



United States Department of State

Washington, D.C. 20520

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January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR Chargé INMI PATTERSON, TANZANIA

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and, specifically, the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Key successes:

1. **Swift policy action.** The Government of Tanzania (GoT) took swift policy actions in FY19, which enabled rapid scale-up of critical program components such as targeted testing, index- testing, HIV self-testing, 3-month multi-month dispensing, and TLD transition.
2. **Reducing over-testing and scale-up of targeted testing strategies.** With support from Government of Tanzania (GoT), the PEPFAR Tanzania program made significant strides in case identification since FY18, which resulted in the percentage of newly identified HIV+ adults through index testing increasing by 722% and the number of HIV+ adult men identified through index testing modality increasing by 478%.
3. **Innovative site management.** PEPFAR Tanzania intensified site management with the use of scorecards thereby improving case identification, linkage, and client retention.
4. **Increasing treatment coverage in regions with high treatment gap.** GoT and PEPFAR Tanzania used the Tanzania HIV Impact Survey (THIS) to inform programming in FY19 and improved treatment coverage in regions with the greatest gap in treatment coverage. Regions that showed a significant increase in the number of clients on treatment (TX_CURR) since FY18 are Dodoma, Geita, Kagera, Morogoro, Mwanza, and Songwe. SPECTRUM estimates post-PHIA show substantial variability in PLHIV estimates by region in some regions. PEPFAR Tanzania, together with S/GAC, should work to get the best possible estimate of true PLHIV burden so that investments can be optimized and matched according to true estimates.

Key challenges:

While much progress has been made on the policy front, certain program areas did not see the same progress as others. Areas of concern include:

1. **Enabling lay health workers to perform HIV testing.** During the COP19 meetings,

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- GoT agreed to pass a policy allowing lay worker testing, but it has not been approved.
2. **Scale up client centered approaches.** The current national policy allows for 6-month ART scripting with 3-month dispensing for stable clients, which is not a client-centered approach. WHO guidelines recommend 6-month dispensing for eligible clients.
 3. **Adoption and scale-up of unique identifier strategy.** Unique identification strategy has not yet been implemented and needs to be scaled up rapidly, as this will be critical to understanding retention of clients in life-long care, particularly when clients move from one facility to another.
 4. **Access to key population (KP) friendly services.** The GoT ban on lubricant and drop-in centers for KP services remains in place since 2016. In addition, the national policy on forced anal exams is noncommittal and does not ban the practice, which is a barrier for unrestricted access to services.

SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows:

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	\$ 411,944,070	\$ -	\$ -			\$ 411,944,070
GHP- State	\$ 374,325,320	\$ -	\$ -			\$ 374,325,320
GHP- USAID	\$ 35,000,000	\$ -	\$ -			\$ 35,000,000
GAP	\$ 2,618,750	\$ -	\$ -			\$ 2,618,750
Total Applied Pipeline				\$ 69,355,848	\$ 500,082	\$ 69,855,930
DOD				\$ 18,171,109	\$ -	\$ 18,171,109
HHS/CDC				\$ 9,394,935	\$ -	\$ 9,394,935
HHS/HRSA				\$ -	\$ -	\$ -
PC				\$ 31,997	\$ -	\$ 31,997
State				\$ -	\$ -	\$ -
USAID				\$ 41,757,807	\$ 500,082	\$ 42,257,889
TOTAL FUNDING	\$ 411,944,070	\$ -	\$ -	\$ 69,355,848	\$ 500,082	\$ 481,800,000

Note. Based on agency reported available pipeline from EOFY.

SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS

Tanzania should plan for the full Care and Treatment (C&T) level of \$357,250,000 and the full Orphans and Vulnerable Children (OVC) level of \$45,800,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

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TABLE 2 : COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	\$ 290,000,000	\$ -	\$ -	\$ 290,000,000
OVC	\$ 31,000,000	\$ -	\$ -	\$ 31,000,000
GBV	\$ 10,476,200	\$ -	\$ -	\$ 10,476,200
Water	\$ 2,097,350	\$ -	\$ -	\$ 2,097,350

* Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year. For countries with GHP-State and GHP-USAID funds the C&T and OVC earmark requirements can be met with FY20 funding from any combination of the two accounts.

TABLE 3 : All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	\$ 130,000,000
VMMC	\$ 27,000,000
Cervical Cancer	\$ 2,000,000
DREAMS	\$ 25,000,000
HBCU Tx	\$ -
COP 19 Performance	\$ 55,000,000
HKID Requirement	\$ 21,000,000

Note. See Appendix 1 for detailed budgetary requirements

SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

Table 4. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	1,136,570	1,468,808
TX Current Peds	59,637	88,007
VMMC among males 15 years or older	778,084	805,053
PrEP (NEW / CURR)	5,312 / 8,723	33,306 / 39,042
DREAMS (AGYW_PREV N)	98,385	—
Cervical Cancer Screening	89,488	290,406
TB Preventive Therapy (Completed / Started)	303,140 / 350,711	478,779 / 562,799

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Table 5. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU	\$559,737,317	\$531,536,580	\$28,200,737
DOD	\$97,434,758	\$82,660,267	\$14,774,491
HHS/CDC	\$155,031,932	\$153,723,399	\$1,308,533
HHS/HRSA	\$2,232,500	\$2,339,613	(\$107,113)
PC	\$2,823,746	\$2,347,356	\$476,390
State	-	-	-
State/AF	-	-	-
State/SGAC	-	-	-
USAID	\$302,214,381	\$290,465,945	\$11,748,436
Grand Total			

*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 6. COP/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays (\$)	Over/Under FY19 Outlays (Actual \$ - Total COP/ROP18 Budget \$)
11528	U.S. Peace Corps	PC	\$113,000	\$132,726	(\$19,726)
12854	Vodafone Foundation PPP	USAID	\$113,084	\$538,602	(\$425,518)
14693	Public Sector System Strengthening (PS3)	USAID	\$9,883,170	\$11,084,786	(\$1,201,616)
16569	MEASURE Associate Award	USAID	\$579,000	\$2,945,139	(\$2,366,139)
16787	Strengthening High Impact Interventions for an AIDS-Free Generation (AIDSFree) Project	USAID	\$10,385,919	\$14,016,808	(\$3,630,889)
16887	MOHSW - Follow On - (GH001062)	HHS/CDC	\$210,557	\$376,433	(\$165,876)
17316	UNICEF Follow on - (GH001619)	HHS/CDC	\$484,500	\$737,344	(\$252,844)
17357	Supporting Operational AIDS Research Project	USAID	\$650,000	\$1,205,670	(\$555,670)
17420	Challenge TB	USAID	\$2,083,885	\$4,470,671	(\$2,386,786)
17991	TBD Comprehensive High Impact HIV Prevention IP (Local) - (GH002018)	HHS/CDC	\$19,771,548	\$24,384,680	(\$4,613,132)
18200	GHSC-TA	USAID	\$3,270,000	\$5,677,380	(\$2,407,380)
18237	Boresha Afya Southern Zone	USAID	\$16,153,000	\$18,539,762	(\$2,386,762)
70355	Quality Improvement for Comprehensive HIV/AIDS	USAID	\$1,000,000	\$1,195,518	(\$195,518)

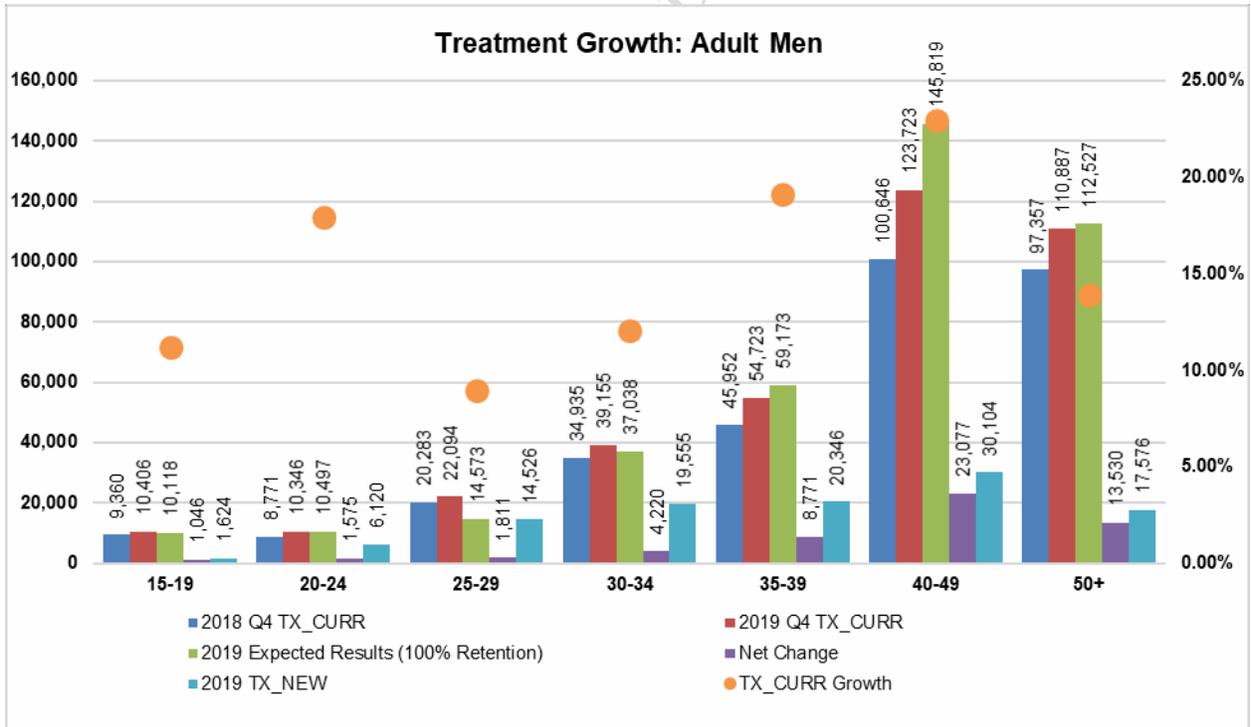
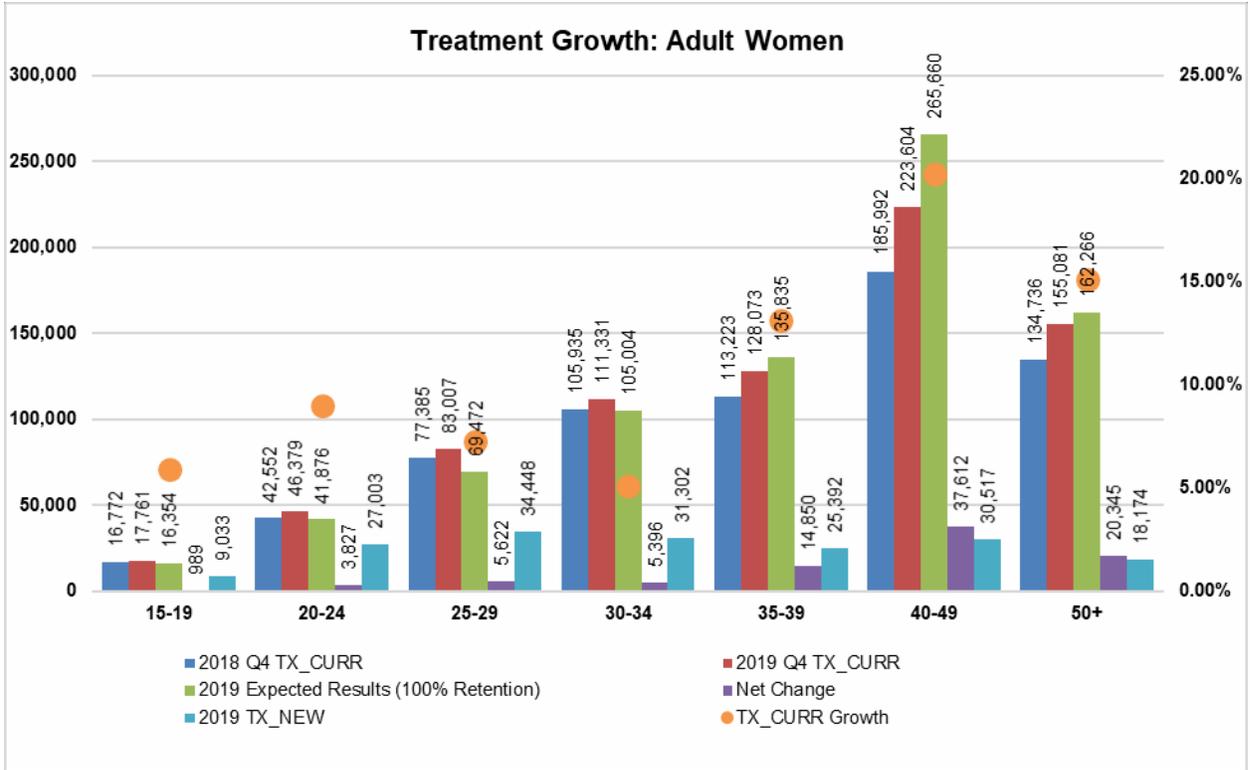
*Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures

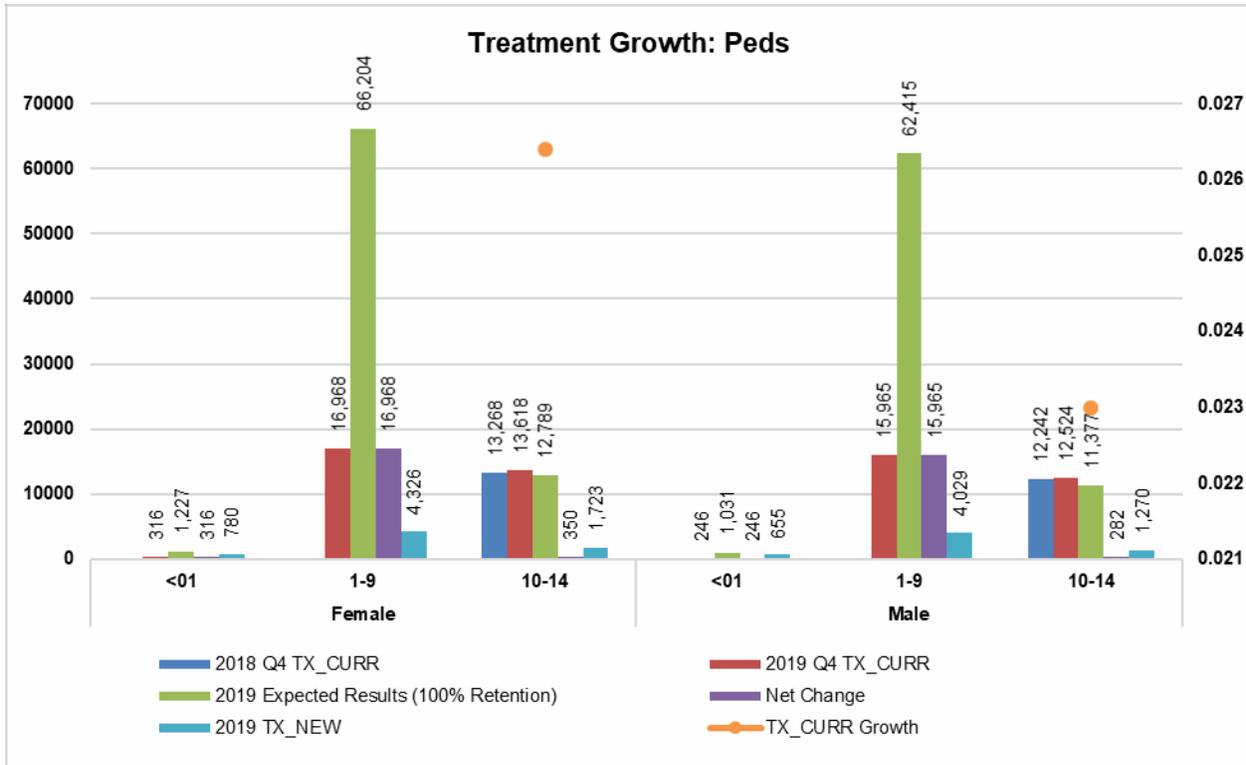
Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	5,103,388	4,521,874	88.6%	HTS Program Area	\$19,654,392	48%
	HTS_TST_POS	171,086	183,626	107.3%			
	TX_NEW	155,720	173,881	111.7%	C&T Program Area	\$53,199,655	52%
	TX_CURR	661,501	581,256	87.9%			
	VMMC_CIRC	410,845	453,764	110.4%	VMMC Subprogram of PREV	\$23,391,465	52%
	OVC_SERV	17,200	0	0%	OVC Major Beneficiary	-	
DOD	HTS_TST	1,251,154	1,221,568	97.6%	HTS Program Area	\$1,890,759	93%
	HTS_TST_POS	42,614	43,436	101.9%			
	TX_NEW	39,066	38,672	99.0%	C&T Program Area	\$12,196,070	90%
	TX_CURR	259,637	231,133	89.0%			
	VMMC_CIRC	217,412	231,238	106.4%	VMMC Subprogram of PREV	\$9,798,352	98%
	OVC_SERV	17,630	10,309	58.5%	OVC Major Beneficiary	\$115,301	58%
USAID	HTS_TST	2,804,613	2,685,159	95.7%	HTS Program Area	\$33,370,999	77%
	HTS_TST_POS	112,244	109,150	97.2%			
	TX_NEW	88,150	87,553	99.3%	C&T Program Area	\$132,289,073	90%
	TX_CURR	396,781	387,090	97.6%			
	VMMC_CIRC	120,481	93,082	77.3%	VMMC Subprogram of PREV	\$11,833,366	100%
	OVC_SERV	897,049	710,641	79.2%	OVC Major Beneficiary	\$12,891,119	78%
	Above Site Programs						\$41,530,721
Program Management						\$71,512,521	

COP/ROP 2018 | FY 2019 Analysis of Performance

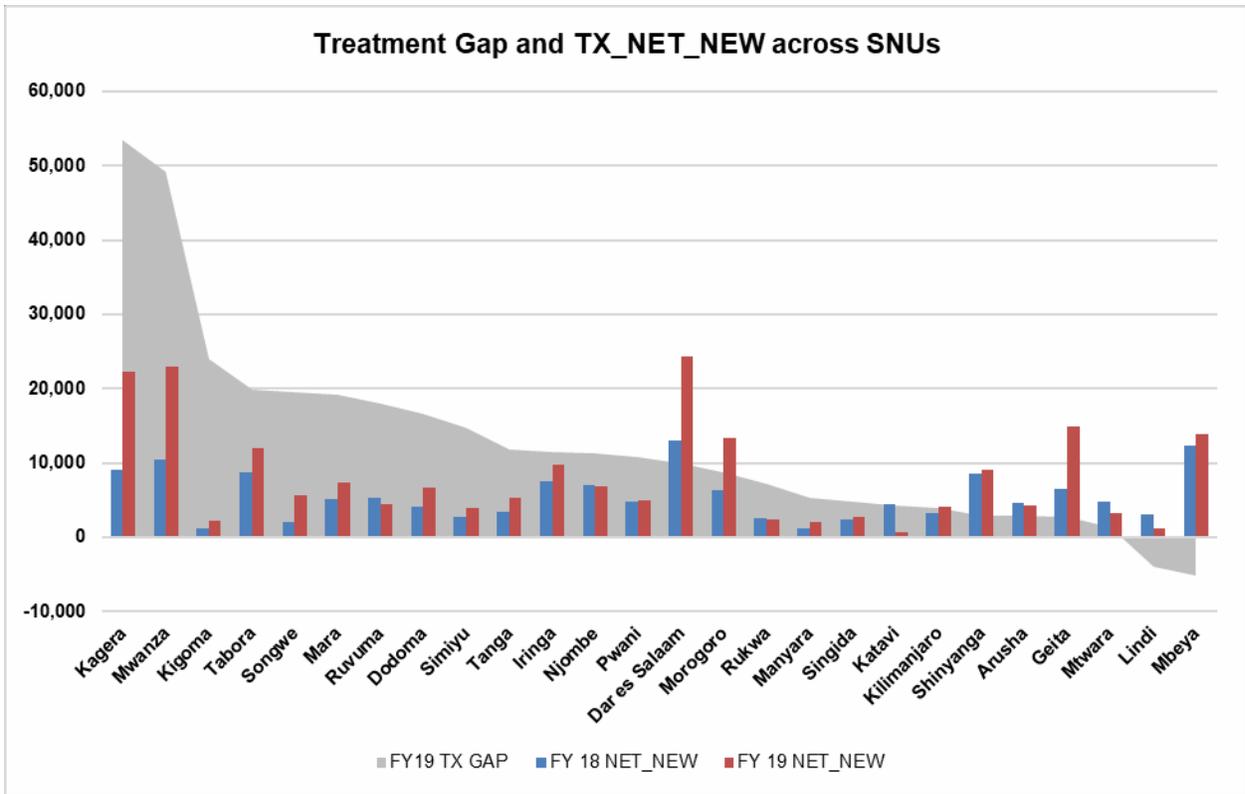
Tanzania experienced growth in treatment across all age bands with the greatest growth seen among women and men aged 40–49 as shown in the charts below:



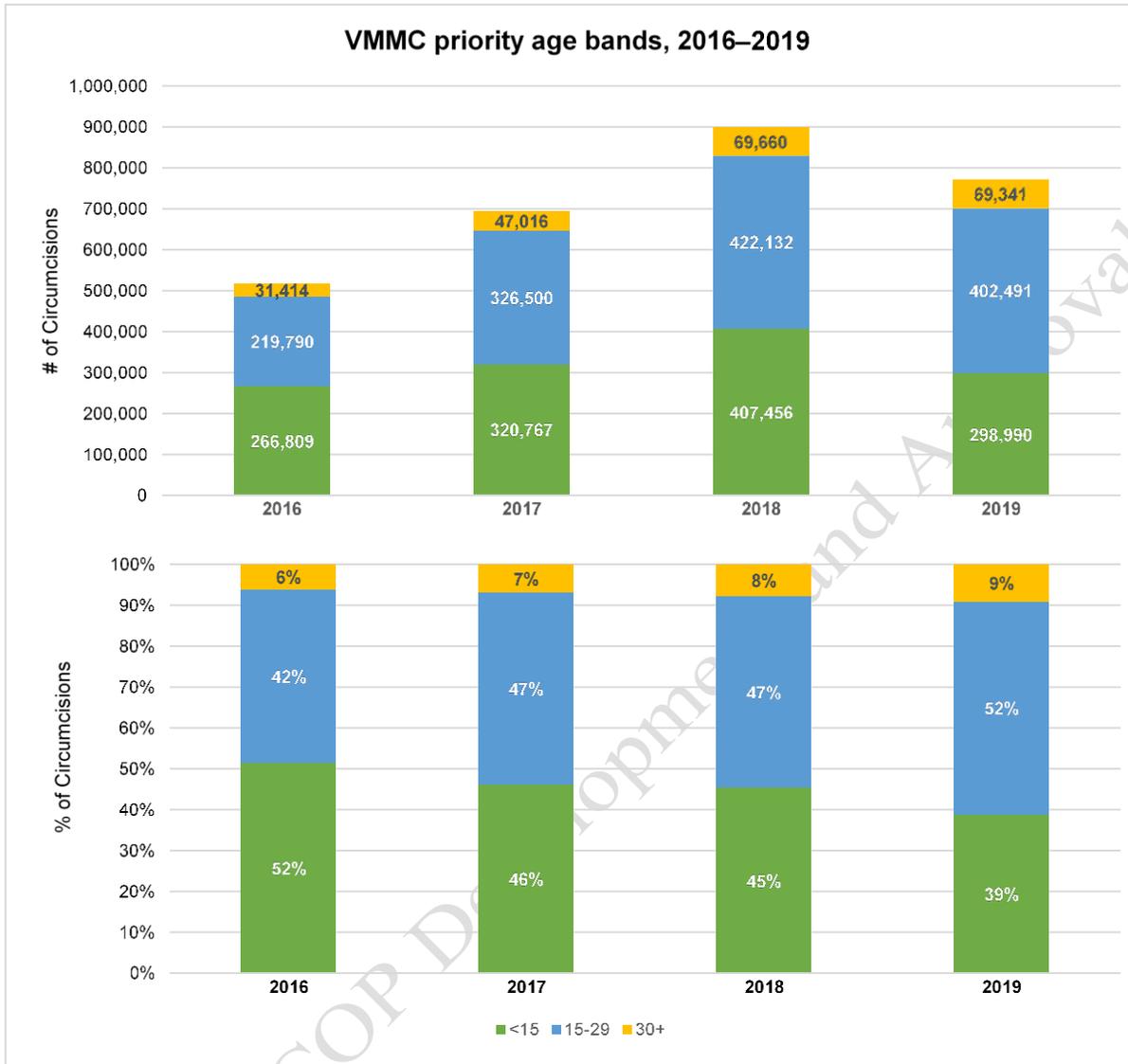
Treatment growth across pediatric age bands was not commensurate with adult treatment growth. Number of children retained on treatment was well below the 100% expected retention rate, as shown in the chart below:



The chart below looks at clients retained on treatment across the regions with the largest treatment gap. Significant improvement in client retention is seen across Kagera and Mwanza– the regions with the largest gaps.



The share of circumcisions conducted among men under the age of 15 continues to decrease, but remains at 39% of the total circumcisions. Teams are required to follow the VMMC guidance mentioned in the COP20 guidance document.



Partner Performance

- Majority of PEPFAR Tanzania implementing partners (IP) showed improvement in FY19. Select IP were put on performance improvement plans (PIPs) in FY19. All IPs that were put on PIPs showed improvement across the clinical cascade compared to FY18.
- Two facility IPs stand out for significant improvements across all areas. MDH-Clinical Services, an indigenous IP, showed significant improvement in case identification (128% of target) and viral suppression. Boresha Afya Southern Zone (Deloitte) showed significant improvement in scaling up index-testing (75% of HTS_POS from index) and achieved 99% of their treatment targets.
- One above-site IP stands out for developing and implementing facility-level structural elements that enable scale-up of services. The Public Sector Systems Strengthening (PS3) project implemented by Abt Associates strengthened HRH optimization at the site level and improved facility-level budget execution, which enables rapid implementation of key policies necessary for HIV/AIDS service delivery.

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- Despite the progress shown by IPs across various technical areas, all are lagging behind in identifying and retaining children under the age of 15 on treatment.
- Performance across the cascade:
 - Case identification:
 - MDH-Clinical Services leads in case identification with 128% of HTS_POS and 68% of HTS_TST, which demonstrates true scale-up of targeted testing strategies with fidelity.
 - AGPAHI achieved less than 80% of HTS_POS while reaching 100% of HTS_TST.
 - EGPAF achieved 80% of their HTS_POS target and reached 102% of HTS_TST.
 - Treatment growth:
 - Two IPs reached above 100% of their treatment targets: AMREF (109%), and JSI (102%).
 - Two IP reached above 95% of their TX_CURR targets: Deloitte (97%) and EGPAF (99%).
 - A retrospective analysis of GoT data using the correct definition of TX_CURR shows that Tanzania continued to grow clients on treatment every month since FY18. However, the gap between new clients initiated on treatment (TX_NEW) and the total number of clients retained on treatment (TX_NET_NEW) continues to exist across all IPs, which shows a net loss of clients.
 - Viral load coverage and suppression:
 - VL coverage is under 80% across majority of clinical IP: HJF (72%), AGPAHI (73%), MDH (73%), Baylor (63), Deloitte (78%), and JSI (66%).
- Remediation measures:
 - While all IPs that received PIPs during COP19 show varied improvement, select IPs require targeted remediation in specific program areas. Henry Jackson Foundation (HJF)–Southern Highlands should improve retention among young adults (males and females, 20–35 years) with a specific focus in Katavi and continue improving VL coverage in Katavi, Mbeya, and Songwe while maintaining at least 90% viral suppression and sustain the scale-up in index testing.
 - 81 facilities resulted in a net loss of 20,000 clients on treatment. PEPFAR Tanzania must immediately develop site-specific remediation plans to stop this loss. The remediation plans should include time-limited performance benchmarks and provision to adjust funding levels based on performance.
- OVC performance: In COP20, OVC and clinical implementing partners in Tanzania must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNU are offered the opportunity to enroll in the comprehensive OVC program.

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- The OVC_SERV achievement for OVC beneficiaries under age 18 was 71% in Tanzania for FY19 (72% USAID, 36% DOD). All agencies and implementing partners should work to improve the OVC_SERV achievement to 90% or higher.
- In FY19, 16% of OVC beneficiaries in Tanzania exited without graduation (16% USAID, 0.8% DOD), reflecting program quality issues. The percentage of OVC beneficiaries that exit the OVC program without graduation should be 10% or lower across agencies and implementing partners.
- The OVC_HIVSTAT known status proxy for FY19 in Tanzania was 84% (85% USAID, 18% DOD). In COP20, all OVC implementing partners and agencies must ensure that 90% or more of OVC beneficiaries under age 18 have a known HIV status or are deemed not to need a test based on a standard HIV risk assessment.

SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Table 8. COP/ROP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. ^[1]	Tanzania has adopted a Test & Start policy, and this year Tanzania aligned its Test and Start policy to align with WHO guidance to initiate HIV-positive clients within 7 days.	N/A
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine- based regimens. ^[2]	Commitment remains strong, and scale-up continues, but needs to move at a faster pace. Focused efforts to scale-up TLD in tier three facilities must be intensified with the goal of transitioning remaining patients in the next 6-8 months.	Tanzania still has not transitioned away from TLE-600. Nevirapine-based formulations remain in country.

^[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

^[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

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	<p>3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.^[3]</p>	<p>The MOH issued a circular endorsing six-month MMD on May 3, 2019. The Ministry issued guidance in August 2019 suspending six-month MMD for both pediatric and adult clients in the context of the pediatric ARV shortage. NACP has since convened clinical and supply chain experts and determined that clients at phase 1 facilities can start 6MMD in January 2020 with continued scale-up from there.</p>	<p>Commitment to 6MMD remains inconsistent with no clear timeline for nation-wide adoption of 6MMD.</p>
	<p>4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.^[4]</p>	<p>Tanzania is on-track for all eligible PLHIV, including children, to complete TPT by the end of Cop 20. Cotrimoxazole has been integrated into the clinical care package. When stock is available at the health facility, it is at no cost to the patient.</p>	<p>There is evidence of negative health impact due to lack of cotrimoxazole among ART patients, particularly children.</p> <p>There is a currently a cost to the patient to purchase cotrimoxazole.</p>
	<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p>	<p>Viral load scale-up remains strong with high lab capacity. Although lab optimization analysis has been completed, status of the implementation of the results is unknown. Triangulation between morbidity and mortality data and viral load testing data hasn't been examined.</p>	<p>Holistic coordination across the lab sector by a fully functioning Lab TWG remains an outstanding challenge, and decisions in the lab sector remain fractured without coordination from a central body.</p>
<p align="center">Case Finding</p>	<p>6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.^[5]</p>	<p>Tanzania has scaled-up index testing</p> <p>The HIV and AIDS (Prevention and Control) Act, 2008 (HAPCA) amendment bill passed on November 12, 2019, allowing self-testing to be rolled out nation-wide in line with current strategies.</p> <p>Self-testing scale-up has started in Mwanza, Njombe, Ruvuma.</p>	<p>Currently the index testing program is reaching approx. 50-70% of index contacts elicited.</p> <p>There is no standardized national index testing register that covers the entire index testing cascade.</p> <p>Self-testing M&E tools need to be finalized and training for peer educators needs to be conducted.</p> <p>No clear timeline for national scale-up.</p>

^[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

^[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

^[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices) ^[6]	National PrEP scale-up has begun in alignment with the target groups identified (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices.)	National PrEP strategy not yet finalized. Though supply is sufficient Truvada stock management doesn't balance PrEP and treatment needs.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	The Government of Tanzania has demonstrated commitment to action and scaling up of all of these interventions. Program emphasis is currently focused on increasing enrollment of CLHIV and providing prevention services to children aged 9-14.	Review of graduation benchmarks
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention. ^[7]	The government of Tanzania prohibits user fees for all chronic diseases including HIV and TB as well as MCH services in both public and private services. There is no evidence of informal user fees.	N/A
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement	CQI is core component of site level management and partner workplans. Joint data review and monitoring with GoT using data	N/A

^[6] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

^[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva:

World Health Organization, December 2005

	(CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. ^[8]	to drive program improvement is grounded in CQI practices. Tanzania National QI Framework currently being updated and development of Community QI Framework completed in 2019 Lab QA/QI support with 11 labs now fully accredited Lab ECHO supporting HTS through certification of non-lab facility testers with expansion from 1 hub and 7 spokes in to now 7 hubs and 52 spokes and close to 2000 non-lab facility testers now certified	
11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Tanzania's Furaha Yangu campaign has been the primary platform to convey messages related to stigma and treatment literacy among the general population. The Sitete Reki campaign focuses on reaching youth on the same. Na weza focuses on women of reproductive potential, mothers, and men. The GOT is involved in campaign development and message approval and integrating consistent messages through other channels.	Campaign resources are insufficient to penetrate all the highest burden districts with messaging. Stigma at the community level.	
12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Tanzania is on track toward its contribution of local, indigenous partner prime funding.	N/A	
13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The GOT has established an AIDS Trust Fund and is exploring an HIV levy as well as partnerships with private sector entities to channel money to the fund. They have indicated a commitment finance at least 30% of the national HIV response.		
14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR supports design of death registration that links to the health sector client register to ensure that information is documented in medical records and HIV patient monitoring systems. There is an ongoing pilot in Iringa through UNICEF for a decentralized death registration system. The long-term goal is to leverage ongoing work to have a national morbidity and mortality system that	Complexity of developing multiple, integrated, national-level health information systems to provide real-time monitoring and tracking of clients.	

^[8] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

		captures both facility and community level data that is linked to a strengthened HIV tracking system for LTFU outcomes.	
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	<p>Tanzania is working on a multi-faceted national unique identification strategy that includes biometrics as one of multiple identifiers and a national health client register for both deterministic and probabilistic matching. Tanzania has implemented system updates in HIV system software and PEPFAR partners will move forward to deploy the unique identification strategy in HIV systems once a GOT ICT system audit has been completed. Client register development is underway.</p> <p>For case-based surveillance, Tanzania has achieved 94% coverage for national client level treatment data that includes visits, prescriptions, viral load and reason for loss. Tanzania has achieved approximately 20% coverage of client level HTS data. Tanzania is scaling an integrated module to cover dispensing. To achieve CBS objectives, the unique identification strategy will link testing, treatment, and dispensing records so the data can be analyzed across sentinel events.</p>	<p>GOT to complete systems audit and issue communication instructing partners to scale the health sector unique identification strategy in supported sites.</p> <p>Ensuring HTS client level data is captured and submitted to client level national repository.</p>

In addition to meeting the minimum requirements outlined above, it is expected that Tanzania will implement the following directives:

Table 9. COP/ROP 2020 (FY 2021) Technical Directives

OU –Specific Directives
HIV Case identification
1. Further optimize the “other PITC” modality and improve yield from the current 3%
2. Focus on scaling up case identification strategies for children under 15, and leverage OVC platforms to enhance case identification
3. Government of Tanzania and PEPFAR Tanzania must work together to ensure that there are adequate and skilled health workers to identify, initiate, and retain clients on treatment. This requires immediate adoption and rapid scale-up of lay worker testing policy and training them to implement targeted testing strategies, and continued HRH recruitment and optimization

HIV Treatment
1. Immediate adoption and rapid scale-up of 6-month dispensing for eligible clients
2. Accelerated TLD transition with tier 3 sites transitioning by the end of FY20 Q3
3. Community ART dispensing for 30 days and refills to be scaled-up with fidelity
4. Immediate adoption and rapid scale-up of Unique Identifier policy
5. Intense focus on pediatric cascade to improve treatment coverage, retention, and viral suppression
HIV Prevention
1. A thorough review of VMMC practices to be completed by FY20 Q2, in light of adverse events
2. Immediate adoption of PrEP policy and strategy to facilitate rapid national scale-up
3. Plan for rapid scale-up of DREAMS activities with inputs from GoT
Other directives/ above-site
1. Move to direct delivery of VL/EID reagents to laboratories via newly negotiated contracts with VL suppliers. Strongly consider vendor management of inventory at lab sites to mitigate risk of cold chain failure and/or stock out of key commodities
2. Provide technical assistance to MSD to strengthen contract management capabilities and explore strategic engagement with private sector supply chain / logistics partners to ensure efficient and effective last mile distribution
3. Continue to strengthen facility-level planning and budget execution to enable rapid adoption and scale-up of key site-level minimum requirements for service delivery

COP/ROP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP20 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic—and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Tanzania must ensure 100% “known HIV status” for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador’s small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and

patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

DREAMS

DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

DREAMS program in Tanzania is receiving an increase in new funding which should be used for the following:

- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Tanzania must present a strategy and a timeline at the COP meeting for the following:
 - Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
 - Implement approved, evidence-based curricula in line with the current DREAMS Guidance
 - Ensure a fully operable layering database with unique IDs across IPs and SNUs
 - Ensure a full geographic footprint in all districts
 - Address challenges and ensure DREAMS implementation in all districts with fidelity

In addition, DREAMS Tanzania should focus on the following:

- Layering: The Tanzania team should focus on ensuring that each AGYW in DREAMS receives a layered package of services, particularly 10-14 year old girls. Q4 AGYW_PREV data show that ~75% of AGYW 15-24 have completed at least the full

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primary package of services, compared to only 20% of AGYW 10-14. It is concerning that no AGYW 10-14 are in the program for longer than 6 months.

- Tanzania should ensure that their DREAMS layering database is fully functional in all SNU and is able to capture both community and clinical services for AGYW.

Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

VMMC

Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:

Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

Viral Load Scale-up and Laboratory Optimization

Viral load scale up remains strong; investments in the laboratory network allow for a high

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capacity in the lab sector. However, laboratory sector advancements, including standardization and optimization, remain stalled, and VL commodity availability remains a challenge. PEPFAR teams should demonstrate a plan and timeline for laboratory network improvements and monitoring. As part of the coordination plan a decision-making body must be identified.

Supply Chain System Strengthening

Strengthening Tanzania's national supply chain system is a priority. Disruptions in the supply chain have direct programmatic impact. PEPFAR and the GOT need closer collaboration to ensure that quantifications are completed, accurate, and approved in a timely manner with review on a regular basis to accommodate programmatic changes. PEPFAR and the GOT need to ensure that stock status and consumption is jointly reviewed on a monthly basis, and that ordering timelines are adhered to.

COP/ROP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements**Table 10. New Funding Detailed Initiative Controls**

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	\$ 374,325,320	\$ 35,000,000	\$ 2,618,750	\$ 411,944,070
Core Program	\$ 298,325,320	\$ 35,000,000	\$ 2,618,750	\$ 335,944,070
COP 19 Performance	\$ 55,000,000			\$ 55,000,000
HKID Requirement ++	\$ 21,000,000			\$ 21,000,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total new FY 2020 funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total new FY 2020 funding programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by

using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal by agency by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.

COP/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Tanzania should hold a 3 month pipeline at the end of COP/ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.