adopt Test and Start for all PLHIV nationwide by October 2016. Due to the expected increase in the number of clients who will need ART, PEPFAR/T is committed to work with the GOT to optimize the service delivery models of care and provide packages of services based on different categories of clients such as: well and stable patients, patients with advanced HIV infection, and patients on ART but also with complex health problems. In collaboration with MOHCDGEC, 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.

In addition, PEPFAR/T is committed to work with the GOT to emphasize customer-focused appointment systems that will involve the Promise to Come Initiative and mobile phone appointment setting that will ultimately improve patient retention on care and treatment. Widespread use of viral load testing and monitoring will help to improve adherence and better identify and serve stable patients.

The basic assumptions in cost reduction include: reduced need for additional health care providers (HCPs)/personnel, physical infrastructure, and laboratory equipment. Other benefits include free work space to cater for incoming new clients and more quality time for HCPs to attend each client. In light of the adoption of the Test and Start policy as well as the new service delivery model, the national care and treatment guidelines will be revised. The guidelines will also advise on the recommended number of clinic visits for stable, unstable and new patients, drug refills, and clinical monitoring schedule. Moreover, effective community engagement, adherence to treatment, and quality of clinical care will be emphasized. Following the recent approval of the task sharing policy, PEPFAR/T is planning to support ARV refill distribution points outside the clinics using community health workers, and will decentralize ARV pick up at designated village dispensaries. PEPFAR/T plans to continue to explore promising models from other countries with GOT and other stakeholders. Adoption of differentiated service delivery models 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.

To address retention challenges, PEPFAR/T will strengthen the use of existing MOHCDGEC appointments and tracking registers, with special emphasis on early tracking of clients who have missed appointments. A block appointment system (e.g. “Promise to Come”) where patients are given the opportunity to choose the most convenient day and time, will also be expanded to roll out to all facilities. PEPFAR/T will work with the GOT and stakeholders to develop a unique identifier for health to track and link patients at all levels of service provision to minimize LTFU. Furthermore, PEPFAR/T will use 1) mobile technology by setting up SMS reminders to alert and assist to follow-up with clients and electronic self-triaging systems, 2) family centered clinic appointments, and 3) back to treatment campaigns to bring back clients who are LTFU. All these interventions aim at improving tracking and retention of patients in care. PEPFAR/T will also support targeted and innovative demand creation, linkages to ART services and retention through community platform.

As explained above, PEPFAR/T will work with MOHCDGEC to revise the national guidelines to align and capture Test and Start and guidance to support the new service delivery models. 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 320,349 new adults on ART and support a total of 1,001,558 patients currently on treatment by APR 2017. The targeted net new on ART in FY

2017 is 109,838 in Scale-Up Councils (an increase of 22% from the FY 2016 targeted number of clients currently on ART) and 19,637 in Sustained Councils (6% increase). All pre-ART adult patients are expected to be on ART following full adoption of Test and Start by the end of FY 2017.

#### **4.9 Pediatric Treatment**

MOHCDGEC adopted the Test and Start guidelines for ART treatment for all HIV+ children less than 15 years of age in May 2015. Tanzania was among the first countries to prioritize ART treatment for children, which demonstrates GOT's commitment to supporting HIV services for children. The majority of health care workers (HCWs) have been trained on the new guidelines and the training materials have been updated and disseminated. During APR 2015, Tanzania achieved 83% of its first year target for ACT for new on ART. The achievement was 80% for current on ART. Tanzania surpassed its targets for adolescent enrollment, enrolling 19,136 children compared to the estimated target of 10,566. Despite this, the number of children receiving ART increased by only 11% from 37,530 (APR 2014) to 42,277 (APR 2015), indicating that retention was very low.

The PEPFAR/T team reviewed retention data and noted that crude retention for both adults and children has been declining over the years. Particularly for children, the crude retention was 77% during APR 2015. After further analysis on LTFU, the team noted that major reasons included children aging out of the indicators, re-testers, undocumented transfer outs, and true defaulters especially in high volume sites.

The PEPFAR/T team will continue to work with partners to address LTFU through a combination of activities, which include strengthening the national Health Information System infrastructure to support integrated service delivery across different sites and services. The program will scale up the new national appointment and tracking registers with emphasis on early tracking of missed appointments including updating patients' contacts at each visit for early follow up. Use of electronic reminders for patients who have access to electronic devices, assignment of dedicated CHW to pediatrics clients and increase in number of support groups and adolescent clinic are among the activities that will be employed to address loss to follow up for children and adolescents. The program will also strengthen involvement of civil society organizations in supporting children, adolescents, and vulnerable children groups.

Retention will also be improved as Tanzania adopts alternative service delivery models, which will decongest clinics and improve quality of care. Other innovations to address LTFU will include the use of back to treatment campaigns, and an OVC partner family case management approach. The PEPFAR/T pediatric program will continue its pivot to support epidemic control.

PEPFAR/T aims to initiate 23,291 new children on treatment in FY 2017 and support a total of 67,190 children current on treatment. The PEPFAR/T strategy for pediatric HIV treatment includes expanding high yield HIV testing for children such as testing all TB suspects, siblings, and children of patients attending HIV care and treatment, systematic OPD screening for PITC using HIV screening tool and testing at malnutrition centers. PEPFAR/T will strengthen identification through the OVC platform, which includes testing OVC at high risk of HIV infection, most vulnerable street children and children who have dropped out of school.

PEPFAR/T will continue to strengthen HCW skills through enhanced supportive supervision and mentorship systems that were established during the ACT Initiative implementation. PEPFAR/T is also working to improve age-disaggregated data for infants, children, and adolescents through the national monitoring and evaluation system.

Key priorities for pediatric and adolescent care and support for the next two years include improving linkage to care and support services after testing through same day enrollment to care, scale up of bidirectional tracking linkage feedback box, use of patient escorts, peer mothers and expert patients, and strengthening implementation of longitudinal follow up for all HIV exposed infants. The program will also scale up quality improvement teams that include both facility as well as community health workers to routinely review linkage indicator. The program will ensure maintenance of high coverage of CTX to children, will improve TB diagnosis, and track TB treatment outcomes for children on ART. COP-funded activities are aligned with the ACT and DREAMS Initiatives councils and the scale-up of adolescent friendly health services will take place in Scale-Up Councils to improve adherence, disclosure, sexuality/reproductive health, and reduce stigma. PEPFAR/T has incorporated the increased coverage of pediatric ART from the ACT Initiative in COP 2016.

COP 2016 prioritizes viral load monitoring for all groups including children in the Scale-Up Councils. Detection of treatment failure for children has been challenging due to limited clinical monitoring skills of health care providers as well as limited immunological monitoring services. Currently only 1% of children on treatment are receiving second line treatment regimens.

PEPFAR/T has supported MOHCDGEC to optimize the national pediatric ARV formulary to increase the number of children less than three years of age using the preferred regimen. The national guidelines recommend use of lopinavir and ritonavir (Lpv/R) oral pellet-based regimens as the first line regimen for children of this age. All d4T-based regimens have been phased out. No reported pediatric ARV stock outs occurred in the last year. During FY 2017, the GFATM will support pediatric first and second line ARVs, while COP 2016 funds will cover any commodity gaps during the FY 2017 implementation year.

#### **4.10 Orphans and Vulnerable Children**

Tanzania has an estimated 3,305,429, million OVC affected by HIV/AIDS (Measure Evaluation, 2016). PEPFAR/T estimates to reach 539,855 OVC less than 18 years old (16% of estimated OVC) in Scale-Up and Sustained Councils. Of the 539,855 OVC, 94% are represented in Scale-Up Councils. Standardized transition tools and approaches have been developed to ensure no harm is caused to children as the OVC program realigns to the Scale-Up Councils. Partners have started to work with the Sustained Councils' leaders and other stakeholders to develop transition plans. The plans will ensure that PEPFAR/T responsibly graduates or transitions all OVC currently supported in Sustained Councils (about 101,055) to existing GOT programs, established community savings groups, and other non-PEPFAR funded projects by 2017. PEPFAR/T will add additional case managers needed in the Scale-Up Councils to ensure provision of quality HIV care services at community levels.

Geographic coverage in the planned OVC program will be aligned with ACT and DREAMS platforms. PEPFAR/T will use the OVC platforms to strengthen case finding, referrals, and

adherence and retention for pediatric HIV and ensure that children identified through ACT are able to maximize social protection services through the OVC program. OVC programming will implement an intensive service delivery model via case management to find the OVC in greatest need, ensuring HIV+ children are getting enrolled in OVC programs and into HIV treatment and care services, and focus on quality programming in Scale-Up Councils. The intensified case findings of the HIV+ children and active follow up of children LTFU will be done through standardized referral and linkage systems between the community and facility. Moreover in efforts to improve the first 90, PEPFAR/T OVC program in alignment with ACT will work to ensure that 377,899 (70%) of OVC know their HIV status.

In identifying OVC and their families in greatest need of assistance, focus will be given on utilizations of HTS at the community or in facilities. Through evidence-based parenting training, the OVC program will support caregivers on how to address age based needs, HIV status disclosure, adherence, and retention of the identified HIV+ children and adolescents living with HIV (ALHIV). OVC supported nutrition and basic health assessment activities will help to identify acutely malnourished children, street children, and frequent school dropouts and link/refer them to HTS.

In Scale-Up Councils, including DREAMS councils, prevention activities will target older OVC to address behavioral and structural interventions, such as targeted school scholarships, to prevent HIV infections and early pregnancies. In addition, age appropriate life skills education will be provided along with school committee training to create a supportive school environment for HIV+ students. The OVC program will collaborate with PMTCT to strengthen follow-up of adolescent mother-baby pair to contribute to the reduction of MTCT during the postnatal period.

The bi-directional linkages between communities and facilities will strengthen the reach of these services to the OVC and their caregivers. CHWs, community volunteers, and para social workers will support monitoring of HIV+ children and their caregivers during household visits using the newly developed household visit checklist and a standard package of the community based services for HIV+ children and ALHIV. Meanwhile tailored economic strengthening interventions will be supported based on the household vulnerability index to ensure income stabilization.

Other COP 2016 activities include child protection and system strengthening activities. The case management system will support capacity building of para-social workers to be responsive to the needs of HIV+ children and their families, equipped with working tools and establish a system to monitor their implementation performance and incentives to ensure retention. System strengthening activities will also support capacity building at national and sub-national levels to create a sustainable model to ensure OVC service provision in the future (*e.g.*, policies, legal framework, strategies, tools, guidelines and social welfare workforce).

## 5.0 Program Activities for Sustained Support for Other Locations and Populations

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## 5.1 Package of services in sustained support locations and populations

For Sustained Councils, PEPFAR/T will maintain patients on treatment in care and treatment services through FY 2017 in both ART and PMTCT sites seeing more than 10 HIV+ patients. In the planned transition of sites seeing fewer than 10 HIV+ patients, and in collaboration with the GOT, patients may be encouraged to transfer from low volume sites to higher volume facilities. Patients in Sustained Councils will receive the minimum package of care for PLHIV and will be passively enrolled into care and treatment services if the request or are in need of testing (e.g. pregnant women, TB clients, and patients with OIs).

The minimum package of services includes CTX provision, routine clinic visits and screening for OIs (including TB), and routine VL screening per the previously described protocol. For areas where VL has not been rolled out, PEPFAR will continue to support CD4 monitoring of patients on ART. No eligible patient will be denied treatment, nor will they be denied services if requested, but PEPFAR/T has discontinued demand generation for testing in Sustained councils.

PEPFAR/T has also discontinued support for community testing programs in Sustained Councils. Finally, OVC currently served in the Sustained Councils will be transitioned to the GOT, national safety nets program, matured community saving groups and other donors' funded programs. The transition will be done in phases, thus, HIV+ children, and other vulnerable children including GBV survivors, will continue to receive support through the end of FY 2017 to ensure quality transition and adherence and retention to ART.

PEPFAR/T has discontinued support for community HTS in Sustained Councils. For VMMC, PEPFAR/T has already contributed to the VMMC coverage of >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 EIMC. This will increase to >80% coverage in at least 61 Councils by October 2017.

PEPFAR/T has calculated the expected volume of patients needing the minimum package of services in these areas by council and overall (Table 5.1.1). The team derived the expected number tested through PMTCT sites based on the assumption that these sites would continue in FY 2016 to test 95% of pregnant women and link 90% of those identified HIV+ 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-supported sites, both due to discontinuation of active demand generation in these areas and transition of PMTCT services at ANC sites to GOT support over FY 2016.

PEPFAR/T has allocated resources to continue supporting facilities with at least 10 clients on ART in CTCs and greater than 10 HIV+ women supported in PMTCT in Sustained Councils. The supported facilities will provide a standard of care package similar to that offered in Scale-Up Councils with the exception of routine viral load testing (they will continue CD4 testing) and the frequency at which supportive supervision is offered by PEPFAR IPs. With this new realignment, facilities in Sustained Councils will implement targeted viral load testing to patients

suspected to have treatment failure; and HIV testing will be on individual patient’s demand or at the provider’s discretion if there is high index of suspicion for HIV infection.

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

<b>Sustained Support Volume by Group</b>	<b>Expected result APR 16</b>	<b>Expected result APR 17</b>	<b>Percent increase (decrease)</b>
HIV testing in PMTCT sites (PMTCT_STAT)	143,578	478,927	0.70
HTS (only maintenance ART sites in FY 2017) (HTC_TST)	405,163	891,868	0.55
Current on ART (TX_CURR)	145,250	171,630	0.15
OVC (OVC_SERV)	102,396	32,133	-2.19

## **5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations**

PEPFAR/T has discontinued support to low or no HIV+ client yield in HTC and PMTCT sites and sites without ART patients starting in 2014. Similarly, in COP 2016 PEPFAR will discontinue direct service delivery in ART and PMTCT sites that see fewer than 10 HIV positive patients. This will be done in close collaboration with the GOT at the national, regional, and council levels, to determine if ART clients in low volume sites maintain support through GOT or are transferred to higher volume sites in FY 2017. PEPFAR will also work with GOT to review geographic distribution of patients to decongest extremely high volume sites and increase volume in lower volume sites. Through this approach, PEPFAR/T will continue to realign its investments to better correspond with the epidemiology, and prioritize investments to increase ART coverage and address the unmet need to achieve epidemic control in the highest burden councils.

PEPFAR/T has planned for the transfer of direct support for blood safety and injection safety to the GOT, with COP 2016 funding for focusing on technical assistance. PEPFAR/T has also minimized support for construction and renovation in COP 2016.

The PEPFAR/T team plans to continue negotiations with the GOT with the goal of developing an agreement outlining the pace of transition of government staffing and operational costs, as feasible, at local and national levels. Advocacy in collaboration with Health Development Partners to the Ministry of Finance and MOHCDGEC about the importance of allocating sufficient funds to pay for in-country distribution and repay outstanding costs for distribution owed to MSD continues.

Because GOT’s VL policy continues to include a baseline CD4 test, PEPFAR/T will continue to maintain 30 BD Facs Calibur and 270 BD Facs count machines in country as the country completes transition of old machines to services contracts with manufacturers as the new machines are put in place. To prevent gaps in equipment service leading to treatment delays, two more years of coverage would be sufficient to allow full successful transition to MOHCDGEC.

### **5.2.1 Transition plans for the OVC Portfolio**

The OVC program is currently being implemented in both Scale-Up and Sustained Councils. PEPFAR/T, in collaboration with the GOT has adopted a plan for phasing out

PEPFAR/T support in Sustained Councils by September 2017. The Department of Social Welfare under MOHCDGEC is mandated to oversee the national support for OVC in Tanzania, and is reviewing critical national guidelines and processes. These processes include the national OVC monitoring and evaluation plan to include bi-directional referral tracking indicators; the OVC identification process and packages of services to ensure the full inclusion of the HIV+ children; and guidance for the implementation of the case management approach to ensure quality care and support for HIV+ children and most at risk for HIV infection vulnerable children and adolescents.

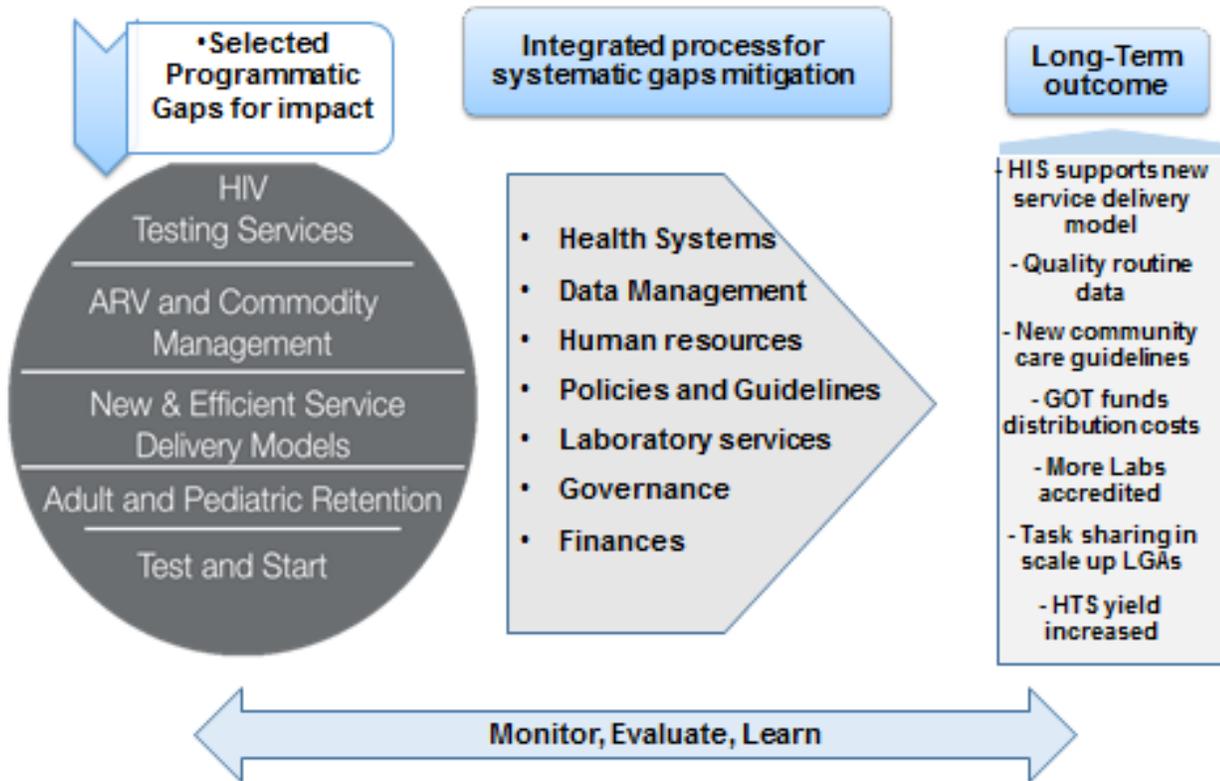
PEPFAR/T has discussed the programmatic shifts with all OVC implementing partners. Strategies and activities for OVC IPs to support the PEPFAR pivot, including OVC transition and graduation, were included as modifications to the program descriptions of the OVC IPs. These modifications outline the specific packages of services to be provided in the Sustained and Scale-Up Councils. The Scale-Up Council package of services focuses on providing comprehensive OVC services, including food, nutrition education, shelter, psychosocial and health support. It also focuses on conducting OVC case management, with a special focus on HIV-infected and exposed children, supporting referrals and linkages to HIV services (counseling, testing and ART), providing parenting skills, and facilitating income stabilization for families to reduce household vulnerability in order to ensure adherence and retention to HIV care and treatment. The Sustained Council package focuses on household economic strengthening support, strengthening community savings and support groups, referral support to access HIV and health services, and support to manage HIV+ children and families to ensure adherence and retention.

Key IPs piloted transition tools. Based on their findings and shared experiences issues to be added into the standardized tools include: criteria for OVC graduation, transition and continued support, and a standardized approach to ensure consistent, broad engagement of community stakeholders. Relevant stakeholders have initiated their transition plans by conducting the household vulnerability assessment in consultation with council officials at all levels, community support groups, CSOs and other donor-funded partners. This resulted in the graduation, transition, or aging out of 131,651 OVC in Sustained and Scale-Up Councils in FY 2015.

The OVC transition was done in collaboration with village leaders and most vulnerable children committees at the community level. Joint plans were developed to ensure graduation of economically stable and other households to the national safety net program and matured savings groups, as needed. PEPFAR/T also developed a tool for periodic follow up to ensure the stabilization of the transitioned families. Finally, PEPFAR/T has outlined plans to consolidate case files and databases for those OVC who have transitioned, as well as those who still need support from IPs.

## 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 2016 will focus on those health systems barriers critical to address the remaining challenges of finding HIV+ 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:

- Adult and Pediatric Retention
- HIV Testing Services
- 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

2016 PEPFAR/T is prioritizing systems investments that will enable the smooth roll out of Test and Start and the new service delivery models in Tanzania. 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 according to Tanzania's COP 2016 SID results which were all red and yellow scores.

### **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 has identified four programmatic barriers in adult and pediatric retention which needs Above Site Investments to support the Tanzania Government meet its annual programmatic targets. The system barriers 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 the service delivery points.

The last gap identifies barriers 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 outcomes 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 include a functioning case based surveillance system that consists of testing data, care & 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 will also 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 anonymous linked services.

To improve HR retention, PEPFAR/T will work to have at least 75% of approved HR permits filled in Scale-Up Councils and have 95% of all sites using 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**

The PEPFAR/T team will work with partners and the GOT to address LTFU through a combination of activities which will focus on tracking and retaining patients across different sites and service programs. Through COP 2016 PEPFAR will 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. 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. A block appointment system, Promise to Come, will give patients the opportunity to choose the most convenient time to come. 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. 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/Tanzania has prioritized three system barriers to be addressed during CP 16 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 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 ten 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 will also complete and disseminate findings from the Integrated Bio-Behavioral Survey in Scale-Up Councils to improve HTS. PEPFAR/T will work with the GOT to lower the age of consent than the current 18 years, establish anonymous HTS, and introduces disclosure policy. 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**

The PEPFAR/T team will work with the GOT and implementing partners 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. Strategies and priority activities will include 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 both 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 drop in centers services 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+ FSW and AGWY will also be encouraged to bring in their children for testing. PEPFAR/T will work closely with the MOHCDGEC 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 and 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. 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 second and third 90 goals. Tanzania is set to adopt the new Test and Start policies and new service delivery models in the treatment, which is expected to increase the number of clients and the demand of more ARVs and commodities. PEPFAR/T is committed to working with 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 community health workers, and to decentralize ARV pick up at designated village dispensaries.

### **Programmatic Barriers**

During COP 2016, three 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;
- Poor linkages between facility patient records, commodity management systems, and ARV dispensing for monitoring and management of commodities;
- Inefficient distribution of commodities under new service delivery 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. These include a coordinated procurement plan for commodities developed and implemented on annual basis. 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. Pharmacy management capabilities and data standards will be added to facility level health information systems to automate reporting and requisition of ARVs and HIV commodities for sites covering 70% of all current on treatment by 2019. 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 team will work with the GOT to ensure that procurement of ARVs is covered by PEPFAR and GFATM, and that the GOT allocate funds to mitigate challenges associated with ARV and commodity distribution. The developed activities expected to be carried out to achieve the three years outcome include to assist the GOT be able to cover the in-country supply chain distribution costs, including the repayment of outstanding debts to Medical Stores Department. 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. PEPFAR/T will strengthening 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 will also strengthen national capabilities in forecasting, budgeting and product availability through improved supply chain management, planning, and accountability to ensure that products are available to patients and clinicians when needed, which is a critical contributing factor to treatment adherence.

**Table 6.1.1 Adult and Pediatric Retention**

Barrier	Outcome	Proposed COP16 Activities	Code and Budget	Associated Implementing Mechanism ID	Relevant SID Element and Score (Cell shade=SID Score)
1. Data: Efforts to use data within planning and resource allocation hindered by low quality data and evidence from evaluations and surveillance are not sufficiently identifying retention barriers	1. Fully functioning case based surveillance system in place, consisting of testing data, care & treatment sentinel events, and facility-based HIV mortality data by 2018, beginning with Scale-Up Councils	Develop case based surveillance system by planning and implementing initial roll out in Scale-Up Councils that consists of both adult and pediatric populations and informs improvements to the national case based surveillance system. Provide TA to Health Sector to work together with Registration, UNICEF and Global Affairs Canada funding to ensure roll out of Civil Registration and Vital Statistics (CRVS) improves mortality and cause of death reporting to support case based surveillance.	HVSI \$500,000	TBD Surveillance TA (17988)	13: Epidemiological and Health Data
		Link viral load results in the laboratory central database with case-based surveillance system to better understand and address trends in loss to follow up.	HVSI \$50,000	APHL Lab Follow on (17292)	
		Develop, disseminate, and implement a five year national strategic plan for Case Based Surveillance (CBS).	HVSI \$50,000	Consolidated MOH CoAg (18170)	
		Scale up birth registration in Scale-Up Councils and case based surveillance priority councils by working with PEPFAR regional partners to expand existing birth registration interventions. Goal is to strengthen availability of registration ID for unique tracking of pediatric HIV clients. Work in synergy with TA activity for Case Based Surveillance.	OHSS \$300,000	UNICEF Follow on (17316)	
	2. Service delivery retention interventions are informed by quality evaluation findings on an annual basis.	Assess and improve the OVC linkage to treatment system to identify and address causes of loss to follow up.	HKID \$300,000	MEASURE Associate Award (16569)	
			Evaluate the impact of a community care model using CHWs including community medication distribution and social support to inform retention efforts, expanding task-sharing, and community service delivery.	HBHC \$400,000	
		HTXS \$592,000			
		HVCT \$250,000			
		Develop and implement acquired HIV drug resistance surveillance system to inform treatment guidelines (includes lab commodities required for the study).	HBHC \$500,000	Local FOA Follow-on (16874)	
	HTXS \$15,000		HJFMRI (16763)		
3. SIMS visits and data confirm improved data quality.	Conduct data quality assessment so as to inform the epidemic control, and conduct data demand and information use to inform decision making at LGA level	HTXS \$200,000	Consolidated MOH CoAg (18170)		
3. SIMS visits and data confirm improved data quality.	Conduct data quality assessment so as to inform the epidemic control, and conduct data demand and information use to inform decision making at LGA level	HVSI \$800,000	MEASURE Associate Award (16569)		
4. 90% of Scale-Up Councils include results of HIV data triangulation within council level annual	Assist Scale-Up Councils to utilize dashboards from national data warehouse, complete District Health Profiles, and compile multi-sectoral data from information systems relevant for decision making (e.g. DHIS2, HCMIS, EpiCor, PlanRep). In addition, close feedback loop between Scale-Up Councils and national level to improve usefulness of dashboards.	OHSS \$250,000	Public Sector System Strengthening (PS3) (14693)	1: Planning and Coordination, 13: Epi and Health Data, 15: Performance Data	

	plans or health profiles by 2019.	Conduct data triangulations in Scale-Up Councils and train/capacitate CHMT to conduct annual triangulations, producing and sharing reports for each geographic area.	HVSI \$150,000	TBD Surveillance TA (17988)	13: Epidemiological and Health Data
		Create and maintain regional Spectrum files and train/capacitate RHMT to routinely update and use files for programming. This includes decision making related to retention, HTS targeting, and target or priority populations.	HVSI \$100,000	TBD Multilateral AIDS Sector Follow On (17992)	
		Train at least 12 Intermediate FELTP Program residents to serve in Council Health Management Teams as evidence-based decision-makers to improve quality and coverage of surveillance, facility-based and community services, and capacity of CQI teams. They will conduct rapid operational research studies on challenges to PEPFAR implementation of Test and Treat and New Service Models.	HTXS \$200,000	University Partnership Field Epidemiology Expansion (17304)	7: Human Resources for Health
		Train at least 16 FELTP Advanced Program residents in 2017 who will serve as Leads for CHMT/RHMT Technical Committees to assure data-based decision-making and do rapid operational studies addressing challenges in implementation of Test and Treat, New Service Delivery Models, and other Linkage/Retention problems.	OHSS \$200,000	AFENET Follow-On (18243)	
5. GOT has a community data reporting system for non-facility indicators by 2019 with 70% data completeness for home based care, OVC served and non-facility based HTC.	Provide programmatic oversight, coordination of community HIV services and standardize system to monitor facility-community linkages and retention in Zanzibar.	HBHC \$100,000	TBD Zanzibar follow on (17970)	6: Service Delivery	
	Support DHIS2/OVC MIS roll-out in Scale-Up Councils, including building organizational capacity of DSWs on mainland Tanzania and Zanzibar to manage the system.	HKID \$375,000	MEASURE Associate Award (16569)	13: Epidemiological and Health Data	
	Support software implementation of DHIS, to support collection and management of HBC and OVC data. Work towards a instance for Community (council/ward) based HIV data according to specifications established by NACP and M&E TA provider. Includes integration of functionality for data exchange of community data between GOT system and PEPFAR DATIM system.	HBHC \$200,000	HIS follow on (16899)		
	TA on CHW and community services to define M&E reporting requirements to be incorporated into MOHCDGEC facility DHIS and new community instance of DHIS.	HBHC \$50,000	TBD Institutional Capacity Building TA (17987)		
2. HIS: Patient level data systems need additional functionality to better support service level follow up on retention, improve quality of routine data and linkages across service delivery points.	1. Tracking and linkage across HIV Services supported via electronic systems for 60% of HIV positives identified and 90% of clients on treatment in Scale-Up Councils by 2019.	CHW Mobile App: Build on ongoing mobile health application initiatives through Public Private Partnership to expand use of community health worker mobile application that tracks services and links with applications within facilities to improve linkages across HIV services.	HBHC \$175,000	CDC PPP Management (17296)	13: Epidemiological and Health Data
		Establish data warehouse for the MOHCDGEC to facilitate analysis of data from multiple information systems (such as HRH, HFR, CTC database, DHIS 2). This will help facilitate use of data for strategic decisions regarding program planning and resources allocation across broader health sector. Develop a Health Information Mediator (HIM) as part of GOT Health Information System architecture to reduce point to point data exchange and support interoperability using standards based approach.	HVSI \$980,000	Maternal and Child Survival Program (MCSP) (17409)	

		<p>Evolution of CTC System Software to adopt standards to improve interoperability with referral services, support new guidelines related to test and start and additional functionality to strengthen facility management of retention and system support for alternative service delivery including new pharmacy management module that links with site level systems for remote drug pick up and support for client categorization.</p> <p>Develop a client register that implements new GOT standards for client identification and supports linkages of client information across HIV services both within and across service delivery sites.</p> <p>Develop test version of shared health record to demonstrate capacity to share client data across services for referrals.</p>	HVSI \$349,300	HIS follow on (16899)	
			HTXS \$322,000	TBD Institutional Capacity Building TA (17987)	
		<p>TA to MOHCDGEC and National AIDS Control Program Tanzania to support information systems analysis, review and oversight of system design issues, support integration with other system and testing and deployment support. Evolution of CTC System Software to adapt to Test and Start, HTC Tracking, Alternative Service Delivery, Incorporate new approach for national Unique ID, and shared health record. (Activity also addresses barriers to Test and start, service delivery models and HTS)</p>	HTXS \$280,000	TBD Institutional Capacity Building TA (17987)	
	<p>1. UIC for KPs including TA to MOHCDGCE to scale up Unique Identifier Code (UIC) system and M&amp;E Package.</p> <p>2. Revise and pilot test M&amp;E tools for KP service recording and reporting and work with NACP to integrate requirements into Ministry DHIS-2 development planning. Support development of training module and roll out training in the use of DHIS-2 for KP monitoring.</p>	HVOP \$350,000	Sauti za Watanzania (16784)		
2. GOT develops and implements a strategy for identifiers and systems that support anonymous linked services.		Develop system and or approach and KP tracking tools across the cascade to support anonymous linked services and coordinate national KP activities.	HVOP \$120,000	NACP Follow-on (14573)	13: Epidemiological and Health Data
		Update national guidance as new international guidelines are developed; provide leadership and coordination for all KP activities. Develop KP tracking tools for anonymous linked services across the cascade.	HVOP \$130,000	Consolidated MOH CoAg (18170)	
3. Human Resources: Scale-Up Councils have a shortage of skilled service providers who follow or implement retention protocols, continuous quality improvement, and guidelines to reduce loss to follow up. Some	1. At least 75% of approved permits are filled in Scale-Up Councils, disaggregated by cadre.	Extend POPSM's HR information system to the facility level to enable facility based permit allocation and increase availability of facility level HR data to support transition of HR for PEPFAR shifts.	HTXS \$250,000	Public Sector System Strengthening (PS3) (14693)	7: Human Resources for Health
		Revise MOHCDGEC's HRH assignment process using evidence-based methods that strengthen deployment and retention.	OHSS \$150,000	PHII (18258)	
		Support data triangulation and analysis between HRIS, HCMIS, and HMIS to provide timely and accurate data in the form of HRH Country profile that informs recruitment, deployment and retention.	OHSS \$200,000	TBD Institutional Capacity Building TA (17987)	
		Support DHRO and DED to improve HR requests in Scale-Up Councils to reflect staffing needs based on service delivery statistics.	HTXS \$250,000	Public Sector System Strengthening (PS3) (14693)	
		Support Scale-Up Councils to implement HR retention packages within financial means.	HTXS \$150,000	Public Sector System	

reductions by activity				Strengthening (PS3) (14693)	
		Support to MOHCDGEC and LGAs to coordinate roll out of CHW cadre. Build capacity of civil society organizations and ward and village level committees to improve retention rates in their communities.	HKID \$200,000	Community Health and Social Systems Strengthening Program (CHSSP) (14692)	3: Civil Society Engagement
	2. 95 % of all sites have a QM/QI system, with routine monitoring of processes and quality of services and involvement of patient, community and council management stakeholders according to SIMS visits and standard by 2019.	Placement and training of volunteers and training of counterparts to support community linkages through VAST grants (small grants) as a result of Community Needs Assessment addressing HIV affected groups and LGAs in Scale-Up Councils.	HVOP \$113,000	U.S. Peace Corps (11528)	13: Epidemiological and Health Data
4. Guidelines: Comprehensive guidelines to support ART retention and adherence	1. Community Care guidelines updated to strengthen retention through improved use of QI approaches in community services.	Develop/adopt community care guidelines that allow refill at community level and categorization of patients according to status.	HBHC \$67,000	Consolidated MOH CoAg (18170)	2. Policies and Governance
		Develop standardized national HIV/AIDS QI guidelines, training package, and SOPs which will be used to build capacity of community QI teams to improve quality of services offered at the community level.	HBHC \$400,000	Twinning Follow on (17305)	6: Service Delivery
Many PLHIV in Dar es Salaam do not know their HIV positive status	Increased proportion of PLHIV who know their status	To establish mobile health teams consisting of 4-5 community health workers and a nurse who will be responsible for sensitizing the community about the importance of HTS, generating demand for HTS collaborating with community testing partners. All new HIV+s will be offered same day ART initiation by the nurse.	HVCT \$400,000	MDH Kagera (17293)	13: Epidemiological and Health Data
PLHIV do not know their HIV status, very few PLHIV participate in HIV testing campaigns	Increased proportion of PLHIV testing and knowing their status	Implement targeted community based campaign to increase uptake for HTS among key populations and vulnerable AGYW. Organize stakeholders meetings as an opportunity to discuss and agree work plan and targets, review progress to target, identify solutions to key challenges, share lessons learned and successful models to scale up for saturation.	HVCT \$300,000	Sauti za Watanania (16784)	
Many PLHIV do not know their HIV status and lack access to information on availability and location of services.	Anonymous and confidential access to information and referral to services with follow-up using mobile technology	Promote service uptake through helpline, SMS, interactive voice record and social media for HIV testing, ART, tracking of linkages and monitoring retention.	HTXS \$300,000	TBD Comprehensive High Impact HIV Prevention IP (Local) (17991)	

PLHIV lack knowledge on health behaviors and locations of HIV services offered	Increased proportion of PLHIV linked to ART, and Care; Increased adherence among PLHIV on ART	Design, produce, and distribute at the regional level radio programs promoting critical health behaviors to include use of health services in the Dar es salaam areas. Produce quality, evidence-based communication resources for demand creation, and linkage to services i.e. IEC materials for use by service delivery partners, community and local partners.	HTXS \$400,000	Comprehensive Platform for Integrated Communication Interventions (CPICI) (18056)	
Upon diagnosis, many PLHIV in Dar es Salaam do not get linked and retained in HIV care and treatment services	Increased proportion of PLHIV linked to ART within 30 days of diagnosis; Increased proportion of newly initiated PLHIV on ART who are retained in care for 12 months	Community based follow up of newly identified PLHIV using community health workers to facilitate retention to care and adherence to ART.	HTXS \$250,000	MDH Kagera (17293)	
Clinical partners are not using data to identify gaps around retention and achievement of viral suppression	Routine review of program data on retention and viral load suppression with active remediation plan for high quality performance.	In collaboration, NACP, clinical partner and LGA establish quarterly forums for reviewing performance on retention and viral load suppression and develop strategies for course correction accordingly.	HTXS \$100,000	MDH Kagera (17293)	
			<b>\$11,818,300</b>		

6: Service Delivery

**Table 6.1.2 HIV Testing Services**

Barrier	Outcome	Proposed COP16 Activities	Code and Budget	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Data: Quality routine data and survey evidence which is not consistently used to inform efforts to target HTS, increase yield and identify barriers and facilitators.	1. M&E paper tools and routine reporting updated to track initial, repeat and confirmatory tests and high quality data available for decision making by 2019.	Create an HIV specific DQA plan and tool that is aligned with Health sector approach to data quality and ensure all regions, councils and implementing partners are oriented on DQA strategy, tools and minimum DQA requirements.	HVSI \$37,500	NACP Follow-on (14573)	9. Quality Management
			HVSI \$62,500	Consolidated MOH CoAg (18170)	
		Revise and print standardized HIV testing logbook and summary reporting form to distinguish between initial test, repeat, retest/confirmatory test upon linkage to care and repeat test by testing points.	HVCT \$280,000	TBD Lab Quality TA (17984)	10. Laboratory
		Update and expand National level M&E tools and systems within and between facility and community services to track all PLHIV and link them to care and treatment, including KP.	HVOP \$80,000	NACP Follow-on (14573)	15. Performance data
			HVOP \$220,000	Consolidated MOH CoAg (18170)	
Upgrading TACAIDS M&E tools, Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and LGA databases, include IT system updates, training of staff to use the upgraded tools. Systems collect multi-sectoral data on number of key population (MSM/TG, CSW, IDUs) in the community accessing testing services, care, treatment and condoms	HVSI \$100,000	TBD GoT AIDS Sector Follow On (17991)	13: Epidemiological and Health Data		

	2. Integrated bio-behavioral survey in Scale-Up Councils completed and findings disseminated and used to improve HTS by 2019.	Implement IBBS in select Scale-Up Councils, by writing protocol, training data collectors, procuring reagents, sample collection logistics, data analysis and report writing.	HVSI \$400,000	TBD Surveillance TA (17988)	
	3. Tanzania uses PMTCT data for HIV prevalence at SNU level to target HTS interventions by 2018.	Develop training materials and conduct ToT for ANC surveillance based on PMTCT routine data with quality and monitoring framework to inform transition and produce estimates of council level prevalence.	HVSI \$75,000	NACP Follow-on (14573)	7: Human Resources for Health
		Implement PMTCT surveillance with quality and monitoring framework to evaluate use of PMTCT data to replace ANC surveillance. Activity includes procurement, training of data collectors, field data collection supervision, sample collection logistics, data analysis and report writing. Activity is done in collaboration with NACP.	HVSI \$175,000	Consolidated MOH CoAg (18170)	
			HVSI \$800,000	TBD Surveillance TA (17988)	15. Performance data
3. Guidelines: Current Policy guidelines and operating procedures on age of consent, CHW testing, repeat testing, certification of testers/sites and anonymous HTS are limiting effective HTS interventions to maximize yield.	1. New GOT Policy lowers age of consent, established anonymous HTS and introduces disclosure policy adopted and implemented.	Work with MOHCDGEC and other stakeholders to lower age of consent for HTS, define mature minor and establish anonymous HTS.	PDTX \$150,000	Health Policy Plus (18061)	2. Policies and Governance
	2. GOT disseminates updated HTS SOPs within 18 months of a new WHO release of guidelines.	Update and disseminate updated HTS policy guidelines, SOPs, protocols, TOTs, curriculum and M&E system revisions. Includes revision for testing algorithm task sharing policy, new WHO guidelines for HIV rapid testing and retesting policy.	HVCT \$100,000	NACP Follow-on (14573)	
		Provide tailored, strategic technical assistance (TA) and capacity building to service delivery implementing partners and regional health management teams (RHMTs) to ensure HIV testing service policy guidance is translated into work plans are being implemented effectively.	HTXS \$800,000	TBD Clinical TA (International) (17990)	6: Service Delivery
4. Lab: Quality of HIV rapid testing according to WHO guidelines (new, repeat, retest, and documented annual certification of testers/sites)	1. Laboratory management and accreditation systems developed and deployed by 2019	Establish and implement a national tracking and monitoring mechanism (national inventory) for all certified HIV rapid testing personnel to regulate the testing practice and ensure quality through the Health Laboratory Practitioners Council (HLPC) and Medical Laboratory Scientists Association of Tanzania (MeLSAT).	HLAB \$90,000	Consolidated MOH CoAg (18170)	15. Performance data
		Disseminate "Strengthening Laboratory Management Towards Accreditation" (SLMTA) training materials for 10 labs in Scale-Up Councils.	HLAB \$75,000	ASCP Lab (16892)	10. Laboratory
		Continue to provide QA, mentorship, and coaching to all 7 zonal centers on step 1 certification to Africa Society for Blood Transfusion (AfsBT) international standards.	HMBL \$150,000	TBD Blood Safety TA (17985)	
		Provide logistical support for implementation of national accreditation TA program for 7 zonal blood centers on step 1 certification through AfsBT international standards.	HMBL \$120,000	Consolidated MOH CoAg (18170)	

		Provide QI technical assistance to the MOHLAB and implementing partners in development of quality improvement initiatives (Training and mentorship of QI teams) for HIV rapid test to ensure quality assurance of HIV counselling and testing services in Scale-Up Councils.	HVCT \$200,000	ASSIST (17082)	9. Quality Management	
			HBHC \$200,000			
	2. HIV rapid test, Quality assurance systems deployed.	Enroll at least 90% PMTCT testing facilities into the National HIV testing Proficiency Testing program and receive panels and return timely results.	MTCT \$50,000	MOHSW Lab Follow on (17294)	6: Service Delivery	
			MTCT \$50,000	Consolidated MOH CoAg (18170)	10. Laboratory	
		Facilitate increase in production, distribution, analysis, and result feedback of HIV external quality assessment and proficiency testing panels to GOT National Lab (NHLQATC) to increase coverage.	HLAB \$105,000	MDH Kagera (17293)		
		Provide logistical support for TA partner quality assurance activities on the implementation of internal & External proficiency (PT) testing for blood and blood products at 7 zonal centers and regional & consultant hospital transfusion facilities.	HMBL \$120,000	MOHSW Blood Follow on (17343)		
		Support strengthening of quality assurance through implementation of internal & External proficiency (PT) testing for blood and blood products at 7 zonal centers and regional & consultant hospital transfusion facilities.	HMBL \$70,000	TBD Blood Safety TA (17985)		
	3. At least 80% of PEPFAR-supported laboratories are accredited with competent staff overseeing non-laboratorian testers by 2019.	Conduct TOT training for HIV rapid testing and implementation of competency assessment.	HLAB \$200,000	AMREF- LAB (14653)	7: Human Resources for Health	
		Provide Technical Assistance to MOHCDGEC Lab for implementation of national competency assessment program for non-laboratorian HIV rapid testing testers in both facilities and community sites.	HLAB \$160,000	AMREF- LAB (14653)	10. Laboratory	
		Coordinate the establishment and implement a certification program (training, annual refresher training, certificates) for non-laboratorian HIV rapid testing testers, in facilities and community sites.	HLAB \$50,000	Consolidated MOH CoAg (18170)		
			HLAB \$50,000	MOHSW Lab Follow on (17294)		
	5. Current HTS modalities not capturing all potential HIV positives.	1. Yield for all HTS tests increased to 7% by 2019.	Develop City Fast Track plans in collaboration with RHMT/ CHMTS in priority cities of Dar es Salaam, Mwanza, Mbeya, and Arusha with focus on targeting Key population for testing and monitoring of prevention, linkages, and treatment strategies at community level.	HVSI \$100,000	TBD Multilateral AIDS Sector Follow On (17992)	15. Performance data
			Revise and disseminate National guidelines for TB/HIV management including the provision for HIV testing of all TB suspects.	HVTB \$150,000	Consolidated MOH CoAg (18170)	2. Policies and Governance
			Updating and revising HIV/TB SOPs, screening tools, supportive supervision, and coordinate HIV/ TB technical teams, QI, provision of IPT by partners, and IPT procurement logistics.	HVTB \$60,000	NACP Follow-on (14573)	7: Human Resources for Health
				HVTB \$120,000	Consolidated MOH CoAg (18170)	
Strengthen blood system capacity to track and notify HIV positives and encourage linkages to Treatment by providing TA for Blood Establishment Information System (BECS). This includes system specifications, oversight on installation, and user trainings to link and establish real-time interoperability and interface the 7 zonal blood centers.		HMBL \$200,000	TBD Blood Safety TA (17985)	13: Epidemiological and Health Data		

HTS partners are not using data to identify gaps around testing yield and linkage	Routine review of program data on HIV testing yield and linkage with active remediation plan to maintain high quality performance.	In collaboration, NACP, clinical partner and LGA establish quarterly forums for reviewing performance on identification and linkage and develop strategies for course correction accordingly.	HVCT \$100,000	MDH (Fast tracking Dar)	
2. HIS: Current paper based systems do not adequately support linkages between HTS and treatment services.	1. HTS service delivery points make use of electronic patient level systems covering 40% of positives identified to improve linkages with treatment by 2019.	Support Community based KP CSOs to create demand for PWID to access services in DAR MAT clinics. Support treatment adherence. Work with MOHCDGEC on development of M&E system to capture KP disaggregated data	HVCT \$150,000	MUHAS-TAPP (16885)	15. Performance data
		1. Develop application for HTC services to support HTC standard practice to track results. 2. HTC Mobile App: Expand mHealth PPP to develop App for HTC testing services, implement standard of care, track results, optionally register clients for access to free information services, and link to health client ID register. 3. Work with HTS and Care and Treatment services to ensure systems are aligned with referral operating procedures.	HTXS \$250,000	CDC PPP Management (17296)	6: Service Delivery
		Work with MOHCDGEC to institute M&E system to capture and provide reports with KP disaggregated data.	HVCT \$150,000	MUHAS-TAPP (16885) (Fast Tracking Dar)	15. Performance data
			<b>6,250,000</b>		

**Table 6.1.3 ARV and other Commodity Management**

Barrier	Outcome	Proposed COP16 Activities	Code and Budget	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Finance: Financing gap between ARV and viral load needs and GOT/PEPFAR/GFATM allocation	1. Coordinated procurement plan for commodities developed and implemented on annual basis.	Adjust quantification process to ensure that supply plans are adjusted and improved based on recent trends in consumption and forecast accuracy.	OHSS \$240,000	Tanzania Supply Chain Program (18200)	8. Commodity Security and Supply Chain
		Toolkit for managing commodities at the LGA's implemented in five Scale-Up Councils. Support the Pharmaceutical Services Unit in budgeting, planning, and coordinating across vertical programs.	OHSS \$500,000	Tanzania Supply Chain Program (18200)	
	2. Sufficient domestic and external financing for HIV commodities identified in annual coordinated procurement plan.	Work with Tanzanian Parliament to ensure increased financing for HIV commodities and in country distribution costs	MTCT \$250,000	Health Policy Plus (18061)	11: Domestic Resource Mobilization
	3. GOT funds the full amount of in-country distribution costs for all donated	Enable CSOs to generate accurate information and effectively advocate for sufficient financing for HIV commodities and in country distribution costs	HTXS \$250,000	Health Policy Plus (18061)	11: Domestic Resource Mobilization
		Provide technical assistance to Ministries of Health and Finance to include funds to cover the agreed upon in country supply chain costs for donated	HTXS \$250,000	Public Sector System Strengthening	11: Domestic Resource Mobilization

	products including HIV-related donated product	commodities to prevent future debt to Medical Stores Department. This is a separate exercise from budgeting for domestic commodity procurement.		(PS3) (14693)	
3. Efficiency: System for distribution of commodities under new service delivery platform	1. Average in-country distribution costs for health commodities reduced from 20% to 15%	2. Institutionalize supply chain data use and improve data quality by ensuring RHMT, CHMT, and Pharmaceutical Services Unit and MSD review available data and take action on the results of that data to improve distribution, quantification, procurement and supply planning.	HTXS \$200,000	Tanzania Supply Chain Program (18200)	8. Commodity Security and Supply Chain
		Improve performance of MSD, third party logistics providers, and suppliers by measuring performance and applying contractual sanctions and/or incentives for poor/good performance	OHSS \$250,000	Tanzania Supply Chain Program (18200)	
		Assist the Pharmaceutical Services Unit and MSD to redesign the supply chain system using the data now available through eLMIS and other information systems. Implement new design with change management and training at all facilities.	OHSS \$600,000	Tanzania Supply Chain Program (18200)	
			HTXS \$600,000	Tanzania Supply Chain Program (18200)	
1. Finance: Financing gap between ARV and viral load needs and GOT/PEPFAR/GFATM allocation	1. Coordinated procurement plan for commodities developed and implemented on annual basis.	TA provided to GOT to ensure that male and female condoms needs are well understood, implement a total market approach to procurement planning, and distribution plans incorporate targeted approaches for KVPs.	HVOP \$400,000	Social Marketing and Communication (17416)	
			<b>3,540,000</b>		

## 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 service delivery models) for Tanzania as critical. The two programmatic gaps were also described in the WHO Guidelines and the PEPFAR 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.

### 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 includes adopting Test and Start nationwide as of October 2016.

### Programmatic Barriers

Five system barriers have been identified to mitigate the gaps toward Test and Start implementation during COP 2016. PEPFAR/T will work with the GOT to improve inefficient human resource systems to successfully implement new service delivery models. Tanzania has low quality data and systems to inform decisions regarding new service delivery models. Tanzania also has challenges with the lab sample referral system and human capacity to support accurate and timely diagnoses,

including OIs (e.g. TB). Current patient tracking systems do not have required functionality to support differentiated service delivery models. Inefficient GOT systems for disbursement, management, and use of funds budgeted for HIV across all levels of government result in reduced GOT investment in HIV.

### **3 Year Outcomes**

PEPFAR team has developed thirteen measurable outcomes that address the barriers associated with the implementation of Test and Start by 2018/19. A Comprehensive Test and Start policy will need to be approved and disseminated by 2017. Related SOPs and supportive supervision structures will need to be implemented. Supervision and assessment of Test and Start will be coordinated between MOHCDGEC and PO-RALG. Information, Education and Communication will be developed for awareness and understanding of Test and Start policy, benefits of early treatment, and promoting service uptake amongst KP and PP.

PEPFAR/T will develop and utilize M&E tools and systems for Test and Start for program monitoring and resource allocation. Test and Start interventions will be informed by quality evaluation findings. The national HIS infrastructure will support integrated service delivery. To increase linkages between programs, PEPFAR/T will develop and utilize a national electronic system for referrals. Service providers will adjust personnel and functions according to the new task sharing policy. At least 75% of approved permits will be filled in Scale-Up Councils, and at least 75% of HCW who report to their post in Scale-Up Councils will be retained for one year. Also, at least 90% of Scale-Up Councils will have systems that facilitate use of multisectoral profile data for decision making with 100% of GOT funds allocated to health and HIV are spent for intended purpose.

### **Activities**

The PEPFAR/T team will work with the GOT and the implementing partners to ensure the implementation of the Test and Start policy achieved by 2018/19 through the following activities. PEPFAR/T will improve effective governance at the council and regional level to effectively implement Test and Start. PEPFAR/T will address the shortages of adequately skilled health workers in Scale-Up Councils to provide HIV testing and treatment services. PEPFAR/T will strive to increase consistency and quality of HIV rapid testing according to WHO guidelines, and monitor the implementation of the updated policy guidelines for Test and Start through evidence-based methods.

PEPFAR/T will maximize program impact by improving data collection practices, systems, data quality and data analysis, and describe the drivers of the epidemic in Tanzania. PEPFAR/T will provide TA on capacity-building, country ownership strategies, data quality, and evidenced-based programming in a coordinated approach with other donors, ensuring the M&E and health information systems (HIS) for patient referral, tracking, and results follow-up are in place. PEPFAR will also support quality data and systems to inform decisions regarding the new service delivery models and evidence-based systems to 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 will also strengthen 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 will work with the GOT to accommodate a more streamlined and standard service delivery model aiming to decongest clinics, improve quality of care, support ARV distribution points outside the clinics using community health workers, and to decentralize ARV pick up at designated village dispensaries that will work in line with the recently approved task sharing policy. Adoption of the new service delivery model will help to decongest clinics even as they absorb the expected patient increases with the adoption of Test and Start. The new service delivery model will also improve the quality of services provided.

### **Programmatic barriers;**

During COP 2016, five barriers have been identified to address the challenges expected during implementation of the new service delivery model by 2018/19. These include improving the GOT human resource systems in place to successfully implement new service delivery models. PEPFAR/T will also strengthen quality data and systems to inform decisions regarding new service delivery models. PEPFAR will seek to improve the lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB). Improving the current patient tracking systems is needed to increase functionality to support differentiated the service delivery models. PEPFAR/T will strive to develop efficient GOT systems for disbursement, management, and use of funds budgeted for HIV 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 service delivery model by 2018/19. New national treatment guidelines will be implemented including alternate service delivery models. PEPFAR/T will work 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 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.

PEPFAR/T and GOT will synchronize HIV-related data systems. 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. Timely and accurate laboratory results will be available for patients in 100% of Scale-Up Councils. PEPFAR/T will increase the percentage of labs confirmed to meet SIMS EQA and accreditation Core Essential Element (CEE) and will strengthen pre-service lab training programs.

PEPFAR/T will increase the number of clients registered within patient level data systems for alternative refill sites to encourage less frequent clinic visits. Programs will 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. Scale-Up Councils will received 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 will work with the GOT and implementing partners to ensure the implementation of a new service delivery model 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. PEPFAR/T will support activities that align with the PEPFAR 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. PEPFAR/T will work closely with the GOT on a phased and increasing transition of government to government activities and salary support for HCWs to allow for PEPFAR to support commodities and target driven service support.

PEPFAR/T will 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 support 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.

PEPFAR/T will continue to scale up HIV viral load (HVL) for routine monitoring and early infant diagnosis services (EID) 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. 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& LIMS), as well as TB detection and monitoring and other OIs.

<b>Barrier</b>	<b>Outcome</b>	<b>Proposed COP16 Activities</b>	<b>Code and Budget</b>	<b>Associated Implementing Mechanism ID</b>	<b>Relevant SID Element and Score (if applicable)</b>
1. Tanzania does not have comprehensive policy or operational guidelines for Test and Start	2. SOPs and supportive supervision structures implemented.	Support MOHCGEC to disseminate revised national treatment guidelines, training manuals, M&E tools, and job aids.	HTXS \$100,000	MDH Kagera (17293)	2. Policies and Governance; 5. Public Access to Information
		Provide tailored strategic technical assistance and capacity building to service delivery implementing partners and RHMTs to ensure that test and start policy is translated to work plans and being implemented effectively	HTXS \$850,000	TBD Clinical TA (International) (17990)	6: Service Delivery

	3. Supervision and assessment of Test and Start are coordinated between MOHCDGEC and PO-RALG	GOT guidance and oversight to implement comprehensive test and start policy, including biannual TWG meetings and subcommittee meetings, full-time positions for hands-on TA with time-bound transition, orientation for RMOS and RCHO for policy translation and feedback on implementation, mentorship and supervision of R/CHMTs, annual stakeholder meetings and monitoring of evaluation of B+.	MTCT \$500,000	Consolidated MOH CoAg (18170)	2. Policies and Governance
		Provide national level technical assistance to the MOHCDGEC PMTCT program to plan and monitor the implementation of EMTCT and improve coordination of PMTCT activities at the LGA, regional and national levels.	MTCT \$500,000	UNICEF Follow on (17316)	7: Human Resources for Health
	4. Information, Education and Communication for awareness and understanding of test and start policy, benefits of early treatment and promote service uptake amongst KP, and PP.	Demand creation on Test and Start for KPs and AGYW.	HVCT \$150,000	Diffusion of Effective Behavioral Interventions (14556)	6: Service Delivery
		Development of strategic behavior change messaging for the new test and start program.	HTXS \$150,000	Diffusion of Effective Behavioral Interventions (14556)	
			HVCT \$500,000	Comprehensive Platform for Integrated Communication Interventions (CPICI) (18056)	13:Epidemiological and Health Data
2. Efforts to use data within planning and resource allocation hindered by low quality data and evidence from evaluations and surveillance are not designed to monitor test and start.	1. M&E tools and systems for test and start developed and utilized for program monitoring and resource allocation.	Assist Scale-Up Councils in the Southern Highlands Zone to triangulate and utilize data from national data warehouse and multi-sectoral data from all information systems relevant for decision making (ex -TOMSHA, DHIS2, HCMIS, EpiCor, PlanRep) for programmatic and social accountability. In addition, close feedback loop between Scale-Up Councils and national level by supporting quarterly/biannual performance review forums involving senior regional and National officials.	HTXS \$350,000	HJFMRI (16763)	15. Performance data
		MOHCDGEC M&E Section arranges for review of M&E tools, gathers all requirements for National DHIS, leads prioritization and evolution of HMIS, establishes national approach to data quality that is used by HIV, follow up on data completeness, timelines and accuracy of HIV data. Create and maintain coordinated M&E investment plans.	HVSI \$40,000	MOHSW – Follow on (16887)	13:Epidemiological and Health Data
			HVSI \$85,000	Consolidated MOH CoAg (18170)	
	2. Test and start interventions are informed by quality evaluation findings.	Conduct and publish in collaboration with NIMR a cost benefit study of the Treat & Train program.	OHSS \$150,000	Touch Foundation-PPP (9618)	7: Human Resources for Health
		Develop and implement acquired HIV drug resistance surveillance system to inform treatment guidelines (includes lab commodities required for the study).	HTXS \$600,000	TBD Surveillance TA (17988)	6: Service Delivery
3. Patient level data systems need additional functionality	1. National HIS infrastructure supports integrated service delivery	HIS Planning to incorporate Care Delivery systems integration into broader National HIS, eHealth and enterprise architecture planning, coordination and detailed specifications across other components of enterprise architecture.	HVSI \$160,000	TBD Institutional Capacity Building TA (17987)	15. Performance data

to better support service level initiation and referral across service delivery points for test and start.		HIS strengthening and support for shared information system services or infrastructure, including hosting, mobile network communications and aggregation, and access to all HIS systems for HIV planning, and HIV service implementers.	OHSS \$100,000	MOHSW – Follow on (16887)	
			OHSS \$110,000	Consolidated MOH CoAg (18170)	
		TA to MOHCDGEC to support planning and creation of shared information services and infrastructure, that are leveraged to support health information systems supported by PEPFAR for increased efficiency across PEPFAR and result in increased use of systems and data by stakeholders for planning and implementation of HIV services.	OHSS \$120,000	TBD Institutional Capacity Building TA (17987)	
4. Scale-Up Councils have a shortage of skilled service providers to follow or implement new test and start protocols and guidelines. Some reductions by activity	1. Service providers functioning according to task sharing policy	Conduct supportive supervision, coordination, and training of TOTs new development in community based care (CBHS) program.	HBHC \$37,000	NACP Follow-on (14573)	7: Human Resources for Health
			HBHC \$73,000	Consolidated MOH CoAg (18170)	
		Develop and implement regulatory mechanisms to regulate task sharing, and monitor and strengthen the capacity of nurses, social workers, and allied health cadres to provide HIV/AIDS services	HTXS \$300,000	Twinning Follow on (17305)	
		Improve performance of CHMTs and RHMTs in Shinyanga and Mwanza through incentive payments to ensure availability of qualified staff, timely submission of HMIS reports, and adequate medicines in facilities	OHSS \$750,000	Results-based Financing (18072)	6: Service Delivery
		Private nursing and midwifery training institutes create and test clinical practice at B+ART certified maternity care facilities of Private Nurses and Midwives Association of TZ in high HIV prevalent areas.	HTXS \$350,000	Strengthening Health Outcomes through the Private Sector in Tanzania (SHOPS+) (18058)	6: Service Delivery
		Revision of Scopes of Practice (SOP) for allied health cadres to support implementation of task sharing policy guidelines, to incorporate HTS, NIMART, pharmaceutical dispensing, and adherence counseling.	OHSS \$350,000	Twinning Follow on (17305)	7: Human Resources for Health
	Strengthen and maintain the national Pediatric HIV phone helpline system for health care workers to consult and seek second opinion when facing challenging pediatrics HIV cases including treatment initiation. The help line will specifically benefits the lower cadre health care workers and support task sharing.	PDTX \$200,000	BIPAI-PPP (17103)		
	Extend POPSM’s HR information system to the facility level to enable facility based permit allocation and increase availability of facility level HR data.	HTXS \$250,000	Public Sector System Strengthening (PS3) (14693)		
	2. At least 75% of approved permits are filled in Scale-Up Councils, disaggregated by sector and cadre	Support DHRO and DED to improve HR requests in Scale-Up Councils to reflect staffing needs based on service delivery statistics.	HTXS \$500,000	Public Sector System Strengthening (PS3) (14693)	

	3. At least 75% of HCW who report to their post in scale-up councils are retained for one year.	Retention improved by ensuring students are well prepared with extensive Treat and Train clinical practice at district and regional hospitals for MD, AMO and nursing students attending Catholic University of Health and Allied Sciences/Bugando Medical Center.	OHSS \$750,000	Touch Foundation-PPP (9618)	
1. Tanzania does not have comprehensive policy or operational guidelines for Test and Start	1. Comprehensive Test and Start policy approved and disseminated by 2017.	TA to MOHCGEC for PMTCT dissemination of PMTCT national guidelines, training manuals, M&E tools, job aids and new cohort registers for tracking mother baby pairs as part of the nationwide implementation of option B+	MTCT \$300,000	MDH Kagera (17293)	2. Policies and Governance; 5. Public Access to Information
	2. SOPs and supportive supervision structures implemented.	Provide TA to support implementation of test and start guideline and service delivery model	HTXS \$170,000	WHO Follow-on (16886)	2. Policies and Governance
	4. Information, Education and Communication for awareness an understanding of test and start policy, benefits of early treatment and promote service uptake amongst KP, and PP.	Coordinate demand creation on Test and Start for KPs and AGYW.	HTXS \$15,000	NACP Follow-on (14573)	6: Service Delivery
			HTXS \$35,000	Consolidated MOH CoAg (18170)	
		TA to the Ministry of Home Affairs advocating for the human rights of KPs to facilitate their access to services.	HTXS \$300,000	Sauti za Watanzania (16784)	2. Policies and Governance
5. Tz Governance structures do not adequately support capacity to plan, implement, and monitor Test and Start.	1. At least 90% of scale-up councils have systems that facilitate use of Multisectoral profile data for decision making	In target LGAs ensure channels and opportunities for private sector engagement regarding HIV services are both established and functional.	OHSS \$250,000	Public Sector System Strengthening (PS3) (14693)	4: Private Sector Engagement
		Within Scale-Up Councils, utilize the data warehouse established at national level to create dashboards with indicators from existing systems across sectors that are used for program planning, promoting transparency and improving the quality of HIV care and treatment services.	MTCT \$300,000	Public Sector System Strengthening (PS3) (14693)	1: Planning and Coordination
	2. 100% of funds allocated to health and HIV are expended for intended purpose	Implement Open LGA Partnership in Scale-Up Councils to increase public access to information and enable civil society to hold government accountable for budget expenditures and HIV service delivery.	OHSS \$250,000	Public Sector System Strengthening (PS3) (14693)	3: Civil Society Engagement
		Support Ministry of Finance to improve timeliness of disbursements to LGA health account.	OHSS \$200,000	Public Sector System Strengthening (PS3) (14693)	12: Technical and allocative efficiencies
			<b>9,845,000</b>		

**Table 6.2.2 New and Efficient Service Delivery Models**

Barrier	Outcome	Proposed COP16 Activities	Code and Budget	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
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1. GOT human resource systems in place to successfully implement new service delivery models Some reductions by activity	1. National treatment guidelines implemented under alternate service delivery models	Develop national SOPs for patient categorization according to their stability and monitor implementation through QI approach.	HTXS \$100,000	ASSIST (17082)	2. Policies and Governance	
	2. 100% of Scale-Up Councils have QA/QI structures in place to ensure quality of HIV/AIDS services provided by health workers and retention of individuals on treatment	Build capacity of tutors to improve quality of clinical practicum training for nurses at clinical sites across health training institutions (HTI) in Geita and Mwanza regions.		OHSS \$400,000	Maternal and Child Survival Program (MCSP) (17409)	7: Human Resources for Health
		Capacity building of QI focal persons at the priority SNU. Provide supportive supervision and mentorship to strengthen capacity of QI teams at the HF level in collaboration with regional implementing partners and CHMTs. The goal is to sustain quality of services for various interventions as part of QI plans or SIMS remediation plan and retention of PLHIV client.		OHSS \$130,000	TBD Institutional Capacity Building TA (17987)	
		Develop standardized national HIV/AIDS QI training package which will be used to provide standard QI framework to improve quality of services offered at the health facility across the priority SNUs with the goal of increasing linkage to care.		OHSS \$100,000	Consolidated MOH CoAg (18170)	6: Service delivery
		Implement accreditation of health training institutions to ensure production of competent nurse midwives capable of providing high quality HIV care for mothers and their newborns.		OHSS \$400,000	Maternal and Child Survival Program (MCSP) (17409)	
		Provide tailored, strategic technical assistance (TA) and capacity building to implementing partners and regional health management teams (RHMTs) to ensure the correct translation of service delivery model into practice.		HTXS \$850,000	TBD Clinical TA (International) (17990)	
		Train at least 6 Intermediate and Advanced Program residents in 2017 to serve in CHMTs to assure data-based decision-making, and to monitor and improve implementation of quality and coverage of use of New Service Delivery Models in facilities. Residents will also do Rapid Operational Research studies on challenges to implementation of Teat and Treat, New Service Delivery Models, and other linkage/retention problems.		HTXS \$100,000	University Partnership Field Epidemiology Expansion (17304)	7: Human Resources for Health
	3. Nursing, Clinical Officer, pharmacy, and CHW cadres providing high quality services per task sharing policy in 100% of Scale-Up Councils	Develop and implement a pharmacy technician cadre to adequately staff low-level health facilities (health centers and dispensaries) for distribution of ARVs.		OHSS \$150,000	Tanzania Supply Chain Program (18200)	
		In collaboration with professional councils and MOH, develop and implement mechanisms that enable lower level cadres practicing task sharing to upgrade to a higher level cadre following adequate training and supervision, which will improve quality of service delivery and strengthen HRH retention.		OHSS \$250,000	Twinning Follow on (17305)	
		Strengthen the Distance education/and e-learning program (DE) to improve HCW/and public health managers' capacity to undertake		OHSS \$300,000	MUHAS-SPH (17102)	

		task sharing roles for improved HIV/AIDS services at facility/and LGA level.			
		TA to the Centre for Distance education under the ministry of health to strengthen distance education /and e-learning platform to enable mid and lower level HCWs to upgrade and build their skills to undertake task sharing roles for improved HIV/AIDS services.	OHSS \$100,000	TBD Institutional Capacity Building TA (17987)	
		Task sharing policy implementation coordinated and rolled out across all levels using supportive supervision.	OHSS \$200,000	MOHSW – Follow on (16887)	
	4. At least one CHW deployed by GOT to each village within Scale-Up Councils	CHW recruitment, payment, and deployment systems established and institutionalized within POPSM.	HBHC \$500,000	Public Sector System Strengthening (PS3) (14693)	7: Human Resources for Health
		Establish plan to transition PEPFAR-supported HRH in Sustained Councils to the GOT payroll.	OHSS \$200,000	HRH2030 (18199)	7: Human Resources for Health
2. Quality data and systems to inform decisions regarding new service delivery models	1. GOT and PEPFAR HIV-related data sets synchronized	M&E and HMIS Planning and data systems TA to support development of GOT HMIS to incorporate additional functionality to support automated data exchange with PEPFAR reporting system and support evolution of data collected where appropriate. This includes TA to both facility level reporting and community level reporting.	HVSI \$300,000	TBD Institutional Capacity Building TA (17987)	13: Epidemiological and Health Data
		Assist Scale-Up Councils to utilize dashboards from national data warehouse, complete District Health Profiles, and compile multi-sectoral data from information systems relevant for decision making (ex -DHIS2, HCMIS, EpiCor, PlanRep). In addition, close feedback loop between Scale-Up Councils and national level to improve usefulness of dashboards.	MTCT \$150,000	Public Sector System Strengthening (PS3) (14693)	1: Planning and Coordination 13: Epidemiological and Health Data
	2. Data used by PEPFAR and GOT to evaluate and scale up sustainable service delivery platforms for prevention and treatment of HIV/AIDS in Scale-Up Councils	Design, implement, and document sustainability models in saturated SNU based on a VMMC sustainability framework enabling a staged transition of VMMC services from PEPFAR to GOT to maintain the 80% MC coverage in target age groups and assess clients' willingness to pay.	CIRC \$500,000	Strengthening High Impact Interventions for an AIDS- Free Generation (AIDSFree) Project (16787)	6. Service Delivery Models
		Build the QI capacity of the MOHCGEC QI directorate in data analysis and use of the reported DHIS2 QI indicators for informed decision making at all levels.	OHSS \$100,000	TBD Institutional Capacity Building TA (17987)	13: Epidemiological and Health Data
		Implement Data Use Strategy, Establish national systems and standard practice to improve dissemination products, feedback, district profiles to support use of data to inform HIV service planning. M&E and HMIS strengthening to improve data quality and MOHCDGEC leadership to incorporate new features to support integrated GOT and PEPFAR data systems.	HVSI \$50,000	MOHSW – Follow on (16887)	13: Epidemiological and Health Data
			HVSI \$100,000	Consolidated MOH CoAg (18170)	
		Provide Technical assistance to Tanzania Peoples Defense Force on military data collection, Management and use.	HVSI \$250,000	SABER Study (18130)	

		Provide technical support and capacity building for GIS and spatial analysis for GOT and PEPFAR implementing partners. Ensure Geo codes for all sites, support Master Facility List within Health Facility Registry, support synchronization of GOT and PEPFAR site lists, ensure availability of latest shape files for planning and maps.	HVSI \$225,000	NIMR Follow On (17300)	
		Support to PEPFAR/T for use of DATIM including management of facility lists. Work with DATIM and MOHCDGEC DHIS teams to support transition of PEPFAR TZ reporting to combination of MOHCDGEC data sharing and DATIM reporting. Continue supporting PROMIS for some PEPFAR/T specific reporting.	HVSI \$750,000	PROMIS (13351)	15. Performance data
	3. At least 90% of CHMTs in Scale-Up Councils implement data-driven planning and accountability approaches when developing Comprehensive Council Health Plans and monitoring their implementation	Build CHMT and DED capacity to utilize data for decision-making in Scale-Up Councils.	HTXS \$300,000	Public Sector System Strengthening (PS3) (14693)	1: Planning and Coordination
		TA to GOT to set up systems for national tools and strategies to enable CHMT, RHMT data use, including templates for district health profiles.	OHSS \$300,000	TBD Institutional Capacity Building TA (17987)	15. Performance data
			HVSI \$200,000	TBD Institutional Capacity Building TA (17987)	
3. Lab sample referral system and human capacity to support accurate and timely diagnoses, including OIs (e.g. TB)	1. Timely and accurate laboratory results available for patients in 100% of Scale-Up Councils	Continue supporting implementation of the centralized laboratory database and new EID, VL labs as well as the interconnectivity to feeder laboratory information in the Scale-Up Councils for real time monitoring of program performance.	HLAB \$400,000	APHL Lab Follow on (17292)	10. Laboratory
		Establish, implement and monitor LIS include web based dashboards for real time program performance management.	HLAB \$90,000	MOHSW Lab Follow on (17294)	
			HLAB \$50,000	Consolidated MOH CoAg (18170)	
		Provide technical assistance to the Central Tuberculosis Reference Laboratory (CTRL) for Gene Xpert machines through annual maintenance and timely calibration. TA to NTLF to strengthen interface of the TB gene expert alert system to the central database at the CTRL to ensure timely data exchange for the number of testes conducted, cartridge usage to facilitate appropriate quantification of TB laboratory diagnostic commodities. TA to also support reporting from TB/HIV Client register to HMIS.	HVTB \$650,000	TB – Follow On (17420)	
		Support implementation of basic laboratory information (BLISS) system in 10 Scale-Up Councils.	HLAB \$100,000	Consolidated MOH CoAg (18170)	

		Support maintenance of NIMR infrastructure and utilities for National HIV Reference Laboratory for effective, efficient, and safe operations including EQA, Viral Load, and EID to prevent service interruption.	HLAB \$75,000	NIMR Follow On (17300)	
	3. Strengthen pre-service lab training programs.	Develop and support a biomedical technician course to provide support to laboratory equipment and ensure timely and accurate laboratory results (currently the only support for lab equipment comes from outside Tanzania).	OHSS \$300,000	Twinning Follow on (17305)	7: Human Resources for Health
		Expand accreditation of curriculum for medical laboratory schools to strengthen lab human resources. (Prepare NTA Level 7 and 8 Assessment plan for the revised medical laboratory schools level 7 and 8 curriculum for lab technicians.)	OHSS \$150,000	ASCP Lab (16892)	
5. Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	1. Increased proportion of facility own revenue in targeted LGAs deposited in facility bank accounts and expended	HIV Community care study to determining the unit cost per client served under HIV community based services.	HBHC \$350,000	HIV Community Care and Support Study (17982)	6: Service Delivery
	2. Facilities in Scale-Up Councils receive timely disbursements of funds from the central level.	Build capacity of facilities to effectively manage facility level bank accounts.	OHSS \$250,000	Public Sector System Strengthening (PS3) (14693)	12: Technical and Allocative Efficiencies
		Improve efficiency in HIV spending by rolling out HIV/AIDS services as part of the benefit package within the Health Financing Strategy and Single National Health Insurance.	OHSS \$300,000	Public Sector System Strengthening (PS3) (14693)	
		Support MOH, PO-RALG, and MOF to ensure on timely disbursement of funds to facility bank accounts, as well as GOT health funds to LGA health account.	OHSS \$450,000	Public Sector System Strengthening (PS3) (14693)	11: Domestic Resource Mobilization 12: Technical and allocative efficiencies
	3. Scale-up LGAs increase allocation of domestic funds for HIV services by 10% in CCHP	Support Scale-Up Councils to increase allocation of domestic funds for HIV services in CCHP.	OHSS \$300,000	Public Sector System Strengthening (PS3) (14693)	6: Service Delivery 11: Domestic Resource Mobilization
	4. Budget execution rate increased to 80% in Scale-Up Councils by 2019.	1. Facilitate CSO engagement on HIV programming. 2. Build capacity of systems and ward and village levels to better engage with CSOs.	HBHC \$500,000	Community Health and Social Systems Strengthening Program (CHSSP) (14692)	3: Civil Society Engagement
		Implement financial management toolkit in Scale-Up Councils to increase budget execution rate and improve effectiveness in use of funds.	OHSS \$450,000	Public Sector System Strengthening (PS3) (14693)	12: Technical and Allocative Efficiencies

4. Current patient tracking systems do not have functionality to support differentiated service delivery models	1. Increased number of clients registered within patient level data systems for alternative refill site and less frequent clinic visits.	Support expansion of mHealth interfaces to support alternate service delivery models. Includes new public check in options that help facilitate longer prescriptions, by providing clinician access to patient check in info and linkages with mobile based information services like Health Pregnancy Health Baby.	PMTCT \$150,000	CDC PPP Management (17296)	13: Epidemiological and Health Data
		Development of strategic behavior change messaging for new service delivery models for providers and the targeted communities at large to raise awareness and create demand.	HTXS \$200,000	Comprehensive Platform for Integrated Communication Interventions (CPICI) (18056)	6: Service Delivery
5. Efficient GOT systems for disbursement, management and use of funds budgeted for HIV across all levels of government results in reduced GOT investment in HIV	2. Facilities in Scale-Up Councils receive timely disbursements of funds from the central level.	Provide TA to the GOT on delivery sites transition process (2,788 service delivery sites transitioned to the GOT)	HVSI \$700,000	TBD Clinical TA (International) (17990)	6: Service Delivery
			<b>12,470,000</b>		

### 6.3 Proposed system investments outside of programmatic gaps and priority policies.

During COP 16, PEPFAR/T identified seven 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. PEPFAR/T partners will provide TA to relevant ministries, including MOHCDGEC, to strengthen the gender and children’s desks and justice system and harmonize GBV/VAC at national level. GOT and PEPFAR data sets for GBV service monitoring and reporting will be harmonized. PEPFAR/T will finalize and roll out community M&E systems to track violence against children and linkage and retention into HIV care. PEPFAR/T will update the unified registry of vulnerable beneficiaries to interface with the MVC database and program. The Ambassador Self Help Grants will engage civil society in addressing the epidemic. PEPFAR/T will also establish 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.

**Table 6.3 Proposed system investments outside of programmatic gaps and priority policies.**

Outcomes	Proposed COP16 Activities	Code and Budget	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Increased number of adolescent and young women linked to prevention and treatment services	Establish information, education and communication services for GBV including integration of messaging into existing mHealth channels and services, expansion to reach wider audiences and specific service and support information for victims of GBV.	HBHC \$150,000	CDC PPP Management (17296)	13: Epidemiological and Health Data
National level Efforts to address gender-based violence is informed by a coordinated National Action Plan.	Provide TA to relevant ministries including MOHCDGEC to strengthen the Gender and Children’s desks and justice system and harmonize GBV/VAC at national level parenting guidelines.	HKID \$250,000	UNICEF Follow on (17316)	
Improved quality of Tanzania-GBV data for targeted GBV interventions across the sector and programs.	Harmonize GOT and PEPFAR data sets (for GBV service monitoring and reporting).	HBHC \$150,000	TBD Surveillance TA (17988)	15. Performance data
Increased number of vulnerable children linked to prevention and treatment services	Finalize and roll out community M&E systems to track violence against children and linkage and retention into HIV care.	HKID \$200,000	National Capacity Building (14698)	13: Epidemiological and Health Data
	Create interface between the Social Safety Net Unified Registry of vulnerable population and OVC database.	HKID \$200,000	Tanzania Social Action Fund (16792)	
	Strengthen OVC case finding and linkage to facilities by providing QI mentorship and supportive supervision to OVC volunteer teams.	HKID \$600,000	ASSIST (17082)	6: Service Delivery
	Create interface between the Social Safety Net Unified Registry of vulnerable population and PLHIV database.	HKID \$50,000 HBHC \$50,000	Tanzania Social Action Fund (16792)	13: Epidemiological and Health Data
Increased support to the HIV program from local CSOs	Ambassador Small Grants.	HKID \$150,000	Ambassador's HIV/AIDS Relief Fund (10970)	6: Service Delivery
		HVOP \$150,000		
		<b>1,950,000</b>		

## 7.0 Staffing Plan

PEPFAR/T utilized the staffing tools for COP 2016 to identify needs for new or repurposed PEPFAR staff across the interagency team. An interagency management team reviewed the tools and determined that no immediate staffing shifts would be 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 23 vacancies spread across the agencies and each of those vacancies are expected to be filled in early to mid-2016, and have not been open for more than one year.

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 decreased from COP 2015.

The implementation of SIMS will continue in FY 2017 and PEPFAR/T estimates that the planning levels from COP 2015 will be maintained in COP 2016 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.

USAID, State, CDC, and Peace Corps are not requesting new positions within COP 2016. DOD requests the addition of a new Extramural Management and Operations Officer to strengthen oversight, operations, and management processes to effectively execute implementation of PEPFAR accountability priorities, as well as evidence-based game changers to support Test and Start and efficient service delivery models. The position will oversee approaches and operations to strengthen PEPFAR accountability including POART as well as robust linkage and data quality monitoring systems to achieve epidemic control in high burden councils.

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.

# 1) APPENDIX A

**Table A.1 Program Core, Near-core, and Non-core Activities for 2016 COP**

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<p>Provision of high quality behavioral, biomedical, and structural interventions for KP and AGYW in Scale-Up Councils that reduce the likelihood of HIV acquisition and onward HIV transmission; Surveillance and mapping interventions to ensure appropriate targeting.</p> <p>Continuum of facility and community health services, including treatment failure detection, clinical monitoring, and demand creation, in Scale-Up Councils.</p> <p>Monitoring of program outputs, outcomes and quality; Health management information systems to support HIV prevention, care and treatment.</p> <p>Implementation of evidence-based quality interventions for PLHIV &amp; OVC support that enhance bi-directional referral and linkages between core community and facility programs and promote retention and adherence to promote viral suppression.</p>		<p>Provision of behavioral, biomedical, and structural interventions for general (non-priority) populations and support in non-priority geographic locations</p> <p>Demand creation, in Sustained Councils</p> <p>Construction and renovation for health facilities and training institutes.</p> <p>Provision of interventions for legal services and direct subsidies for scholarships, transport, health insurance to the OVC and PLHIVs.</p> <p>Support basic and refresher training in pain management and palliative care.</p>
Sub-national level	<p>In strategic locations, provision of high quality behavioral, biomedical, and structural interventions for KP and AGYW that reduce the likelihood of HIV acquisition and onward HIV transmission; Surveillance and mapping interventions to ensure appropriate targeting</p> <p>Coordination and monitoring of HIV services at regional and council levels.</p> <p>Monitoring of program outputs, outcomes and quality; Health management information systems to support HIV prevention, care and treatment</p> <p>Capacity-building of the local government authorities, CSO and PLHIV clusters to provide TA on service provision and supportive supervision.</p>	<p>Capacity-building for data for decision-making; Health Information Systems inclusive of HIV/AIDS</p> <p>Implementation of the interventions that will support council monitoring and reporting, mapping of services to facilitate referrals linkages and coordination of services, dissemination of the policy and guidelines to harmonize service provision.</p> <p>Allowance and top ups for health care providers.</p>	<p>In low burden areas, provision of behavioral, biomedical, and structural interventions for the general population</p> <p>Surveys for Sustained Councils</p> <p>Support monthly council meetings and Training of Trainers</p>
National level	<p>Provision of TA to GOT on establishing guidelines and policy that create a supportive environment for key and carefully selected priority populations to access health services; and access VMMC, HTC, condoms</p>	<p>Capacity-building for data for decision-making; HIS inclusive of HIV/AIDS</p> <p>Policy and guideline development, printing and dissemination.</p>	

**Table A.1 Program Core, Near-core, and Non-core Activities for 2016 COP**

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	<p>Monitoring of program outputs, outcomes and quality; Population-based HIV impact assessments (PHIA); Health information systems to support HIV prevention, care and treatment. Key population surveillance.</p> <p>Provision of TA to GOT on formalization of the community health workers, strengthening of the social welfare work force , and establishing guideline and policy that create a supportive environment for HBC and OVC</p>	<p>Procurement of commodities and supplies to cover needs above GFATM and MOHCDGEC coverage</p> <p>National data management system and Community human resource development to ensure sustainability of programs.</p> <p>Technical assistance for blood safety and infection prevention and control</p>	<p>Routine procurement of commodities such as HBC kits, and water treatment tablets.</p> <p>Subsidized ITN procurement &amp; residual spraying,</p> <p>Surveys for non-essential areas</p>

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for 2015 COP**

<b>Program Area</b>	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
<b>Key and vulnerable populations</b>			
Key populations (SW, MSM/TG, PWID)	Geographically-targeted continuum of behavioral, biomedical, and structural interventions that address stigma and discrimination and community empowerment while providing: peer education, STI screening and treatment, condoms and lubricant, HTC, ART, and opioid substitution therapy.	Geographically-targeted continuum of behavioral, biomedical, and structural interventions that support legislation and policies and address violence against KPs while providing: sexual and drug use assessment, post exposure prophylaxis, prevention and management of co-infections and co-morbidities, and reproductive health services.	
AGYW	Geographically-targeted continuum of behavioral, biomedical, and structural interventions for AGYW that include: targeted risk assessment, condom promotion and skills training, community mobilization and health communication activities to increase health-seeking and maintenance behaviors, HTC, ART, activities that promote gender equitable principles, and economic strengthening interventions		
Orphans and vulnerable children	Package of family-strengthening interventions: economic strengthening, Violence Against Children (VAC) services and systems, positive parenting, Early Childhood Development , child and social protection services, adolescent sexual reproductive health , HIV testing and counseling, and HIV treatment.  Linkage to the OVC to HTC services. Linkage of HIV+ OVC to care and treatment services at the facility level.	Facilitating access to primary and secondary education Support vocation education Strengthen government system to prevent and respond to child abuse Legal protection services; direct subsidies to MVC (e.g., scholarships, transport, health insurance)	Direct support of the IGAs
Gender-Based Violence (and violence against children)	Address harmful gender norms and harmful social practices (VAC) with targeted communities using support groups and community leaders	Establishment of the “one stop centers” to support the VAC & GBV survivor. Training of the service providers on support of survivors	Renovation of the centers
<b>Prevention</b>			
Prevention of Mother to Child Transmission, Option B+ EID	PMTCT option B+ in Scale-Up Councils  EID, geographically targeted to follow PMTCT	EID commodity procurement	
HIV testing and counseling	In Scale-Up Councils, opt-out PITC, with a focus on in-patient, ANC, and children, and community-based HTC for key and priority populations as well as family members of index clients.  In Sustained Councils, PITC in ANC and TB settings when	Community-based HTC to key and vulnerable populations in non-identified hot spots in Sustained Councils  Rapid test kit procurement above those	

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for 2015 COP**

<b>Program Area</b>	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
Voluntary medical male circumcision	clients present with OIs or other signs and symptoms suggestive of HIV infection, and in children known to be exposed to HIV perinatally. Community-based HTC only for family members of index clients. Service delivery, demand creation, and commodity procurement for 10-29 year old males	procured by GFATM  TA and service delivery, including commodity procurement, for early infant male circumcision in regions that have achieved or are approaching 80% coverage of 10-29 year old males	
Behavior change communication	Targeted health communications, focused on KP and AGYW that minimize risk or increase protection and increase acceptability, demand for, and uptake of core biomedical interventions.  Interventions should be based on behavioral theory and address: biomedical interventions relevant to the population and setting, social and gender norms, structural barriers to prevention, and link activities to clear behavioral objectives		Interventions that cannot be brought to scale or target non-priority populations (e.g., in-school youth and general population)
Condoms and lubricant	Targeted condom and/or lubricant distribution for key and priority populations  Support for condom total market approach to ensure that all sectors are appropriately targeted	Bulk procurement of condoms, both socially marketed and public sector for general population (GFATM/other procured)	
Infection prevention and control	Procurement/packaging of lubricant for key populations	Upgrade the HCWM final treatment and disposal systems, and strengthen waste segregation and transport for HCWM model sites  Ensure availability of PEP starter packs for HCWs  Support roll out in facilities of PEP database and M&E tool; and integrate PEP data base into GOT DHIS-2 reporting systems  Develop HCWM planning and budgeting tools for regions/councils.  Strengthen R/CHMTs systems to coordinate IPC-IS and HCWM	Training of health care providers  Procurement of commodities and supplies for IPC-IS  Implementation of standards-based management and recognition (SBM-R) QI approach for improving the quality of IPC practices at hospitals to MOHCDGEC, MOHZ and RALG ministries

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for 2015 COP**

Program Area	Core Activities	Near-core Activities	Non-core Activities
		program activities, and advocate incorporation of IPC-IS in service training into Comprehensive Council Health Plans (CCHPs).	
Blood safety		Provide TA to implementing partners to integrates IPC-IS Into their programs TA to National Blood Transfusion Service on QA of blood and blood products, blood service information and accreditation of blood centers and satellite sites, and building the capacity of GOT entities to assume operational oversight in eight regions	Direct service delivery, as related to safe blood mobilization, collection, testing and distribution; staff salaries and staff welfare; and procurement of HIV rapid test kits and blood-related supplies.
<b>Care and treatment</b>			
Adult and pediatric treatment and clinical care	Continuum of facility and community health services, including treatment failure detection, clinical monitoring, and demand creation, in Scale-Up Councils and populations  Policy and guideline development, printing and dissemination. Coordination and monitoring of HIV services at regional level.	Procurement of First and Second Line and Peds ART Procurement for gap filling beyond GFATM and MOHCDGEC coverage	Demand creation, in Sustained Councils and populations
PHDP	Clinical package: OI screening and management, STI screening, treatment & referral, nutritional assessment, CD4 monitoring, VL monitoring, adherence counseling and referral, couple/partner/ household HTC  Community package: Status disclosure, Partner and family referral for testing Condom distribution, Nutritional assessment, counseling, and support services and adherence through quality improvement methodologies support; couple/partner and household HTC	Procurement of selected commodities and supplies to cover needs above GFATM and MOHCDGEC coverage (gap filling for PEPFAR scale-up) CTX procurement for gap filling  Procurement and distribution of PHDP kits and water treatment tablets	Family planning counseling Procurement and distribution of ITNs
Community care	Referral and linkages across the continuum care, training of community volunteers, Support to community support groups/volunteers to track LTFU clients and link them back care, Strengthening PLHIV networks (access, retention and adherence)	Linkage of PLHIV to other community-level socio-economic services (e.g. community savings/loan activities, food security programs) TA on QI/QA, M&E, QA Advocacy for sexual and reproductive health rights	
TB/HIV	CHW support -adherence counseling and referral services Screening; case finding, infection control; referral, ART, INH; HTC in areas and populations with highest number of HIV	OI Procurement to cover needs above GFATM and MOHCDGEC coverage (gap	Routine TB Drug Procurement (GFATM Procured)

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for 2015 COP**

<b>Program Area</b>	<b>Core Activities</b>	<b>Near-core Activities</b>	<b>Non-core Activities</b>
infections		filling for PEPFAR scale-up)	
Cervical cancer		Client screening, treatment & referral support; training of TOTs and providers, procurement of commodities, supplies, equipment; QA and performance monitoring, reporting and QI	
<b>Health systems strengthening</b>			
Laboratory services	Rapid Test Kit QA, GenXpert, VL, CD4	Equipment, training, accreditation, maintenance in areas with highest number of HIV infections	
		Support for equipment maintenance service contracts for CD4 machines.	
		Procurement of lab commodities for gap filling beyond GFATM and MOHCDGEC coverage	
Quality improvement	Monitoring of program quality through joint supportive supervision and mentoring using quality improvement methods; Remediation activities to address gaps identified during SIMS visits and continuous follow up	Support the development of national QI data system to align with MOHCDGEC HMIS QA/QI TA to support certification towards accreditation of health facilities	
Human Resources for Health – Human Capacity Development	Strengthen HR management systems to improve recruitment, deployment, and retention of HCWs at moderate and high volume sites or high burden areas.	Support framework to standardize pre- and in-service HIV training curricula for HCWs and CHWs. This includes interventions for pediatric HIV, PITC, PMTCT Option B+, and VMMC.	
		Implement task sharing policy to expand supply of HCWs that can provide HIV services at PEPFAR priority sites.	
		Improve HRH performance and quality through strengthening effective supportive supervision structures and incentive systems	
		Strengthen capacity-building of	

**Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for 2015 COP**

Program Area	Core Activities	Near-core Activities	Non-core Activities
Institutional capacity-building (units/ organizations/ GOT institutions)		zonal health resource centers to conduct and manage HCW, CHMT, RHMT and faculty trainings in the regions	
		Support sustainability approaches in order for GOT to effectively deliver HIV/AIDS services. These components are outlined in the Sustainability Index:	
Supply chain	Supply Chain Management TA	Institutionalize data availability, domestic program and service delivery (especially at the central and regional level), CB to GOT for domestic health financing and strategic investments, strengthen framework for accountability and transparency	
	Support for eLMIS	Procurement of select commodities (mentioned above)	Procurement of select commodities (mentioned above)
Strategic information	Monitoring of program outputs, outcomes and quality	Capacity-building for interpreting and using data for decision-making	Surveys for non-essential areas
	Population-based HIV impact assessments (PHIA)		
Health financing	HMIS at the facility level	Support (software, application and infrastructure) for interoperability between facility and above site levels of Health Information Systems inclusive of HIV/AIDS	
	Key populations surveillance; TA to increase domestic financing for health, particularly for HCW salary and benefits, for improved effectiveness in use of funds, inclusive of innovative mechanisms that garner value for money (e.g., RBF, private insurance schemes, and HIV/AIDS Trust Fund); costing to inform government investment		
Research	Implementation science/ operations research for core and intervention improvement	Implementation science/ operations research for near-core intervention improvement	Implementation science/ operations research for non-essential interventions
Infrastructure support		Constructions/renovations for laboratories in Scale-Up Councils	Constructions/renovations for health facilities and training institutes.

**Table A.3 Transition Plans for Non-core Activities**

Transitioning Activities	Type of Transition	Funding in 2016 COP	Estimated Funding in COP 2017	# of IMs	Transition End date	Notes
Behavior change communication interventions that cannot be brought to scale or target non-priority populations (e.g., in-school youth and general population)	N/A	\$0	\$0	0	N/A	All such interventions have been terminated and are not encouraged for transition
Infection prevention and control direct service delivery raining of health care providers	Transition to Government	\$0	\$0	0	2016	Government to include budgets for direct service delivery and training into CCHPs
Procurement of commodities and supplies for IPC-IS	Transition to Government	\$0	\$0	0	2016	Government has included the essential IPC-IS commodities and supplies including personal protective equipment (PPEs) into the National Essential Drug List.
Implementation of standards-based management and recognition (SBM-R) QI approach for improving the quality of IPC practices at hospitals to MOHCDGEC, MOHZ and RALG ministries	Transition to Government	\$0	\$0	0	2015	Introduce and transition the SBMR & QI approach to Government to support IPC standards; supportive supervision tools; facility performance and improved facility recognition programs
Blood Safety direct service delivery	Transition to Government	\$0	\$0	0	2015	GOT to support blood safety operations, ranging from salaries to utilities to procurement of blood safety related commodities and supplies
Demand creation, in areas and populations with low number of HIV infection	Other development partners	\$0	\$0	0	2015	GOT currently receives support from other donors for demand creation
TB Drug Procurement	None	\$0	\$0	0	n/a	Already GFATM supported
Implementation Science for non-essential interventions	No plans for renewal or transfer to another entity	\$0	\$0	0	n/a	
Constructions/renovations for health facilities and training institutes.	Transition to Government	\$0	\$0	0	2017	New constructions/renovations for labs in Scale-Up Councils remain near-core. PEPFAR/T will spend down current pipeline for any remaining infrastructure activity in previously approved COPs. HBC kit transitioning to GOT in 2016
Procurement of Commodities such as HBC Kits, Water treatment tablets and condoms. Subsidizing ITN procurement & residual spraying.	Transition to government	\$0	\$0	0	2016	
Support monthly council's meetings	Transition to local	\$0	\$0	0	2015	

and the training of ToTs. Volunteer incentives	government Transition to local government	\$0	\$0	0	2016	Efforts to harmonize the community health workers and integration in the GOT payroll is in progress
Support for equipment maintenance service contracts for CD4 and Viral Load (VL) machines.	Service contracts with manufacturers as machines are placed	\$1,500,000	\$0	1	2017	All VL machines on reagent rental agreement with manufacturers who will be responsible for equipment maintenance. Transition of maintenance of 30 BD Facs Calibur and 270 BD Facs count machines in country to GOT on its final year (COP16).

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### 3) APPENDIX B

#### B.1 Planned Spending in COP 2016

**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$49,375,392	\$380,624,608	\$430,000,000

**Table B.1.2 Resource Allocation by PEPFAR Budget Code**

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$25,249,164
HVAB	Abstinence/Be Faithful Prevention	\$0
HVOP	Other Sexual Prevention	\$13,179,524
IDUP	Injecting and Non-Injecting Drug Use	\$3,348,839
HMBL	Blood Safety	\$736,500
HMIN	Injection Safety	\$57,612
CIRC	Male Circumcision	\$36,204,691
HVCT	Counseling and Testing	\$17,665,146
HBHC	Adult Care and Support	\$21,886,013
PDCS	Pediatric Care and Support	\$2,018,630
HKID	Orphans and Vulnerable Children	\$34,718,504
HTXS	Adult Treatment	\$115,873,281
HTXD	ARV Drugs	\$94,324,063
PDTX	Pediatric Treatment	\$9,788,153
HVTB	TB/HIV Care	\$7,597,359
HLAB	Lab	\$2,747,325
HVSI	Strategic Information	\$8,623,712
OHSS	Health Systems Strengthening	\$12,148,822
HVMS	Management and Operations	\$23,832,662
<b>TOTAL</b>		<b>\$430,000,000</b>

#### B.2 Outlier Analysis and Mitigation Plan

PEPFAR/T conducted a detailed outlier analysis using EA 2015 data using the suggested five times greater than and 10 times greater than the weighted average UE where applicable. Each technical team in consultation with mechanism program managers from the respective agencies looked at the respective outliers, associated programmatic context, and cost drivers. To derive greater technical and allocative efficiencies, the Tanzania interagency team as a whole and each U.S. Government agency derived an outlier mitigation plan to address these outliers. Any IM outlier that will continue to be funded will be closely monitored through routine partner management during the course of the year. Additionally, for mature programs with similar context, the team elected to use the adjusted applied national UEs for partners in the budgeting for COP 2016, rather than partner specific UEs (see section B.3 for more details).

There were eight IMs with outlier UEs in multiple program areas and 11 in multiple councils.

>5 in 1 program area	>10 across program areas
ZACP	ZACP
CSSC	CSSC
FBO Networks	LIFE Program
LIFE Program	Sauti za Watanzania
Sauti za Watanzania	Local FOA Follow on
TCRS	HJFMRI
Local FOA Follow on	Helpline & Youth
HJFMRI	Tanzania Social Marketing Program
Helpline & Youth	
Tanzania Social Marketing Program	
Pamoja Tuwalee	

There were 20 councils with multiple (>5) outliers (across program areas and IMs).

Councils		
Bagamoyo DC	Kigoma DC	Mkoani
Busokelo DC	Kinondoni MC	Njombe TC
Ilala MC	Kusini	Nyamagana MC
Iringa MC	Magharibi	Temeke MC
Kahama TC	Mbeya City Council	Wanging'ombe DC
Kaskazini A	Mbozi DC	Wete
Kibaha TC	Micheweni	

Each agency will utilize their periodic monitoring structures to implement an actionable outlier mitigation plan. This would include, but not limited to:

- Review of IM cost drivers; especially those where PEPFAR Tanzania will not provide support.
- Capture lessons learned from ending awards to inform efficient implementation of new awards
- Capture trends in spending for new awards e.g., certain IMs will reach targets at increasingly lower cost since demand creation activities are/will be in place.
- Conduct review of expenditures in Sustained Councils as pivot is made.

### B.3 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) conducted an outlier analysis as described in section B.2. Since FY 2015 expenditure data was not yet reflective of the COP 2015 pivot and furthermore, PEPFAR/T in COP 2016 will move to adaptation of the new guidelines for differentiated models of service delivery and test and start, COP 2015 applied UEs across all program areas were utilized as a starting point. 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 and in the development of partner budgets. 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 partner and SNU and programmatic context, PEPFAR/T used the same adjusted applied national UEs for partners to budget in COP 2016. Any adjustments necessary due to program context e.g., various environmental factors in the councils where partners operate, was further applied where necessary. PEPFAR/T will implement routine monitoring strategy from the start of FY 2017 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 decided to budget for all HIV commodities separately through the PBAC's commodity calculator. Thus, the cost of all commodities (ARVs, non-ARV drugs/reagents, HIV test kits, and condoms) 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 calculated the additional number of patients to be served above the Global Fund procurements. Unit costs (calculated using the current cost of the product and increased by 17% 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.

The Health Systems TWG including the SI and Lab teams did extensive analysis of EA data. By first filtering for target driven partners, PEPFAR/T was able to provide information to each TWG, how much of their expenditures had been on above-site health systems activities. TWGs used this information to inform how much of their budget should be for non-target (or non-unit expenditure) driven activities. The HSS TWG used the COP 2015 budget as a starting point in review of activities and budgets as part of the strategic alignment (SBOR) process.

## **HTS**

Facility-based testing (FBTC), largely PITC, will be supported by clinical partners who receive HTXS funding. The unit cost of \$1.62 was applied to FBTC in Scale-Up Councils and in Sustained Councils. The UE excludes costs for RTKs which were budgeted in the PBAC commodities calculator.

For community-based HTC, the unit expenditure of \$9.65 (excluding RTKs) in all SNUs was used. Funding was also allocated to support coordination, technical assistance to improve service quality and development of communication materials. Based on the shift in site support and the geographic focus, saved resources will be re-invested to support modalities with the greatest HIV-positivity yield in Scale-Up Councils in line with the scale-up trajectory in those areas.

## **Care and Treatment**

PEPFAR/T used COP 2015 UEs as a starting point and made adjustments to account for adaptation of differentiated models of service delivery. 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, i.e. Scale-Up and Sustained Councils. This was done under a consideration that there is no major difference in the package of services at facility level between Scale-Up or Sustained Councils. UEs adjustment were made on by adjusting cost categories which TWG agreed to not increase funds (i.e., hold constant) as the targets increase but fixing the FY 2015 expenditures for COP 2016. The cost categories include personnel (fixing supportive supervision), in-service training, new infrastructures and program management. 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 adjusted average national IM unit expenditures were 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. It is worth noting that an outlier analysis was done to identify IM unit expenditures that exceeded the five times threshold above and below average national unit expenditure.

No Pre-ART UEs were used for budgeting since there are no associated targets in COP 2016.

Below are the adjusted applied national unit expenditures used:

Adult ART (incl. lab, excl. commodities)	\$97.57
Pediatrics ART (incl. lab, excl. commodities)	\$124.40

For community-based care, treatment and support, the applied COP 2015 UE was used \$70.31 for Scale-Up to Saturation and Aggressive Scale-Up Councils, a UE of \$40.81 was used for Sustained Councils.

## PMTCT

For PMTCT, PEPFAR/T used the COP 15 UEs except for PMTCT on care, where the UE from EA 2015 was used via the EA Data Navigation tool. 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 (TX\_CURR (<1 year old))

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

	Methodology
# of pregnant women tested and received results (PMTCT_STAT) UEs	COP 2015 UE was used. Scale-Up and Sustained have the same UE. UE excludes HIV test kits and condoms. The applied COP 2016 UE is \$3.56
# of women receiving ART as Option B+ (PMTCT_ARV disaggregate Life-long ART	From EA 2015 The applied UE is \$157.72 and B+ Lab is \$11.60

<p>(Option B+)</p> <p># of infants tested (PMTCT_EID Numerator)</p>	<p>The following adjustments were made:</p> <p>Investments:</p> <p>(a) In-Service Training: This will be covered by the PMTCT program (EID trained is part of the PMTCT training-combined curriculum) - zeroed out</p> <p>(b) Construction &amp; Renovation: No additional construction and renovation is expected for SD or Lab - zeroed out</p> <p>(c) Vehicles: No additional new vehicles are to be purchased for SD or Lab - zeroed out</p> <p>(d) Equipment &amp; Furniture: No site expansion is expected, although there might be some need for replacing outdated equipment or furniture - assumed 50% reduction for SD (this will be covered by the PMTCT program), zeroed out for Lab.</p> <p>Recurrent:</p> <p>(a) Personnel: Mostly supportive supervision. IMs will conduct this irrespective and will not need additional resources with increase in targets - 25% reduction both SD and Lab.</p> <p>(b) Non-ARVs, Drugs &amp; Reagents: Marginal component for needed items - assumed 75% reduction</p> <p>(c) Other supplies, Travel &amp; Transport: Since the supportive supervision format is likely to not change, 25% reduction is estimated.</p> <p>Program Support:</p> <p>(a) Program Management: Since the supportive supervision format is likely to not change, 25% reduction is estimated.</p> <p>(b) SI: Unchanged</p> <p>The UE used for COP 16 is \$61.19 and for EID_Lab is \$26.21</p>
<p># infants receiving care (TX_CURR (&lt;1 year old))</p>	<p>The following adjustments were made:</p> <p>Investments:</p> <p>Zeroed out all investments except for ""Other investments"" since costs will be carried by the PMTCT program.</p> <p>Recurrent:</p> <p>(a) Personnel: Stayed unchanged since this is needed to intensify infants follow-up</p> <p>(b) Non-ARVs, Drugs &amp; Reagents: Marginal component for needed items - assumed 75% reduction</p> <p>(c) Other supplies, Travel &amp; Transport: Since the supportive supervision format is likely to not change, 25% reduction is estimated. Sample transportation is critical to improve turnaround time</p> <p>Program Support:</p> <p>(a) Program Management: Since the supportive supervision format is likely to not change, 25% reduction is estimated.</p> <p>(b) SI: Unchanged</p> <p>The UE used for COP 2016 is \$1503.46</p> <p>Note that PEPFAR/T is aware that the TX_CURR (&lt;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.</p>

## VMMC

VMMC TWG created a total service delivery budget to saturate VMMC using a UE of \$51.74. The UE was calculated by adding demand generation and waste management to the 2015 EA UE. 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 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 2015 UEs for COP 2016 for all prevention targets (PP-PREV, MSM/TG, FSW, PWID, and MAT).

## **OVC**

UEs for Scale-Up councils based off of COP 2015 UE for scale-up of \$41.27. National UE excluding training, construction/renovations, vehicles; equip/furniture; ARVs; non ARV drugs; food supply. Cluster agreed to keep UEs the same as COP 2015 and will add a lump sum site level budgets for in service training and personnel for case management. Sustained: Based off of COP 2015 UE for maintenance of \$ 34.

# APPENDIX C

## Systems Investments for Section 6.0

Included Activities	Excluded Activities
<b>Human Resources for Health (HRH): Systems/Institutional Investments</b>	
Pre-service training; in-service training systems support and institutionalization; HR Requests and retention plans at LGA levels, POPSMS HRH permit allocation process, POPSMS 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	N/A
<b>Human Resources for Health (HRH): Personnel Costs for Service Delivery</b>	
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
<b>Governance</b>	
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	N/A
<b>Finance</b>	
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
<b>Systems Development</b>	
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
<b>Institutional and Organizational Development</b>	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
<b>Strategic Information</b>	
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
<b>Laboratory</b>	

Quality management and bio-safety systems; implementation and evaluation of diagnostics (POC and 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 and supplies, travel and transport, building rental and utilities will not be included
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