United States Department of State

Washington, D.C. 20520

FY 2015 Tanzania Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Tanzania.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

TANZANIA

Country Operational Plan

(COP) 2015

Strategic Direction Summary

August 12, 2015

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Goal Statement

Working collaboratively across U.S. Government agencies and 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 42 highest burden districts. These 42 "Scale-Up" Districts represent approximately 55% of persons living with HIV (PLHIV) in Tanzania and are subdivided into 27 "Scale-Up to Saturation" Districts, 13 "Aggressive Scale-Up" Districts, and two key population hotspot districts. The goal in the Scale-Up to Saturation Districts is to reach 80% coverage of all PLHIV on ART by 2017, while the goal of the Aggressive Scale-Up Districts will be to reach 80% coverage by 2019. Two key population hotspot districts are also prioritized for saturation. The remaining 129 "Sustained" Districts will continue with a passive enrollment plan.

Within the Scale-Up Districts, IPs will focus implementation and site level targets in epidemiologic hotspots. PEPFAR/T has strategically narrowed its prevention focus and scope to key and carefully selected priority populations in Scale-Up Districts with comprehensive packages that optimize uptake of antiretroviral therapy (ART). This package will include scaling up evidence-based behavioral and clinical prevention activities for key and priority populations.

PEPFAR/T has established a minimum package of prevention, care, treatment, and support for all beneficiaries currently in care and treatment, pregnant women provided ART at PMTCT sites, and core services for orphans and vulnerable children (OVC) in COP 2015.

The interagency team designed programs and allocated funding to achieve 80% coverage of all PLHIV on ART in the Scale-Up to Saturation Districts by the end of FY 2017, reaching nearly half of the scale-up coverage in FY 2016. The recently approved, but not yet implemented, Ministry of Health and Social Welfare (MOHSW) treatment guidelines to initiate ART at CD4 of 500 will support the 80% coverage target. PEPFAR/T will work with the GOT to develop a roll out strategy for the new national guidelines that emphasizes Scale-Up Districts. GOT has indicated that they intend to initiate the new criteria by January 2016 and have already extended access to all PLHIV under 15 years old regardless of CD4 cell count.

Through the testing yield analyses initiated in 2014, PEPFAR/T identified 2,438 no and low yield facility and community testing sites that, subsequently, are no longer receiving PEPFAR support for HIV testing and counseling. PEPFAR/T also reviewed FY 2014 Annual Program Report (APR) and FY 2015 Semi-Annual Program Report (SAPR) data to identify low volume ART facilities in Sustained Districts. In Sustained Districts, there were 849 sites that were seeing no patients. Additionally, there were 2,352 sites in Sustained Districts supporting fewer than 100 clients, and seeing a total of 21,494 PLHIV. PEPFAR/T will review this support with the GOT and geographically map sites and discuss the potential to transfer clients to higher yield sites by FY 2017. PEPFAR/T will also reduce IP site visits to these locations, while working with the GOT to continue site supervision and support.

The Tanzanian Parliament recently approved the AIDS Trust Fund (ATF) to facilitate increased domestic contribution to address the epidemic, from both public and private sector sources. PEPFAR/T is collaborating with the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) and other donors to advocate that the GOT utilize ATF and other domestic resources to support key strategic priorities, including commodities. PEPFAR/T will continue to implement a health diplomacy strategy to address key gaps in the sustainability of the national HIV plan, including: mobilization of domestic investments to provide direct support for ART, selected medication and lab commodities, human resources and quality

service delivery. PEPFAR/T will 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 support. PEPFAR/T will continue to plan closely with the ATF and the GFATM to avoid duplication and maximize efforts to achieve epidemic control.

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

According to the 2014 UNAIDS Gap Report and most recent national census, adult HIV prevalence in Tanzania is estimated at 5.0%, with 1.4 million Tanzanians living with HIV and a total population of 47,451,847. An estimated 72,000 new infections and 78,000 AIDS-related deaths occur in Tanzania annually, with regional HIV prevalence ranging from 14.8% (Njombe) to 0.1% (Kaskazini Unguja, Zanzibar).

Since 2004, PEPFAR/T has worked closely with the GOT, the GFATM, and other donors to respond to the HIV epidemic. Tanzania has made significant strides in reducing prevalence and incidence, but to attain epidemic control more geographic and population-focused interventions will be required. This includes shifting resources toward higher volume and yield sites and higher burden districts, and aligning partners for better program efficiency.

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 to implement the Third National Multi-Sectoral Framework on HIV and AIDS (NMSF III) and other relevant national strategic documents, which closely correspond to the PEPFAR Blueprint: Creating an AIDS-free Generation, and the UNAIDS Fast Track Strategy by strategically prioritizing prevention of mother-to-child transmission (PMTCT) option B+, targeted scale-up of both adult and pediatric ART coverage, increasing access to and uptake of voluntary medical male circumcision (VMMC), targeted and focused HIV counseling and testing (HTC), and increased condom use.

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 GDI 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 recently approved the creation of the ATF, the funding level was set at only $1.5 million, and the GOT's expectation is to add funding from private sources and donors. PEPFAR/T is working with the GOT as the ATF is established to ensure that activities are well prioritized. UNAIDS will also complete an Investment Case in 2015 that will help to identify resource gaps and assist the country to prioritize activities.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	47,451,847	100%	10,401,153		10,403,018		13,950,569		12,697,107		National Bureau of Statistics Estimation, 2014
Prevalence (%)		5%									UNAIDS, AIDSinfo, 2014
AIDS Deaths	78,000 (2013)										UNAIDS, AIDSinfo, 2014
PLHIV	1,400,000 [1,300,000-1,500,000] (2013)						690,000 (2013)				UNAIDS, AIDSinfo, 2014
Incidence Rate (Yr)		72,000 (2013)									UNAIDS, AIDSinfo, 2014
New Infections (Yr)	72,000 [59,000-87,000] (2013)										UNAIDS, AIDSinfo, 2014
Annual births	1,780,606										UNAIDS SPECTRUM Estimates for 2016
% >= 1 ANC visit	5,519	96%									2010 Tanzania DHS
Pregnant women needing ARVs	91,869	100%									UNAIDS SPECTRUM Estimates for 2016
Orphans and Vulnerable Children (2014)	3,280,199	100%									2014 Estimated Population of MVC and OVC
Orphans (maternal, paternal, double) due to AIDS (2013)	1,300,000 [1,200,000-1,500,000] (2013)										UNAIDS, AIDSinfo, 2014
TB cases (Yr)	65,732										NTLP Annual Report, 2013
TB/HIV Co-infection	20,072	100%									NTLP Annual Report, 2013
Males Circumcised	553,388	100%			254,530	46			298,858	54	PEPFAR Tanzania Annual Program Results (APR) performance for FY 2014 (October 2013-September 2014)

Key Populations	235,150										Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Total MSM*	49,700										Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
MSM HIV Prevalence		25									Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Total FSW	155,450										Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
FSW HIV Prevalence		26									Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Total PWID	30,000										Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
PWID HIV Prevalence		36									Consensus estimates on Key Populations Size HIV Prevalence in Tanzania, July 2014
Adolescent Girls and Young Women[2] Military Community[4]	4,782,906 61,632	2.74									Calculations based on NBS (2014) projections and THMIS (2012) Calculations based PEPFAR program data and partner information, FY 2013

[1] *Estimates are only for Dar es Salaam, Iringa, Mbeya, Njombe, Mwanza, Ruvuma, Shinyanga, and Zanzibar.*

[2] *Calculations based on NBS (2014) projections and THMIS (2012).*

[3] *Estimates are for Dar es Salaam, Mbeya, and Mwanza.*

[4] *Estimates are for Dar es Salaam, Iringa, Mbeya, Njombe, Shinyanga, and Ruvuma.*

[5] *Estimates are for Mbeya and Shinyanga.*

[6] *Estimates are for Dar es Salaam, Mwanza, and Zanzibar.*

[7] *Estimates are for Dar es Salaam, Mbeya, Mwanza, and Shinyanga.*

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence[2]** (%)	**Total PLHIV[2]** (#)	**In Care[3]** (#)	**On ART** (#)	**Retained on ART 12 Months** (#)	**Viral Suppression** 12 Months	**Tested for HIV** (#)	**Diagnosed HIV Positive** (#)	**Initiated on ART** (#)
Total population[1]	47,451,847	5.0	1,400,000	705,646	640,084	Not available	Not available	Not available	Not available	Not available
Population less than 15 years[1]	20,804,171	Not available	250,000	49,478	41,882	Not available	Not available	Not available	Not available	Not available
Pregnant Women[4]	2,049,766	5.6 (2011 ANC)	97,898	Not available	65,341	49,006 (75% of PW on ART)	Not available	1,744,013	71,092	Not available
MSM[5]	49,700	25	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
FSW[5]	155,450	26	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
PWID[5]	30,000	36	Not available	Not available	Not available	Not available	Not available	Not available	Not available	Not available
Adolescent Girls and Young Women[6]	4,782,906[1]	2.74[6]	130,877[6]	Not available	Not available	Not available	Not available	Not available	Not available	Not available

[1] *National Bureau of Statistics Estimation, 2014.*

[2] *UNAIDS AIDS Info, 2014.*

[3] *National AIDS Control Program.*

[4] *MOHSW PMTCT Unit.*

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

[6] *Calculations based on NBS (2014) projections and THMIS (2012).*

[7] *Calculations based PEPFAR program data and partner information, FY 2013*

[8] *2014 Drug Control Commission estimates and the 2012 IBBS report.*

[9] *Provided by GOT.*

The Tanzania HIV/AIDS Malaria Indicator Survey (THMIS) 2011-12 shows that the epidemic varies significantly within the country, with the highest prevalence region estimated at 14.8% (Njombe) and the lowest at 0.1% (Kaskazini Unguja, Zanzibar). PEPFAR/T utilized district level PMTCT program data to estimate PLHIV populations for each district to prioritize districts and set district level targets. The supplemental documents include a district triangulation analysis. There is a difference in the prevalence between urban (7.2%) and rural (4.3%) areas, as well as significant gender disparity, with male prevalence at 3.8%, and female prevalence nearly twice as high, at 6.2%. Girls acquire HIV at a younger age. Key populations (KPs) also play a critical role in HIV transmission dynamics. Data indicate that injection drug use, specifically heroin use, is on the rise in urban Tanzania and Zanzibar. Studies in Dar es Salaam estimate that the HIV prevalence is 42% among people who inject drugs (2007) and 31.4% among sex workers (2010), while unpublished data for men who have sex with men estimates prevalence over 30% (2012).

1.2 Investment Profile

Tanzania's national HIV program is heavily donor dependent with major donors (led by PEPFAR and the GFATM) contributing 97.5% of all financing according to the 2011 Public Expenditure Review, HIV and AIDS. Moreover, the share of health sector spending by the GOT from its own resources has significantly declined from 13% in 2006/7 to approximately 6% in 2013/14. The GFATM approved the HIV/TB Concept Note submitted in October 2014 for mainland Tanzania and identified $285.7 million as Unfunded Quality Demand, the majority of which is for commodities. The GFATM also approved $78.6 million in incentive funding but only provided enough resources to maintain current patients on ART and over a two year period. PEPFAR/T has increased the funding portfolio for COP 2015, including $26,767,603 of Treatment Plus-Up funds, and announced several central funding opportunities, including the Determined, Resilient, AIDS-free, Mentored, and Safe (DREAMS) and the Accelerating Children on Treatment (ACT) initiatives. PEPFAR/T has also pivoted the program to prioritize districts and high impact activities, which has diminished the commodities funding gap.

Recognizing the funding limitations in the context of a growing HIV care and treatment program, 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 Scale-Up Districts (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, domestic resource mobilization (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 the MOHSW to achieve the Fast Track Goal and will continue to plan with the GOT 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	$324,151,534	33.14%	59.03%	7.83%	0.00%
Community-based care	$17,976,776	95.71%	4.29%	0.00%	0.00%
PMTCT	$37,530,455	99.05%	0.41%	0.53%	0.00%
HTC	$24,392,809	69.08%	30.92%	0.00%	0.00%
VMMC	$37,766,930	100.00%	0.00%	0.00%	0.00%
Priority population prevention	$12,446,373	42.13%	57.87%	0.00%	0.00%
Key population prevention	$7,131,692	80.16%	19.84%	0.00%	0.00%
OVC	$18,291,912	99.99%	0.00%	0.01%	0.00%
Laboratory	$36,302,713	53.65%	46.35%	0.00%	0.00%
SI, Surveys and Surveillance	$21,176,931	75.00%	24.24%	0.76%	0.00%
HSS	$74,181,817	72.41%	4.58%	3.42%	19.59%
Total	$611,349,950	54.76%	38.24%	4.63%	2.38%

Source: Preliminary Data PER FY 2013/14
Program Area disaggregates not available outside of PEPFAR EA

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% GOT	% Other
ARVs	$111,512,348.72	30%	70%	-	-
Rapid test kits	$13,514,071.00	13%	87%	-	-
Other drugs	$1,168,560.53	100%	-	-	-
Lab reagents	$15,809,667.51	7.40%	90.50%	-	2.10%
Condoms	$3,312,645.00	58%	4%	5%	33% (UNFPA)
VMMC kits	$2,099,452.78	100%	-	-	-
Other commodities	$94,496.67	100%	-	-	-
Total	**$147,511,242.21**				

Expenditures do not include which partners may have supported commodities directly to facilities/districts.
This table includes shipments that were delivered in country within FY 2013/14.
For ARVs, this was the last year of planned PEPFAR support. No expenditures have been made in FY 2014/15.
PEPFAR condom support was for socially marketed condoms only.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$12,735,000	$10,882,222	10	$79,645,091	Maternal and Child Health
USAID TB	$5,000,000	$4,406,276	5	$65,355,815	Tuberculosis control
USAID Malaria	$34,350,000	$24,642,400	9	$48,161,520	Malaria control
Family Planning	$26,400,000	$20,764,766	14	$74,929,587	Family planning
NIH	$331,898	$281,898	2	$2,717,749	Health research
CDC NCD	$1,200,000	$0	0	N/A	PMI and GHS
Peace Corps	$225,000	$0	$0	N/A	Community Health
DOD Ebola	$3,525,000	$0	0	N/A	DTRA, HIV Vaccine research, Malaria drug and vaccine research, Avian Influenza surveillance
MCC	$0	$0	0	N/A	No health resources in the COP 2015 period
Private Sector	$8061,792	$7,711,792	5	$7,411,792	PPPs to update HIV pre-service curriculum; directly link AGYW at risk to testing and care; mobilize private sector resources for health insurance; promote mHealth information and demand creation;

PEPFAR Central Initiatives	$33,738,420	$31,888,420	18	$277,439,977	develop appointment reminders; and support facility accreditation Pediatric HIV treatment (ACT); combat sexual violence against girls (Together for Girls); address cervical cancer (PRRR); PEPFAR-Global Fund Collaboration (CCI)
Total	$125,567,110	$100,577,774	63	$555,661,531	

1.3 National Sustainability Profile

The Sustainability Index Dashboard (SID) identified health financing, supply chain, and performance and financial data collection as areas where the national HIV and AIDS response is currently weak and unsustainable. 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 HIV and AIDS response, the GOT has taken steps to promote DRM and financial sustainability. Specifically, the GOT established the ATF and is submitting a comprehensive health care financing strategy to the Cabinet, with a focus on scaling up health insurance coverage, strengthening value for money, and engaging the private sector. Similarly, PEPFAR/T, selected for PEPFAR's Sustainability Financial Initiative, has also prioritized DRM activities in COP 2015 activities.

PEPFAR/T funding for health care workers (HCW) supports epidemic control through ensuring appropriate levels of human resources across the HIV care continuum, particularly in Scale-Up Districts. However, to ensure that Tanzania can sustainably meet the needs of the HIV and AIDS response, it must start a phased and increasing transition of salary support for prioritized positions to the GOT. COP 2014 health worker salary data showed that PEPFAR partially or fully supported more than 18,000 HCWs.

The availability and accessibility of life-saving commodities are the cornerstones of epidemic control. While the GFATM procures most of the commodities, PEPFAR/T addresses many of the current challenges of the supply chain resulting from limited or poor planning. PEPFAR/T's technical assistance (TA) focuses on strengthening supply chain performance management in all facilities in Scale-Up Districts providing HIV services, as well as national level institutions through the monitoring of key performance indicators.

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 will include the development and 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, media, national thought leaders, visiting congressional delegations, and civil society. In addition, health diplomacy dialogue through PEPFAR/T's Executive Committee and the Tanzania National Coordination Mechanism (TNCM) will be critical to cooperatively plan across all funding streams and to negotiate specific areas for phased and increasing host country stewardship. Additionally, the Department of the Treasury will place a technical advisor within the Ministry of Finance and Economic Affairs (MOFEA) who will be instrumental in liaising between USG, MOHSW, and MOFEA.

Since the first stages of PEPFAR, the program has worked to build the government institutions which are required for a sustained epidemic response. In COP 2015, PEPFAR/T initiates a phased and increasing transition of funding for these government agencies to the GOT which requires the GOT to support their own governmental functions, but allows for them to plan for sustainability within their programs.

1.4 Alignment of PEPFAR investments geographically to disease burden

Figures 1.4.1.a and 1.4.1.b compare PEPFAR/T expenditures in 2014 to burden of disease by region. Figure 1.4.1.a illustrates that PEPFAR/T spent on average $236.92 per PLHIV in Tanzania in 2014. Spending per PLHIV across regions varied from $94 to $16,947. Some of this extreme variation can be explained by the variance in the size of the programs. In the five regions of Zanzibar, which has the lowest prevalence and burden of HIV in the country, expenditures per PLHIV are very high, ranging from $420 per PLHIV in the urban area of Mjini Magharibi up to $16,947 in the rural region of Kusini Unguja. Excluding Zanzibar, spending in the regions varied from $94 to $292.

Figure 1.4.1.a 2014 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by SNU

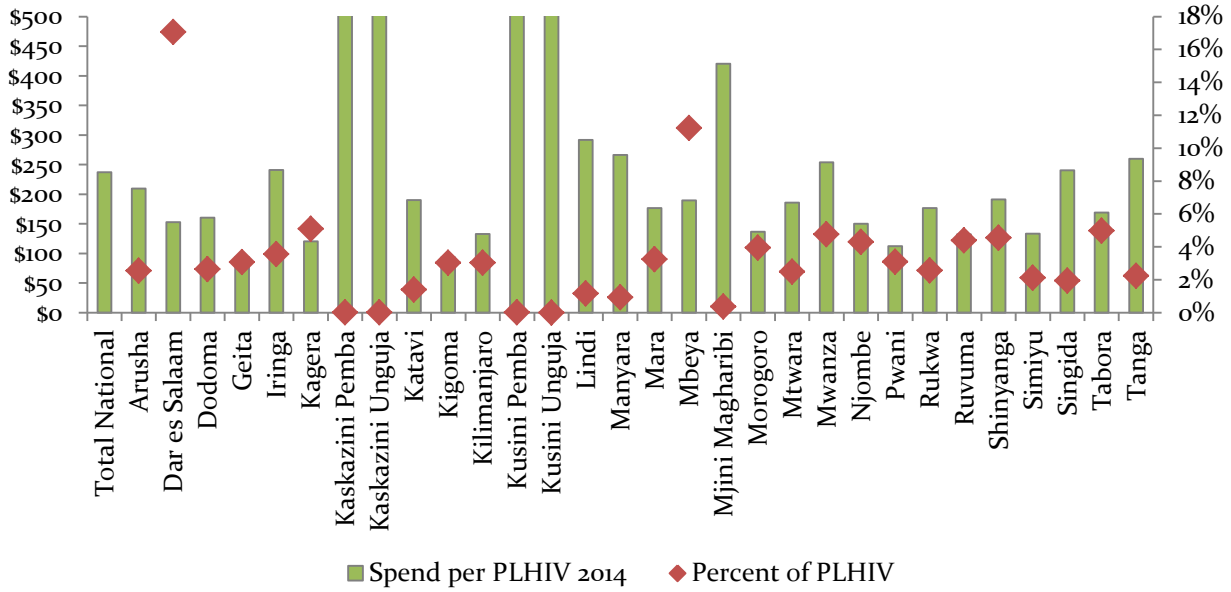
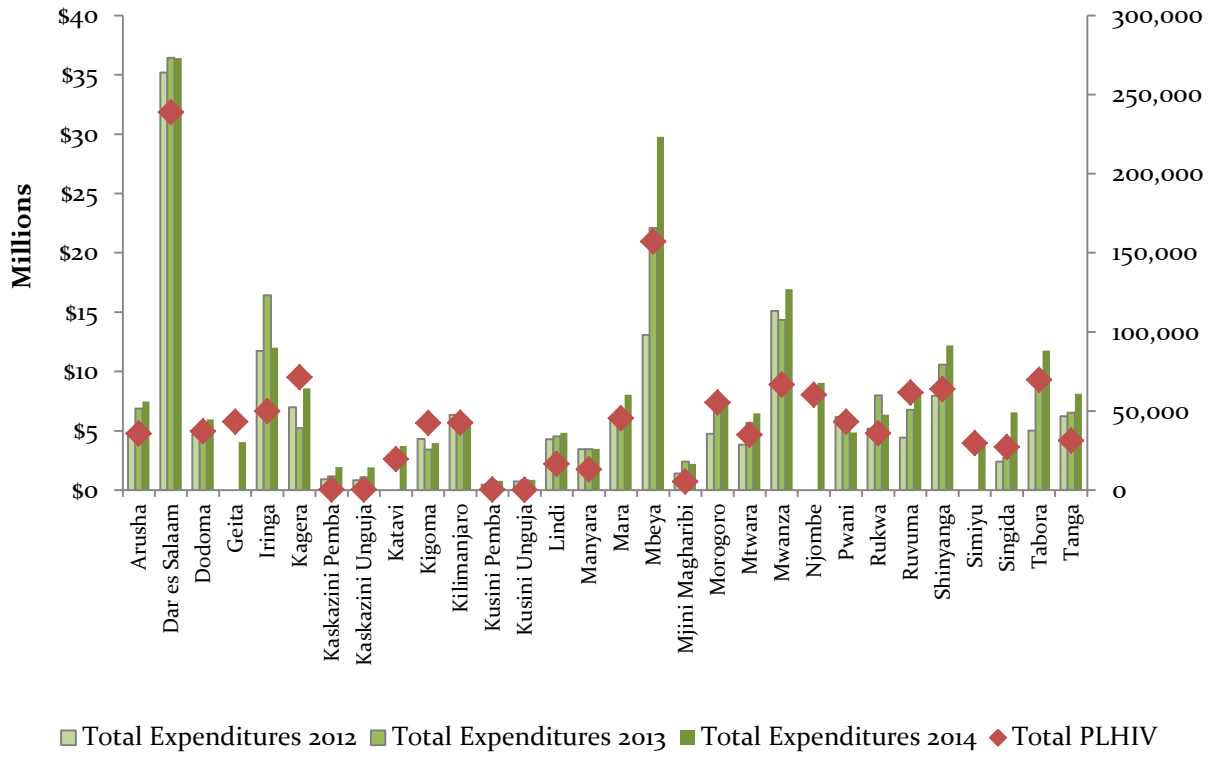


Figure 1.4.1.b reviews the total expenditures and PLHIV per region. With a few exceptions, the expenditures appear proportionally similar to total PLHIV in each region. In 2012 Tanzania announced the four new regions of Geita, Katavi, Njombe, and Simiyu, which all have only one expenditure value in the chart. Previously, each of these new regions was part of one or more other region.

Table 1.4.1.b Total PEPFAR Expenditures and Total PLHIV by SNU by Fiscal Year



1.5 Stakeholder Engagement

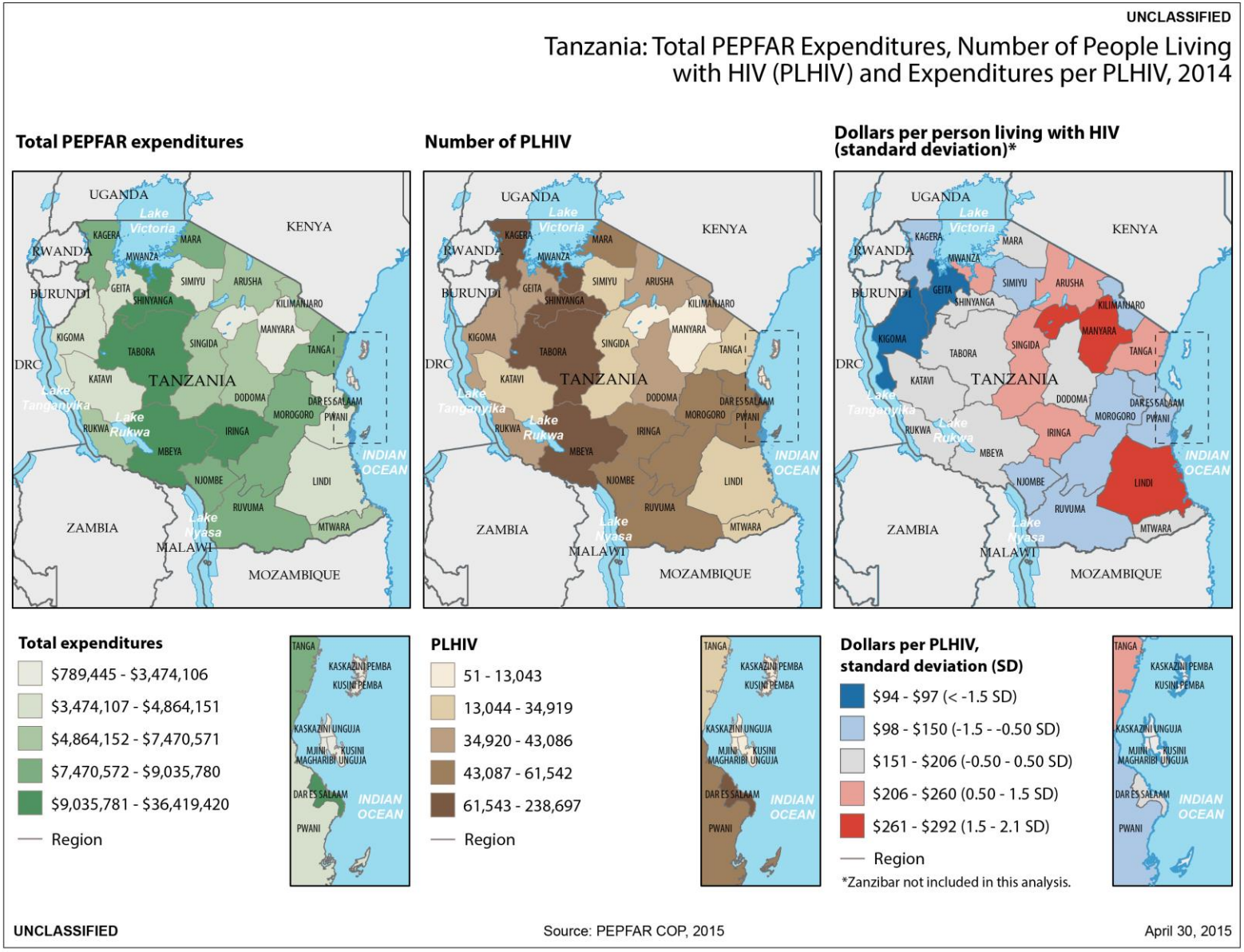
PEPFAR/T has facilitated continuous engagement with external stakeholders in country to benefit the program through their feedback and expertise, including the GOT, the GFATM secretariat and local constituents, other bilateral and multilateral development partners, civil society, and the private sector. In 2013, PEPFAR/T initiated the Executive Committee (EC) through which primarily PEPFAR/T and the GOT discuss high level strategy for PEPFAR implementation in Tanzania, with the solicited participation of multilateral donor and civil society representatives. In these sessions, PEPFAR/T provides an overview of the strategic direction of the COP in development and reviews successes throughout the year. During the COP 2014 pivots, the EC reviewed data on HTC and ART site yield; data around the determination of priority regions; the core/near core/non-core document; and the service package for sites in non-priority areas. PEPFAR/T will align quarterly EC meetings with Program Oversight and Accountability Response Team (POART) calls to review progress toward achievement of the Fast Track goals. The quarterly EC will also allow PEPFAR/T, the GOT, and other stakeholders to review data sets to work toward better aligning the data, its analysis, and programming.

PEPFAR/T has a close and productive relationship with the GFATM and two PEPFAR/T team members sit on the GFATM's Tanzania National Coordinating Mechanism. PEPFAR/T will also continue to collaborate closely with UNAIDS, WHO, UNICEF, GFATM, and other multilateral partners to guide the strategic direction of Tanzania toward achieving UNAIDS Fast Track Goals by 2020. PEPFAR/T has provided significant TA and worked closely with the GOT, UNAIDS, WHO, and UNICEF on the inputs for the SPECTRUM analysis and the development of an Investment Case for Tanzania.

For COP 2015, PEPFAR/T builds on its efforts of previous years to consult with civil society organizations (CSOs), and received input from more than 70 organizations. In conjunction with a meeting of all IPs on February 10th, PEPFAR/T held a session with CSOs to review the SID. PEPFAR/T engaged with CSOs at a subsequent meeting on March 10th to detail PEPFAR's organizational structure, activities funded from COP 2014, and strategic shifts planned for COP 2015. In addition, focus group discussions were held to solicit specific feedback on PEPFAR/T programming for consideration by all technical teams. In concert with the POART calls, PEPFAR/T plans to meet quarterly with CSOs in feedback sessions and to update CSOs on progress toward achievement of the saturation goals.

PEPFAR/T will continue to work closely with the GOT to align programs and is advocating for a governing structure that better aligns GFATM, PEPFAR/T, and ATF activities and increases inputs from external stakeholders such as civil society, other bilateral and multilateral development partners, and the private sector. As the ATF is established, PEPFAR/T will continue to provide TA to the GOT to ensure that activities funded from the ATF will directly benefit epidemic control and allow for phased and increasing transition of key activities from PEPFAR.

Figure 1.3.2 Total expenditure, PLHIV, and Expenditure per PLHIV by District



2.0 Core, Near-Core and Non-Core Activities

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. 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 Districts. Although PEPFAR/T is the major financial contributor to the HIV and AIDS response in Tanzania, the country team has articulated non-core activities that will PEPFAR will no longer support. Appendix A contains more details on the elements classified as core, near-core, and non-core, as well as transition plans.

3.0 Geographic and Population Prioritization

Based on the epidemiologic data, the 42 Scale-Up Districts represent over 55% of the disease burden; however, PEPFAR/T is currently operational in all 30. In order to reach 80% ART coverage nationally, based on APR 2014 data, an additional 563,648 patients will need to be initiated on ART and will require scale in HTC, PMTCT, community outreach through priority population and key population interventions, and investments in HSS.

PEPFAR/T is realigning its investments to better correspond with the epidemiology, and prioritizing investments to address the unmet need to achieve epidemic control in the highest burden districts. PEPFAR/T reviewed epidemiologic data and burden of disease at the regional and district levels, including total number of PLHV; prevalence; total unmet need along the cascade of prevention, care, and treatment services. Additionally, strategic application of epidemiologic data will be necessary to achieve epidemic control, given the funding gap for commodities.

To better respond to the variety of epidemics across the regions in Tanzania, PEPFAR/T established 42 Scale-Up Districts in which to gain control of the epidemic based on numbers of PLHIV from THMIS 2011-12 data and coverage data from APR 2014/SAPR 2015. These districts are:

Prioritization-level	Region	Districts	Prevalence	PLHIV
Scale-Up to Saturation	Arusha	Arusha CC	4.86	15,985
	Dar es Salaam	Ilala MC	6.45	66,763
	Dodoma	Dodoma MC	3.75	16,726
	Geita	Geita DC	3.51	18,011
	Iringa	Mufindi DC	13.85	19,373
	Iringa	Iringa MC	8.84	7,933
	Kagera	Muleba DC	3.35	16,260
	Lindi	Lindi MC	8.1	1,916
	Mara	Musoma MC	4.71	5,523
	Mara	Rorya DC	6.3	13,313
	Mbeya	Chunya DC	8.58	16,999
	Mbeya	Kyela DC	9.48	15,164

	Mbeya	Mbeya CC	9.85	28,928
	Mbeya	Mbeya DC	6.9	14,912
	Mbeya	Mbozi DC	4.95	15,190
	Morogoro	Morogoro MC	5.88	12,766
	Mwanza	Nyamagana MC	6.77	15,340
	Njombe	Njombe TC	15.34	15,022
	Rukwa	Sumbawanga MC	5.82	14,279
	Ruvuma	Songea MC	10.04	16,309
	Shinyanga	Kahama TC	8.33	13,799
	Shinyanga	Shinyanga MC	10.17	11,682
	Tabora	Igunga DC	7.07	17,524
	Tabora	Nzega DC	4.5	14,168
	Tanga	Korogwe TC	5.33	1,895
	Tanga	Muheza DC	4.28	4,432
	Tanga	Tanga CC	5.93	8,545
Aggressive Scale-Up	Dar es Salaam	Kinondoni MC	6.37	98,296
	Dar es Salaam	Temeke MC	6.41	73,638
	Kagera	Bukoba DC	4.88	12,820
	Kigoma	Kigoma Ujiji MC	3.38	13,352
	Kilimanjaro	Moshi DC	4.67	13,573
	Mbeya	Mbarali DC	12.87	27,031
	Mbeya	Rungwe DC	9.06	22,251
	Mwanza	Sengerema DC	4.37	16,018
	Njombe	Wanging'ombe DC	9.71	11,338
	Rukwa	Sumbawanga DC	3.41	11,316
	Ruvuma	Mbinga DC	5.84	15,706
	Shinyanga	Kahama DC	5.45	17,735
	Tabora	Tabora MC	7.6	11,947
	Mjini Magharibi	Magharibi DC	0.92	2,342
	Mjini Magharibi	Mjini DC	0.83	1,382
	Total			767,502

For COP 2015, PEPFAR/T reviewed updated epidemiological data to refine this approach. PEPFAR /T conducted additional analysis with program, ANC, and Spectrum data to triangulate across regions and districts. District-level PLHIV estimates were calculated using PMTCT program data as a proxy for PLHIV and adjusted to the regional PLHIV estimates from the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS). These estimates were vetted with the GoT and approved.

The GFATM grant maps and aligns activities geographically to maximize the coverage of prevention packages for key and priority populations across Scale-Up Districts.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Based on initial geographic and population prioritization decisions for the COP 2015, PEPFAR/T used the Supplementary Data Pack and additional data sources and analysis tools to set the FY 2016 treatment targets. Using district level PLHIV estimates based on PMTCT program data, PEPFAR/T selected 42 districts with the largest HIV burden (40) or significant key population HIV burden (2) in which to focus attention to reach epidemic control. Of these 42 districts, 27 Scale-Up to Saturation Districts 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 15 districts of high burden where it was not feasible to scale to 80% coverage by 2017, PEPFAR/T set targets to reach 80% saturation by 2019. For the remaining 129 Sustained Districts, 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 the CD4 of 500 guidelines are released by the GOT.

In FY 2016, PEPFAR/T aims to enroll 122,949 patients on treatment in the 42 Scale-Up (Scale-Up to Saturation, Aggressive Scale-Up, and Key Population Hotspot) Districts, with the goal of supporting 782,208 patients current on ART by APR 2016. This represents an increase in coverage from 50% to 63% (Table 4.1.1). Continuing to scale at a similar pace through FY 2017, the prioritized Scale-Up to Saturation Districts should reach 80% coverage of PLHIV by APR 2017.

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 first year. This will be funded primarily through strengthening adherence to testing protocols for both HIV care and TB sites and the integration of TB and HIV services (Section 4.7).

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 Districts, PEPFAR/T is also prioritizing diagnosis and ART initiation for HIV+ pregnant women. The goal in FY 2016 is to test 95% of pregnant mothers in all regions and enroll 95% of those testing HIV positive into ART programs for Scale-Up Districts and 90% in Sustained Districts, which is expected to yield an additional 55,559 newly initiated on ART. PEPFAR/T will identify the remaining 29,436 required to meet the target for PLHIV newly initiated on ART in Scale-Up Districts and link them to treatment via provider-initiated, voluntary, and mobile counseling and testing models targeted to key and priority populations (Section 4.5). Based on prior year program data, PEPFAR/T expects to link half of those diagnosed HIV+ through these HTC platforms to care programs. Both linkages and positivity yield should improve in FY 2016, suggesting the total estimated number requiring testing in Scale-Up Districts may be conservatively overstated.

Table 4.1.1 ART Targets in Priority Sub-national Units for Epidemic Control

Prioritization-level	Region	Districts	PLHIV	Expected Current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (TX_CURR)	Newly initiated (TX_NEW)
Scale-Up to Saturation	Arusha	Arusha CC	15,985	9,841	2,947	12199	2541
	Dar es Salaam	Ilala MC	66,763	40,940	12,470	50931	8993
	Dodoma	Dodoma MC	16,726	7,786	5,595	9614	2155
	Geita	Geita DC	18,011	7,236	7,172	9808	2592
	Iringa	Mufindi DC	19,373	12,165	3,334	14979	2083
	Iringa	Iringa MC	7,933	8,759	0	10189	1863
	Kagera	Muleba DC	16,260	5,770	7,238	3142	2826
	Lindi	Lindi MC	1,916	2,361	0	3334	770
	Mara	Musoma MC	5,523	5,790	0	897	291
	Mara	Rorya DC	13,313	4,924	5,726	6931	2473
	Mbeya	Chunya DC	16,999	9,788	3,811	11315	2467
	Mbeya	Kyela DC	15,164	9,316	2,815	10843	2290
	Mbeya	Mbeya CC	28,928	16,516	6,627	25638	3684
	Mbeya	Mbeya DC	14,912	7,299	4,630	12498	2746
	Mbeya	Mbozi DC	15,190	10,271	1,881	12498	2746
	Morogoro	Morogoro MC	12,766	7,492	2,721	10325	3329
	Mwanza	Nyamagana MC	15,340	15,480	0	20418	1569
	Njombe	Njombe TC	15,022	7,980	4,038	9844	906
	Rukwa	Sumbawanga MC	14,279	6,294	5,129	8891	2872
	Ruvuma	Songea MC	16,309	8,988	4,059	15061	3526
	Shinyanga	Kahama TC	13,799	6,907	4,132	8301	1578
	Shinyanga	Shinyanga MC	11,682	6,127	3,219	7386	1021
	Tabora	Igunga DC	17,524	6,299	7,720	8851	3538
	Tabora	Nzega DC	14,168	7,748	3,586	9451	2467

	Tanga	Korogwe TC	1,895	3,173	0	4259	1249
	Tanga	Muheza DC	4,432	4,451	0	5255	1914
	Tanga	Tanga CC	8,545	9,195	0	11007	1970
Aggressive Scale-Up	Dar es Salaam	Kinondoni MC	98,296	35,854	42,783	44964	9821
	Dar es Salaam	Temeke MC	73,638	34,187	24,723	45059	12123
	Kagera	Bukoba DC	12,820	3,338	6,918	1417	1371
	Kigoma	Kigoma Ujiji MC	13,352	2,405	8,277	5420	3284
	Kilimanjaro	Moshi DC	13,573	3,278	7,580	5232	1860
	Mbeya	Mbarali DC	27,031	11,473	10,152	13416	4681
	Mbeya	Rungwe DC	22,251	7,754	10,047	9354	2448
	Mwanza	Sengerema DC	16,018	6,532	6,283	8209	2254
	Njombe	Wanging'ombe DC	11,338	3,990	5,080	5487	721
	Rukwa	Sumbawanga DC	11,316	3,947	5,106	5418	2374
	Ruvuma	Mbinga DC	15,706	5,898	6,667	7467	2535
	Shinyanga	Kahama DC	17,735	6,162	8,026	5596	2196
	Tabora	Tabora MC	11,947	4,087	5,471	7341	8794
	Mjini Magharibi	Magharibi DC	2,342	367	1,507	190	178
	Mjini Magharibi	Mjini DC	1,382	3,090	0	3773	1850
	Total		**767,500**	**381,259**	**247,470**	**482,208**	**122,949**

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-Up Districts (FY16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	3,269,800	166,454	122,949
TB-HIV Patients not on ART	33,898	18,406	16,566
HIV-positive Pregnant Women	757,249	47,528	45,153
Female Sex Workers	59,029	15,702	9,421
MSM	9,968	2,492	1,495
PWID	5,725	2,061	1,337
People on Medically-Assisted Therapy	3,168	1,140	684
Adolescent Girls and Young Women (Vulnerable AGYW)[1]	464,451 (79,352)	28,749	22,429
Total	**4,218,189**	**253,783**	**197,605**

[1]The SP ITT defined Vulnerable AGYW as girls 15-24 who are not in school and are sexually active and are identified through a vulnerability index. This number (79,352) was then used to define the priority population. However, while there is a known HIV prevalence for the general population of AGYW, we do not know the prevalence of HIV among vulnerable AGYW, as defined by the SP ITT. Hopefully, a Tanzania specific measure of vulnerability will be identified during FY16 through Sauti, which we will be able to utilize for more accurate planning in the future.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate	Current Coverage[4]		Size Estimate	*Target VMMC_CIRC*	Expected Coverage
	(priority SNUs 2014)[1,2]	APR14 performance (*VMMC_DSD*)	(*Through FY2015*)	(*the 34 VMMC priority SNUs for 2016*)[5]	(in FY16)	(in FY16)[6]
<1	N/A	N/A	0.01%	36,943	12,000	NA
[1-9 years]	N/A	N/A	NA	N/A	NA	NA
[10-14 years]	1,304,505	254,532	48.7%	192,073	126,708	NA
[15-19 years]	996,985	164,025	70.08%	145,687	78,844	NA
[20-24 years]	756,023	69,183	60.4%	114,768	39,422	NA
[25-29 years][3]	641,711	62,236	45.5%	100,644	36,606	NA
[30-34 years]	546,391			NA	N/A	NA
[35-49 years]	1,115,388			NA		
[50+ years]	1,912,734	3,415	0.42%	NA	N/A	NA
Total	**7,273,737**	**553,391**	**28.5%**	**590,115**	**293,580**	**NA**

[1] VMMC priority districts in 2014 are all districts in 12 regions, i.e. Iringa, Mbeya, Njombe, Shinyanga, Geita, Kagera, Mwanza, Katavi, Rukwa, Simiyu and Mara.
[2]Based on Tanzania 2012 census population projection for FY2014 for the twelve (12) VMMC priority SNUs in FY14.

[3] In FY14, the reported age band was [25-49 yrs]. FY14 results and coverage reflect the numbers this group.

[4] *Coverage estimate through end of FY 2015 – (DMPPT-2 modeling). Coverage in 30+ yr band is estimated at 34.8%*

[5]Based on Tanzania 2012 census population projection for FY2014 for the 34 VMMC priority SNUs in COP 2015. # for infants is total male infants in five priority SNUs for EIMC in FY2016
[5] Estimates based on DMPPT-2.0 modeling estimates for COP2015 VMMC districts – # uncircumcised by end of FY2015

[6] Coverage estimates available at regional (not at district) level. PEPFAR/T is planning to support modeling focused to VMMC scale-up SNUs

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control in Scale-Up Districts

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY16)	FY16 Target KP_PREV	FY16 Target PP_PREV
Female Sex Workers[1]	72,469	82%	57,403	
PWID[1]	6,864	83%	5,727	
MSM/TG[1]	16,366	61%	10,218	
Priority Populations[2]	158,705	50%		79,352
Total	**254,404**	**61%**	**73,348**	**79,352**

[1] In all Scale-Up Districts.

[2] Priority Populations only include AGYW. In all Scale-Up Districts except for Magharibi DC and Mjini DC.

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

Prioritization -level	Region	Districts	PLHIV	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries from OVC programs (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART (FY16 Target)
Scale-Up to Saturation	Arusha	Arusha CC	15,985	1,999	10,594	3,178	14770	1,014
	Dar es Salaam	Ilala MC	66,763	8,783	46,360	13,908	14952	4,556
	Dodoma	Dodoma MC	16,726	2,241	9,063	2,719	116	1,359
	Geita	Geita DC	18,011	1,885	40,420	12,126	9597	1,180
	Iringa	Mufindi DC	19,373	1,659	12,563	3,769	327	1,361
	Iringa	Iringa MC	7,933	465	7,888	2,366	1189	588
	Kagera	Muleba DC	16,260	2,794	9,922	2,977	1051	1,643
	Lindi	Lindi MC	1,916	256	2,884	865	700	182
	Mara	Musoma MC	5,523	772	8,851	2,655	6110	511
	Mara	Rorya DC	13,313	2,382	546	164	17154	1,335
	Mbeya	Chunya DC	16,999	3,027	11,409	3,423	1993	1,633
	Mbeya	Kyela DC	15,164	2,294	9,748	2,924	25744	1,307
	Mbeya	Mbeya CC	28,928	3,684	23,851	7,155	24252	3,352
	Mbeya	Mbeya DC	14,912	2,394	13,738	4,121	19427	546
	Mbeya	Mbozi DC	15,190	2,647	21,348	6,404	5127	1,321
	Morogoro	Morogoro MC	12,766	1,552	15,080	4,524	387	1046
	Mwanza	Nyamagana MC	15,340	1,327	12,910	3,873	2579	1,359
	Njombe	Njombe TC	15,022	1,109	5,497	1,649	1069	874
	Rukwa	Sumbawanga MC	14,279	2,220	7,752	2,326	22920	1,204
	Ruvuma	Songea MC	16,309	2,324	12,445	3,733	25133	1,784
	Shinyanga	Kahama TC	13,799	1,499	12,517	3,755	10380	963
	Shinyanga	Shinyanga MC	11,682	1,126	5,147	1,544	6385	804
	Tabora	Igunga DC	17,524	3,104	18,338	5,501	5074	1,743
	Tabora	Nzega DC	14,168	2,440	20,757	6,227	20162	1,569
	Tanga	Korogwe TC	1,895	254			1596	146
	Tanga	Muheza DC	4,432	651	4,969	1,491	4385	394
	Tanga	Tanga CC	8,545	1,096	5,878	1,763	7661	849
Aggressive Scale-Up	Dar es	Kinondoni	98,296	11,707	65,379	19,614	13388	4,786

Salaam	MC						
Dar es Salaam	Temeke MC	73,638	10,079	55,093	16,528	13718	4,639
Kagera	Bukoba DC	12,820	2,148	3,428	1,028	6770	1,318
Kigoma	Kigoma Ujiji MC	13,352	1,928	6,676	2,003	24978	1,042
Kilimanjaro	Moshi DC	13,573	1,929	14,914	4,474	5176	1,130
Mbeya	Mbarali DC	27,031	4,500	13,071	3,921	22503	2,199
Mbeya	Rungwe DC	22,251	3,339	14,203	4,261	21274	1,693
Mwanza	Sengerema DC	16,018	1,942	19,653	5,896	10313	1,026
Njombe	Wanging'ombe DC	11,338	948	7,490	2,247	1069	616
Rukwa	Sumbawanga DC	11,316	2,130	10,810	3,243	22597	1,147
Ruvuma	Mbinga DC	15,706	2,596	14,874	4,462	21970	1,204
Shinyanga	Kahama DC	17,735	2,487	25,975	7,792	2627	666
Tabora	Tabora MC	11,947	1,551	12,636	3,791	24904	1161
Mjini Magharibi	Magharibi DC	2,342	744	1,121	336	126	74
Mjini Magharibi	Mjini DC	1,382	336	360	108	412	227
TOTAL		**767,500**	**104,346**	**614,733**	**184,420**	**442065**	**57,551**

4.2 Priority and key population prevention

Based on key and priority population data, 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: condom provision and promotion, PMTCT, VMMC, and targeted community prevention interventions for key and priority populations. The interagency team has reduced the community prevention scope to support the Scale-Up Districts, many of which are burdened with high numbers of key and priority populations. PEPFAR/T key populations (KPs) include: commercial sex workers (CSW), men who have sex with men (MSM), and persons who inject drugs (PWID). Priority population (PP) programs are focused on adolescent girls and young women (AGYW).

PEPFAR/T will work with the GOT to implement and train clinical staff on the National Guidelines for the Comprehensive Package of HIV Interventions for Key Populations, which was released in September 2014 by the GOT. The goal of the National Guidelines is to "increase access to a comprehensive package of quality health and social services to KP in order to significantly minimize the transmission of HIV and to reduce HIV related mortality, morbidity, stigma, and discrimination." To achieve this goal PEPFAR/T IPs will provide KPs and PPs with comprehensive packages of interventions that incorporate the continuum of services needs in prevention, care, and treatment. Interventions will include access to condoms and lubricants, STI screening and treatment, targeted demand creation, HIV testing and counseling, active identification, and HIV care and treatment. The implementation will target identified KP hot spots in selected Scale-Up to Saturation and Aggressive Scale-Up Districts. PEPFAR will monitor coverage of services for key and priority populations through mapping and enhanced M&E which will provide localized population estimates and service data for the identified sub-populations. In

COP 2015, PEPFAR/T will continue technical assistance for a total condom market, including complementary support to meet the needs beyond GFATM support for socially-marketed condoms. Support for condom programming will remain national in scope, yet promotional activities will be limited to Scale-Up Districts. PEPFAR/T will no longer support direct service delivery for system support activities, including national blood safety and infection control programs, but will maintain a modest, strategic TA program in COP 2015 in these areas.

4.3 Voluntary medical male circumcision (VMMC)

PEPFAR/T supported 1,226,682 VMMC procedures through the end of FY 2014, with 45% of these (553,388) from APR 2014 alone. Based on the FY 2015 target of 257,906, the cumulative number of VMMC performed in all VMMC priority regions at APR 2015 is anticipated to be 1,484,588. With the current shift to Scale-Up Districts, the target for FY2016 is 293,580 VMMC (adults: 281,580; infants: 12,000), with an overall need of 551,643 within the 10-29 year age band. This will leave a gap of 270,063 VMMC 10-29 year old males to be reached to achieve 80% in Scale-Up Districts in FY2017. PEPFAR/T was not able to directly use VMMC Expenditure Analysis (EA) data for FY 2014 to set budgets, as more than half of all expenditures came from central funds, which were not included in the EA report. In Tanzania, PEPFAR is the only donor program supporting VMMC programming. Two priority locations in Tanzania are rapidly realizing high VMMC coverage. Six districts of Njombe region will have achieved >80% coverage by the end of FY2015 and five districts of Iringa by end of FY2016. These will transition to a sustained phase, which will include: increased government ownership, roll out of EIMC, and supporting those districts to maintain VMMC coverage above 80%. PEPFAR/T will therefore achieve at least 80% coverage in 34 VMMC Scale-Up Districts by the end of FY 2017.

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. Priority for PEPFAR-supported services is given to 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 10-29 year old males will obtain maximal impact for both short- and long-term impact. Given latent demand in the youngest age cohort, all demand creation activities in COP 2015 will exclusively target 15-29 year olds.

4.4 Preventing mother-to-child transmission (PMTCT)

Tanzania has been implementing the PMTCT option B+ strategy of lifelong ART for pregnant and breastfeeding women since October 2013. As of APR 2014, 4.4% of pregnant women tested at ANC were found to be HIV+. Out of 76,000 HIV+ women identified, 67,000 (88%) received ART. About 53% of the HIV-exposed infants were tested through the early infant diagnosis (EID) program. Out of these, 2,990, four% were identified as HIV+. Data from Site Improvement and Monitoring System (SIMS) visits indicate low rates of linkage to HIV care and treatment of HIV+ infants. PEPFAR/T has discontinued support for testing at the 1,063 PMTCT sites that reported zero pregnant HIV+ women identified and 2,694 PMTCT sites that reported less than five pregnant HIV+ women identified in the last twelve months.

In order to balance the goals of MTCT elimination with epidemic control in Tanzania, the interagency team set targets for Scale-Up Districts in COP 2015 for PMTCT to reach 95% of pregnant women with HTC and initiate 95% of HIV+ women identified on ART. For sites in Sustained Districts, the target is to reach 95% of pregnant women with HTC and initiate ART to 90% of HIV+ pregnant women. PEPFAR/T will continue support for care and treatment to a diminishing cohort of pregnant women currently enrolled on ART in these sites through FY 2016 as patients are referred/ integrated into existing ART sites. PEPFAR/T has budgeted resources to support these patients for the remaining areas.

COP 2015 also targets Scale-Up Districts for increased community outreach to encourage antenatal care and 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 seroconvert; 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. ART/PMTCT integration central funding will largely support these additional activities, as well as resources freed up from redirection of PEPFAR support away from testing outside of the Scale-Up Districts. PEPFAR/T had also received $5 million in Family Planning Integration funding which is being used to enhance availability of FP methods, including long-acting reversible methods in MCH clinics and ART clinics. Improvements in FP availability are reflected in the increase from 31% (APR 2013) to 36% (APR 2014) in the number of ART sites providing FP services.

4.5 HIV testing and counseling (HTC)

In accordance with the geographic focus outlined above, the interagency team calculated HTC targets based on cascade analysis to meet the target number of new treatment slots. To reach 80% treatment coverage in the Scale-Up Districts, the team used regional prevalence data as a baseline to calculate the number of new HIV diagnoses, as well as estimates of LTFU (11%) and linkage to/enrollment in HIV care by modality (70% facility-based testing; 60% community-based testing). Table 4.1.1 outlines targets allocated to Scale-Up Districts.

PEPFAR/T expects to identify significantly more PLHIV by targeting mainly key and priority population who are more likely to be HIV positive. Several changes in the HTC approach will contribute to this. First, in Scale-Up Districts, PITC will have an intensified focus on in-patient wards, family testing in HIV clinics, ANC, and pediatrics, translating to higher yield than in past years. Also, community-based HTC will no longer be directed to the general population but solely focus on well-defined, geographically sub-targeted key and priority populations as well as family members of index clients in Scale-Up Districts. Community HTC will be targeted to areas with large concentrations of key and priority populations, and will specifically reach out to these populations that have historically been hard to reach. A vulnerability index will be used to identify vulnerable AGYWs (based on sexual behavior, sexual and gender-based violence, impoverishment, isolation, and schooling and literacy), who will then be offered HTC.

Second, in Sustained Districts, PITC will only be supported in ANC and TB settings, when clients present with opportunistic infections (OIs) or other signs and symptoms suggestive of HIV infection, and in children known to be exposed to HIV perinatally. This combination of a more focused PITC program and a targeted community-based HTC program should translate to greater efficiency and higher yield. In addition, the portfolio will place special focus on ensuring that community prevention partners that reach key and priority populations successfully link their beneficiaries to HTC services and then validate referrals of HIV-diagnosed clients to HIV care and treatment services.

After reviewing EA 2014 data for HTC by mechanism and region, the team used a range of variables to determine regional unit expenditures, considering testing modality, target populations, and package of services.

4.6 Facility and Community Based Care Support

PEPFAR/T will support implementation of evidence-based approaches to optimize retention in care and adherence to ART to promote viral suppression. At the facility, services will not differ between Scale-Up

and Sustained Districts, and will include regular clinical and laboratory monitoring, WHO staging, CD4 count and/or viral load (VL), screening for active TB, intensified case finding and provision of Cotrimoxazole (CTX) prophylaxis for those who are eligible. Community services will include TB screening, training of community support groups/volunteers to follow-up/track patients from the point of diagnosis, adherence support, linkage to facility based services, and social–economic support among other relevant services. In Sustained Districts and low volume sites, PEPFAR/T will actively engage the GOT and the GFATM and other stakeholders to discuss the potential transition of clients on ART from low volume sites by FY 2017 (see ART section). PEPFAR/T will also reduce IP site supervision at facilities with fewer than 100 clients in Sustained Districts.

Linkages between facility and community based services need improvement, and partners are working to address local gaps and barriers for the linkages to care at all stages, from HIV testing and pre-ART to enrollment on ART in order to increase adherence and retention. In addition, PEPFAR/T is supporting a study to assess the bi-directional referral monitoring tracking system, which will further improve linkages. At APR 2014, 28% of first year patients in care services were LTFU. Improving retention in care for both ART and pre-ART patients is a high priority; PEPFAR/T is utilizing community support groups such as PLHIV networks and peer support groups to promote adherence to care and timely initiation of eligible PLHIV to ART, testing of index family members and positive health, dignity, and prevention (PHDP).

Implementation of interventions to strengthen the bi-directional linkages with facility will improve follow up of PLHIV health status, including CD4 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 estimation, and EID at national and subnational levels.

The interagency team developed a core package of care and support which outlines the services that will be available (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 key populations, children under 5 years, and AGYW.

The human resource challenges facing the health sector constrain its ability to deliver quality services. The HSS log frame in Section 6.3 consequently has a focus on supporting human resources for health (HRH).

4.7 TB/HIV

Tanzania is among the top 22 high TB burden countries in the world, and has the 6th highest TB burden in Africa. World Health Organization (WHO) estimates that the prevalence of all forms of TB is 172 per 100,000 and that the incidence is 164 per 100,000 (WHO 2014). The most recent information from the first national TB prevalence survey (PST) completed in 2012 showed a prevalence of 295 per 100,000 populations among adults ≥ 15 years, and a case detection rate of 42% – 54%. Based on the observation on disease trend during the past ten years, case notifications were gradually declining until 2013. In 2013, a total of 65,732 cases of all forms were notified, showing an increase of 1,840 cases or 2.9% compared to the year 2012. Of the 65,732 TB cases notified, 54,504 (83%) were counseled and tested for HIV status. Among those tested, 20,072 (37%) were found to be co-infected with HIV. Furthermore, analysis shows that of the co-infected cases 18,354 (91%) cases were registered at HIV Care and Treatment Centers (CTCs) for HIV care and treatment services. Among them, 19,596 (98%) were put on Cotrimoxazole Preventive Therapy (CPT) while 14,679 (73%) were initiated on ART within the three month reporting period after a two week TB drugs tolerability period. This was a major improvement compared to the 2012 cohort, with an increase of patients initiated on ART from 10,993 (54%) to 14,679 (73%).

PEPFAR/T screens for TB among PLHIV, including PMTCT clients, home-based care clients, and OVC. PEPFAR/T also supports early initiation of ART for co-infected patients and refers patients for other services including HIV care and treatment. Programs also include Isoniazid Preventive Therapy and HIV testing for all registered TB patients in TB clinic settings. In COP 2015, PEPFAR/T will focus activities to increase uptake of ART from 73% to 90%.

Since 2012, Tanzania started scaling up the use of molecular technology in TB case diagnosis to enhance case detection among PLHIV and detection of multidrug resistant TB patients. Through a PEPFAR central initiative, Tanzania received 15 Gene Xpert machines which were installed in February 2015. Tanzania currently has a total of 60 machines and now is in the process of establishing the strategic document for laboratory, which will include the sustainability plan for the new technology encompassing the Gene Xpert MTB/RIF test roll out and implementation plan. Through COP 2015, the PEPFAR/T team plans to support the cost for maintenance of the Xpert machines. TB/HIV services have been scaled up in all regional and district hospitals and in a majority of lower facilities.

4.8 Adult Treatment

PEPFAR/T aims to initiate 236,421 new adult and pediatric patients in FY 2016 and support a total of 835,288 patients on treatment by APR 2016. The growth from APR 2015 includes 100,949 ART patients in Scale-Up Districts representing an increase of 26% in these areas, and 107,426 patients in Sustained Districts, assuming a 15% increase due to passive enrollment plus 60% of pre-ART patients who will become eligible for ART as national guidelines are updated. While the recent rollout of PMTCT option B+ and treatment initiation to all TB/HIV co-infected patients provide the opportunity for early ART initiation, the PEPFAR/T program will continue to advocate to the GOT and other stakeholders to ensure adequate DRM as the GOT increases the eligibility threshold to CD4 $\leq$ 500 cells/mm3 and enable more patients can be started on ART earlier.

Diagnosis and treatment of specific key and priority populations will have special focus. PEPFAR/T will increase services for AGYW, through DREAMS, ACT, and COP funded activities, through a more integrated and targeted approach to address the social and cultural conditions of the AGYW as informed by application of the vulnerability index. Linkages and referrals with comprehensive key population programs as outlined in the National Guidelines for the Comprehensive Package of HIV Interventions for Key Populations – Sept 2014. The PEPFAR/T treatment strategy will continue to focus on increased linkages along the prevention, care, and treatment continuum, and high adherence and retention of patients on ART with quality clinical services.

Since the beginning of PEPFAR in Tanzania, the GFATM has procured the majority of ARVs. The current HIV GFATM grant only funds commodities up to 657,000 current on ART patients. PEPFAR/T has programmed funding to cover commodity gaps for COP 2015 targeted patients, and will work with the GOT to support DRM efforts which will allow PEPFAR to shift funding to cover commodities, including but not limited to ARVs, beyond FY 2016.

PEPFAR/T is working with the MOHSW and other key stakeholders to roll out the national strategic plan for scale-up of VL monitoring, following the recent development of the national VL testing strategy. In COP 2015, PEPFAR/T will support procurement of VL reagents for patients in Scale-Up Districts, as well as for the development of the sample transport network for EID and VL specimens. The VL monitoring scale-up in Tanzania will focus in the Scale-Up Districts targeting all eligible clients from six months after initiation of ART.

PEPFAR/T reviewed APR 2014 data to identify low volume ART and PMTCT facilities whose patients could be considered for transfer to geographically accessible higher volume sites. In Sustained Districts, there were 849 sites that were seeing no patients. Additionally, there were 2,352 sites in Sustained Districts supporting fewer than 100 clients, and seeing a total of 21,494 PLHIV. PEPFAR/T will continue to review data quarterly as well as facility mapping, with the GOT and discuss the potential to transfer these clients to higher yield sites in FY 2016 (see also care section).

4.9 Pediatric Treatment

MOHSW is in the process of adopting the 2013 WHO consolidated treatment guidelines and initiating ART treatment for all children below age 15 years regardless of CD4 count. Training of health care providers is being conducted. In the last year, the number of children receiving ART increased by only 9% from 34,524 (APR 2013) to 37,530 (APR 2014) and children less than 15 years still only account for approximately 8% of total number of people on ART. Pediatric ART is provided at all PEPFAR-supported sites providing ART to adults, which account for 95% of all care and treatment sites in the country. The PEPFAR/T pediatric program will dramatically increase the strategic scale-up pediatric ART coverage in support of epidemic control in Scale-Up Districts.

Tanzania has been selected to receive additional funding through the ACT Initiative and plans to double the number of children receiving treatment by the end of 2016. PEPFAR/T aims to initiate 47,505 new children on treatment in FY 2016 and support a total of 77,256 children current on treatment by the end of the ACT initiative. The PEPFAR/T strategy for pediatric HIV treatment includes expanding high yield, early HIV identification and testing for children through EID and PITC, strengthening HCW skills through enhanced supportive supervision and mentorship systems, and improving age disaggregated data for infants, children and adolescents. In order to improve identification of HIV+ children, the country plans to improve the EID system through building an efficient system for monitoring EID results, tracking, and feedback to the site, and established aggressive opt out HTC targets to test 80% of all children hospitalized, with TB, malnutrition, and/or receiving OVC services, as well as children of adults attending care and treatment services in high yield regions.

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 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 ensure maintenance of high coverage of CTX to children and improve TB diagnosis and track TB treatment outcomes for children on ART. PEPFAR, ACT Initiative and DREAMS Initiative districts are aligned and the scale-up of adolescent friendly health services will take place in Scale-Up Districts to improve adherence, disclosure, sexuality/reproductive health, and reduce stigma.

COP 2015 prioritizes VL monitoring for all groups including children in high burden regions. 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 have been identified and are receiving second line treatment regimens.

PEPFAR/T has supported the MOHSW to optimize national pediatric ARV formulary. No reported pediatric ARV stock outs occurred in the last year. The national guidelines recommend use of LPV/r-based regimens as the first line regimen for children under age of 3 years; this has not been effectively implemented, and only a few children of this age are currently receiving this preferred regimen. On the other hand, all d4T-based regimens have been phased out. During FY 2015, the GFATM will support all pediatric first and second line ARVs, with ACT funds to cover commodity gaps.

4.10 Orphans and Vulnerable Children

Tanzania has 3,245,274, million OVC affected by HIV/AIDS (Measure Evaluation, 2015). Given the new PEPFAR direction emphasizing implementation of core and near-core interventions in Scale-Up Districts, PEPFAR/T estimates to reach 757,198 OVC and caregivers in FY 2016 – 614,733 in the 42 Scale-Up Districts and 142,465 in the Sustained Districts. PEPFAR/T will begin to transition support for OVC services in the 129 Sustained Districts to existing GOT programs, established and graduated community savings groups, and other non-PEPFAR funded projects by the end of September 2017. OVC geographic coverage is aligned with ACT and DREAMS platforms services.

PEPFAR/T will use the OVC platforms to strengthen case finding, referrals, and adherence and retention for pediatric HIV and ensure that ACT and DREAMS platforms are able to maximize social protective services under OVC programming. The OVC program will specifically use a case management model to identify HIV exposed and LFTU children and refer them back to treatment. Moreover through family based and parenting support interventions, the OVC program will support caregivers on how to address HIV status disclosure, adherence, and retention of the identified HIV positive children and adolescents living with HIV (ALHIV). Also, OVC interventions such nutrition and basic health assessment activities will help to identify acute malnourished children and families with chronic illness and refer them to HTC services. The OVC program will collaborate with PMTCT to strengthen follow-up of 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 OVCs and their caregivers. The community volunteers and para social workers will support assessments and monitoring of HIV positive children and their caregivers during household visits using the newly developed household visit checklist and standard package of the community based services for HIV positive children and ALHIV. Different economic strengthening interventions will be supported based on the household vulnerability index to ensure income stabilization.

Other COP 2015 activities include child protection and system strengthening activities for building the capacity at national and sub-national levels for an enabling environment and for the sustainability of OVC service provision (i.e. policies, legal framework, strategies, tools, guidelines and social welfare workforce).

5.0 Program Activities for Sustained Support for Other Locations and Populations

5.1 Package of services in Sustained Districts

For Sustained Districts, PEPFAR/T will maintain current patients on treatment in care and treatment services through FY 2016 in both ART and PMTCT sites. Where possible, and in collaboration with the GOT, patients will transfer from lower volume sites to higher volume and higher quality facilities. Patients in Sustained Districts will receive the minimum package of care for PLHIV and passive enrollment into care and treatment services for those who present requesting or in need of testing (e.g. pregnant women, patients with OIs). The minimum package includes CTX provision, routine clinic visits and screening for OIs (including TB), and routine laboratory testing, including one VL (or two CD4 tests) per year. No eligible patient will be denied treatment, nor will they be denied services if requested, but PEPFAR/T will discontinue demand generation for testing and most community testing programs in Sustained Districts, except for key population targeted programs. Finally, OVC currently served with core interventions in the Sustained Districts—primarily promotion of HTC and confirmatory HIV testing, clinic-based child abuse and GBV response, and continued support for primary and secondary

education—will continue to receive support through the end of FY 2016. These core services will then transition out along with other OVC services in the Sustained Districts.

Outside of passive testing and linkage to care in PMTCT and ART sites, PEPFAR/T will discontinue support for HTC in Sustained Districts. For VMMC, PEPFAR/T projects to reach 80% coverage in Scale-Up Districts by 2017. Eleven Districts (5 in Iringa and 6 in Njombe region) will have achieved 80% coverage by end of FY 2016 and will transition to a maintenance phase, that will include increased government ownership and roll out of EIMC and supporting those SNUs at rates above 80%.

PEPFAR/T has calculated the expected volume of patients needing the minimum package of services in these areas by district 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 testing in no and low yield sites without ART patients. 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 one client on ART in Sustained Districts. The supported facilities will provide a standard of care package similar to that offered in Scale-Up Districts with the exception of routine viral load testing, demand creation for HIV testing and the frequency at which supportive supervision is offered by PEPFAR implementing partners. With this new realignment, facilities in Sustained Districts 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 discretion of the provider's especially if there is high index of suspicion for HIV infection. Additionally supportive supervision visits will only be done twice a year to facilities with less than 100 clients receiving ART and consequently these patients will not be reported under MER (as MER reporting system demands for at least one visit per quarter).

The interagency technical teams budgeted for these activities prior to setting targets for scale-up in Scale-Up Districts (Appendix B).

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Districts

Maintenance Volume by Group	Expected result APR15	Expected result APR16	Percent increase (decrease)
HIV testing in PMTCT sites[1]		252,320	
HTC (only sustained ART sites in FY 16)[1]		871,729	
Current on care (not yet initiated on ART)	78,222	17,654	-77%
Current on ART	260,741	53,080	35%
OVC[1]		143,946	

[1]*District-level targets were not set for COP14 (APR15) thus it is difficult to estimate.*

5.2 Transition plans for redirecting PEPFAR support to Scale-Up Districts and priority populations

PEPFAR/T discontinued support to low or no yield HTC sites and PMTCT sites without ART patients in 2014. Similarly, for ART sites, PEPFAR/T will review current and upcoming data, as well as facility mapping, with the GOT to discuss the transfer of clients in Sustained Districts to higher yield sites in FY

2016. Conversely, in Scale-Up Districts, PEPFAR will work with GOT to review geographic distribution of patients to decongest extremely high volume sites and increase volume in lower volume sites.

PEPFER/T has planned for the transfer of direct support for blood safety and injection safety to the GOT, with COP 2015 available for TA. PEPFAR/T has also minimized support for construction and renovation in COP 2015.

PEPFAR/T has budgeted for commodity procurement in COP 2015 above the patient threshold set by the GFATM. Although commodities have been primarily funded by the GFATM, the current grant has a cap of 657,000 patients supported. PEPFAR/T and GOT activities will exceed that limit by the end of FY2015. Through DRM efforts, PEPFAR/T will continue to collaborate with the GOT on a plan for commodity procurement above the GFATM cap as needed, and support increased resources through the priorities articulated in the GOT Health Financing Strategy, including the ATF, private sector, and health insurance. PEPFAR funding for commodity support will be made available by shifting resources from government to government activities and salary support for HCW with GOT assuming funding for a phased and increasing proportion of activities in these areas. The PEPFAR/T team plans to initiate negotiations with the GOT during the quarterly EC meetings with the goal of developing an agreement outlining the pace of transition for each element, including transition of government staffing and operational costs, as feasible, at local and national levels.

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 gap in equipment service leading to treatment delays, two more years of coverage would be sufficient to allow full successful transition to MOHSW.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

The network of laboratory services in Tanzania is comprised of a National HIV reference laboratory, five zonal referral hospital laboratories, 28 regional laboratories, and 168 district laboratories, as well as 583 larger health centers with laboratory facilities and 5525 dispensaries that can perform simple diagnostic procedures. Of all these, PEPFAR/T currently supports 2380 facilities with the capacity to perform clinical laboratory testing, including 839 laboratories and 1541 Point-of-Care (POC) testing sites.

In order to strengthen Tanzania's laboratory infrastructure for improved access, quality, and coverage of HIV related diagnostic testing, PEPFAR/T will focus its core activities on supporting:

- Quality assurance and quality management systems programs for HIV rapid testing, CD4 testing, EID and VL testing
- Sample referral system and transport networks
- Quality Management Systems in laboratories and testing sites
- Laboratory Information Management Systems
- Regular VL monitoring for PLHIV
- Equipment maintenance systems and provision of laboratory commodities
- Laboratory workforce training and retention systems
- POC diagnostics to increase access to HIV/AIDS diagnostic and monitoring services
- Routine HIV Drug Resistance Surveillance
- Technical assistance for laboratory services strengthening.

1. Brief Activity Description	Deliverables		Budget allocation		6. Implementing Mechanism		7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016	Name	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Quality Assurance of HIV Rapid Testing												
Scale-Up national production and distribution of Proficiency Test (PT) panels for HIV Rapid Testing at PEPFAR- supported testing sites (a subset of the 7,700 facilities with ~30,000 testing points)	15,000 PT panels produced and distributed each quarter to 7,500 testing points at 2500 facilities in Scale-Up Districts. ~18,000 PEPFAR - supported testing points in 6,000 facilities transitioned to GOT	15,000 PT panels produced and distributed each quarter at all testing points in all 2500 facilities in Scale-Up Districts	40,000	50,000	AMREF Lab	14653	Access & Demand Score: Green	X	X	X		X
			160,000	200,000	MDH Kagera	17293						
			120,000	150,000	HJFMRI	16763						
			75,000	100,000	MOHSW Lab Follow on	17294						
Provide PT specific training and retraining to HIV Rapid Testing Personnel in Scale-Up Districts	Two HCWs (lab and QI) trained as TOTs at a quarter of the 2500 facilities in Scale-Up Districts (Total = 1250 HCW)	Two HCWs (lab and QI) per new facility or facility with staff turn-over trained as TOTs at 625 facilities in Scale-Up Districts (Total = 1250)	187,500	250,000	MOHSW Lab Follow on	17294	Access & Demand Score: Green	X	X	X		X
Conduct training for QI teams on HIV rapid testing at facilities in Scale-Up Districts	Training provided on QI/QA for two HCWs forming Work Improvement Teams per facility trained as TOTs in 2500 facilities in Scale-Up Districts (Total = 5000 HCW)	Training provided on QI/QA for two HCWs forming Work Improvement Teams per facility trained as TOTs in 2500 facilities in Scale-Up Districts (Total = 5000 HCW)	450,000	600,000	MOHSW Lab Follow on	17294	HRH Score: Red	X	X	X		X
Quality Management Systems												
Provide mentorship and coaching on accreditation of 72 eligible laboratories throughout country	38 laboratories accredited to national or international standards, including subset of 17 labs in Scale-Up Districts	46 laboratories accredited to national or international standards including all 17 labs in Scale-Up Districts	400,000	500,000	CLSI Lab	16891	Quality Mgmt Score: Yellow	X				X
			120,000	150,000	ASM Lab Follow on	17295						
			160,000	200,000	ASLM	14560						

Support Strengthening Laboratory Management Towards Accreditation (SLMTA) training to 18 regional and district laboratories	One year SLMTA mentorship for 18 labs.	One year SLMTA mentorship for 18 labs.	225,000	300,000	MOHSW Lab Follow on	17294	Quality Mgmt Score: Yellow	X				X
			88,000	110,000	ASCP Lab	16892						
	STAR-recognition by ASLM for at least eight labs		120,000	150,000	AMREF Lab	14653						
			225,000	300,000	NIMR Follow on	17300						
Laboratory Information Management Systems (LIMS)												
Support implementation of centralized laboratory database and interconnectivity to feeder Laboratory Information Systems for use throughout country	Web-based dashboard on program performance available, with MOHSW capacity to manage central database by establishing connectivity, maintaining infrastructure, and supporting mentorship and supervision at centralized labs	Web-based dashboard on program performance available with MOHSW capacity to manage central database by maintaining connectivity and infrastructure, and supporting mentorship and supervision at centralized labs	240,000	300,000	APHL Follow on	17292	Quality Mgmt Score: Yellow	X	X	X		X
			37,500	500,000	MOHSW Lab Follow on	17294						
			75,000	100,000	NIMR Follow on	17300						
Support Implementation of Basic Laboratory Information System in 55 District Hospitals in Scale-Up Districts	Real time data collection and use available in all 55 district hospitals in Scale-Up Districts	Real time data collection and use available in all 55 district hospitals in Scale-Up Districts	200,000	250,000	APHL Follow on	17292	Quality Mgmt Score: Yellow	X	X	X		X
			160,000	200,000	*[REDACTED]*	*[REDACTED]*						
Support deployment and implementation of Sample Tracking Electronic System at 165 hubs in Scale-Up Districts	Real time monitoring of sample PT panels, quality control results, and reagent stock levels in place	Real time monitoring of sample, PT panels, quality control results, and reagent stock levels in place	65,000	650,000	THPS/ Local FOA Follow on	16874	Quality Mgmt Score: Yellow	X	X	X		X
			80,000	100,000	ASM Lab Follow on	17295						
Equipment Maintenance Systems (2.2.3) & Biosafety												
Support certification of laboratory Bi0safety Cabinets (BSCs)	70 BSC machines serviced using four MOHSW Biomedical Engineers in four zonal laboratories associated with Scale-Up Districts	70 BSC machines serviced using four MOHSW Biomedical Engineers in four zonal laboratories associated with Scale-Up Districts	30,000	40,000	MOHSW Lab Follow on	17294	Supply Chain Score: Yellow	X	X	X		

Laboratory Workforce Training and Retention Systems												
Support pre service curriculum reviews (i.e. SLMPTA) by incorporating modern techniques and in-service training topics	National Technical Level (NTA) 7 and 8 pre-service curricula reviewed and implemented	National Technical Level (NTA) 7 and 8 revised pre-service curricula evaluated	80,000	100,000	ASCP Lab 16892	HRH Score: Red	X			X	
			40,000	500,000	ASM Lab Follow on 17295						
			75,000	100,000	MOHSW Lab Follow on 17294						
Strengthen pre-service faculty capacity building by sponsoring laboratory schools tutors for advance level training programs	Five lab school tutors sponsored for specialist level microbiology, immunology, chemistry or hematology for 10 institutions in Scale-Up Districts	Five lab school tutors sponsored for specialist level microbiology, immunology, chemistry or hematology for 10 institutions in Scale-Up Districts	32,000	40,000	I-TECH 13359	HRH Score: Red	X				
Support new training school laboratories with basic teaching materials such as equipment, textbooks, etc. among the 26 training institutions nationally	Three new training institutions training equipped with basic teaching equipment. Textbooks available for 100 newly enrolled laboratorians	Three new training institutions training equipped with basic teaching equipment. Textbooks available for 100 newly enrolled laboratorians	240,000	300,000	ASCP Lab 16892	HRH Score: Red	X				
HIV Drug Resistance Surveillance and Monitoring												
Support development of curriculum and training of lab staff, lab supplies/ commodities and QI/QA for roll-out of drug resistance monitoring and surveillance	Curriculum developed for TOT on lab equipment for drug resistance monitoring and surveillance. Training of lab staff conduced. Lab supplies/ commodities procured for launch	Training of lab staff conducted,. Additional shipments of lab supplies/ commodities procured. QA/QI conducted of lab staff on collection and reporting	75,000	50,000	MOHSW Lab Follow on 17294	Access & Demand Score: Green HRH Score: Red Quality Mgmt Score: Yellow	X	X	X		X
			40,000	50,000	HJFMRI 16763						
Institutions and Policies												
Finalize development of a national laboratory policy	National level policy drafted through stakeholder meetings and workshops	Policy adopted by MOHSW	37,500	50,000	MOHSW Lab Follow on 17294	Access & Demand Score: Green	X	X	X		

6.2 Strategic information

PEPFAR/T Strategic information (SI) activities strive to strategically monitor PEPFAR investments and progress to an AIDS-free generation, maximize program impact, improve data collection practices, systems, data quality and data analysis, and describe the drivers of the epidemic in Tanzania. This is accomplished through support for TA, capacity-building, country ownership, data quality and evidenced-based programming in a coordinated approach with other donors. The SI activities attempt to leverage other resources and to ensure investments in the collection of quality data, Health Management Information Systems (HMIS) and Health Information Systems (HIS) system strengthening, and surveys and surveillance activities are aligned and integrated with the GOT.

For COP 2015, PEPFAR/T will continue strengthening the completeness, timeliness and accuracy of routine HIV data, and support the availability of high quality data to for policy and programmatic decision-making for HIV epidemic control. PEPFAR/T will maintain investments for core M&E activities while establishing a gradual road map towards unified PEPFAR and GOT reporting and collaborative decision-making.

COP 2015 investments in data use will support updating of decision processes that require the use of data; decision support tools; capacity-building to understand data; advocacy for data use; and analysis and dissemination of data.

PEPFAR/T will continue to work with the GOT to address gaps in surveillance and surveys including, IBBS, SABER study, key population size estimations, mortality, pediatric, case-based surveillance, ANC/PMTCT comparison, HIV incidence, and hot spot and HIV drug resistance surveillance. Central funding is supporting a Population-based HIV Impact Assessment (PHIA) that will address some critical data gaps by the end of 2016, including incidence and viral load suppression estimation. The country will use the results from all these activities to inform and update strategic and geographical program focus. PEPFAR/T will support commodities and staff capacity to implement surveillance activities.

PEPFAR/T is investing in the integration of key HIS to support effective management of resources and availability of data for evidence-based decision-making. PEPFAR/T is supporting a learning and review process for patient level records requirements and priorities. In COP 2015, 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 support the integration of and data-sharing across administrative systems including logistics management, human resource management, financial management and planning systems, and automated sharing of aggregate data into MOHSW HMIS/DHIS. PEPFAR/T will continue supporting use of GIS mapping and analysis in planning and decision-making to identify areas where there is the greatest potential to have impact and achieve epidemic control.

1. Brief Activity Description	Deliverables		Budget allocation		6. Implementing Mechanism		7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016	Name	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Surveys and Surveillance Activities												
Conduct HIVDR Surveys.	HIV DR strategy developed. HIVDR survey protocols developed. SOPs and training materials developed and disseminated to stakeholders.		100,000	100,000	NACP Follow-on	14573	Epidemiological & Health Data Score: Yellow		X	X		X
Conduct integrated behavioral biological Surveillance IBBS in Mainland.	KP Protocol for Mainland developed with GOT and stakeholders. Data collection instruments, SOPs and training materials developed		100,000	100,000	NACP Follow-on	14573	Epidemiological & Health Data Score: Yellow	X	X	X	X	X
Conduct integrated behavioral biological Surveillance IBBS in Zanzibar	KP IBBS protocol for Zanzibar approved through CDC ADS and ZAMEC. Data collection instruments developed and data collection completed		119,548	119,548	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X	X	X

TA support to conduct integrated behavioral biological Surveillance IBBS in Zanzibar and Mainland.	KP IBBS protocol for Zanzibar approved through CDC ADS and ZAMEC. Protocol for Mainland developed with GOT and stakeholders. Data collection instruments developed for Mainland and data collection completed for Zanzibar.		88,800	88,800	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X	X	X
Conduct size estimation KP and mobile populations.	Protocol developed. All CDC ADS and NIMR approvals completed. Data collection completed		50,000	50,000	NACP Follow-on	14573	Epidemiological & Health Data Score: Yellow		X			
TA support to conduct size estimation KP and mobile populations.	Protocol developed. All CDC ADS and NIMR approvals completed. Data collection completed		160,000	160,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow		X			
Conduct Case-Based Surveillance HIV Case Reporting as a Pilot in Scale-Up Districts.	SOP and Protocol developed and approved by CDC ADS and NIMR. Data collection initiated and electronic reporting system implemented.		50,000	50,000	NACP Follow-on	14573	Epidemiological & Health Data Score: Yellow	X	X	X		X
TA support to conduct Case-Based Surveillance HIV Case Reporting as a Pilot in Scale-Up Districts.			64,000	64,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X		X

Conduct Mortality Surveillance.	Districts identified with stakeholders for mortality surveillance, consistent with PEPFAR geographic prioritization. SOP for expanding the SAVVY method or using a case-based approach developed with GOT. SOP or protocol developed and submitted to CDC ADS and NIMR for approval.		200,000	200,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow				X	
Conduct Pediatric Surveillance. Work with the GOT to establish a pediatric HIV case reporting system.	Consensus meeting with GOT and stakeholders to adapt UNAIDS/WHO guidelines to Tanzania context. SOPs and Protocol develop and submitted to CDC ADS and NIMR for approval.		200,000	200,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X		X
Conduct ANC surveillance as part of ANC/PMTCT comparison study. Support implementation of comparison study to help with decision making to move to PMTCT-based surveillance.	Protocol under development submitted and approved by CDC ADS and NIMR. Training materials developed. Consensus meetings with stakeholders and GOT.		80,000	80,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X		
Conduct assessment on the utility and availability of routine PMTCT data for HIV surveillance in Tanzania Mainland by comparing PMTCT-derived HIV prevalence estimates and prevalence trends to those of ANC sentinel surveillance data. Conduct PMTCT process evaluation (DQA) in the selected PMTCT sites.	Assessment on the utility and availability of PMTCT data conducted.		150,000	150,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X			X	

Implement hot spot surveillance.	Consensus meeting with stakeholders and GOT. Protocol developed and submitted to CDC ADS and NIMR for approval. Training and data collection materials developed.		160,000	160,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X		X
Conduct HIV Incidence surveys to identify recent HIV infections, including feasibility and pilot study to determine best survey method for measuring HIV incidence or recentness of infections.	Consensus meeting with stakeholders and GOT. Protocol for feasibility and pilot developed and submitted for approval. Training and data collection materials developed. Study identified based on PHIA design and findings.		200,000	200,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X				
Provide technical support on SPECTRUM activities to produce regional and national level estimates.	National and regional HIV SPECTRUM estimates		75,000	75,000	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow		X	X		X
M&E Activities												
Provide leadership for national HIV/AIDS Program Monitoring Systems SI activities by coordinating CHMTs, RHMTs and other stakeholders on National SI activities related to HIV and AIDS.	>90% facilities with timely reporting. Updated recording and reporting tools with new disaggregates. Completed data quality audits reports.		149,914	149,914	NACP Follow-on	14573	Performance Data Score: Yellow	X	X	X		X
Provide leadership for national HIV/AIDS Program Monitoring Systems SI activities by coordinating CHMTs, RHMTs and other stakeholders on National SI activities related to HIV and AIDS.	>90% facilities with timely reporting. Updated recording and reporting tools with new disaggregates. Completed data quality audits reports.		100,000	100,000	*[REDACTED]*	*[REDACTED]*	Performance Data Score: Yellow	X	X	X		X
			176,000	176,000	*[REDACTED]*	*[REDACTED]*	Performance Data Score: Yellow	X	X	X		X

Implement activities to improve M&E systems on HIV/AIDS interventions. Increase number of sites which use electronic reporting to reach all high volume CTC2 facilities.	Updated recording and reporting tools. Increase in functional number of CTC2. Automated web based data exchange of aggregate data from CTC to DHIS/HMIS for quarterly C&T. Pilot Testing of Next Generation HIV EMR system for C&T with capability to link with other systems and registries within a Health Information Exchange infrastructure.		100,000	100,000	NACP Follow-on	14573	Performance Data Score: Yellow	X	X	X		X
Implement activities to improve M&E systems on HIV/AIDS interventions. Increase number of sites which use electronic reporting to reach all high volume CTC2 facilities.	Updated recording and reporting tools with new disaggregates. Completed data quality audit reports		50,000	150,000	TACAIDS-M&E	12234	Performance Data Score: Yellow	X	X	X		X
Conduct Data Triangulation activities at the sub-national level	Data triangulation reports from 15 priority districts. Improved data quality, culture of data processing, analysis, and use		160,000	160,000	*[REDACTED]*	*[REDACTED]*	Performance Data Score: Yellow	X	X	X		X
Support National Program Monitoring Systems for national collection, aggregation and transmission of core indicator data from service delivery, district and national levels.	Increased # and % of HMIS reports received from PEPFAR-supported facilities. Regular measured improvement in data timeliness and data quality. Comparison and reconciliation of DHIS data with PROMIS Data.		171,166	171,166	RTI/ Data Warehouse	12728	Performance Data Score: Yellow	X	X	X		X
			107,500	107,500	MOHSW - Follow On	16887	Performance Data Score: Yellow	X	X	X		X
			100,000	100,000	*[REDACTED]*	*[REDACTED]*	Performance Data Score: Yellow	X	X	X		X

HIS											
Support revisions to PROMIS to integrate OGAC requirements.	All MER indicators with disaggregates integrated. COP targets captured. Data transfer with DATIM enabled. All required facility level and site level target reporting to OGAC achieved. Integration and data exchange with DHIS. Two-way exchange to share PEPFAR-collected data with GOT.		950,000	950,000	Northrup Grumman/ PROMIS 13351	Performance Data Score: Yellow	X	X	X	X	X
Provide technical support and capacity building for GIS and spatial analysis, maintenance. Update the iPSL facility geocodes.	iPSL coordinated and vetted against GOT MFL. PEPFAR reporting system with latest location information for facility and community sites. Facility sites with latitude and longitude and latest shapefiles available. GIS tools produced as planning tools to generate maps.		225,000	225,000	NIMR Follow on 17300	Performance Data Score: Yellow	X	X	X	X	X

Execute Information System strategic planning, coordination of inputs. Conduct systems analysis.	Leadership, management and coordination of e-Health investments by MOHSW. Planning for Core HIV Information System Needs incorporated into broad sector wide e-health planning and HIV specific e-health planning. Guidelines for data exchange between HFR and external systems written and disseminated for use. At least 3 core health sector information systems with links to HIV connected to shared health facility registry		161,657	161,657	RTI/ Data Warehouse	12728	Performance Data Score: Yellow	X	X	X	X	X
			80,000	80,000	*[REDACTED]*	*[REDACTED]*						
Harmonize key HIV- related HIS eLMIS, PlanRep, Epicor, HRHIS used by MOHSW and other related governmental systems at the national level. Link them into an interoperability framework.	Requirements mapping updated and interoperability framework designed. For HRHIS, All MOHSW employees enrolled. Facility code assigned to employee. Interim internal mapping of facility type and ownership enabled. HR classification code assigned to employee.		960,000	960,000	JHPIEGO/ MCSP	17409	Epidemiological & Health Data Score: Yellow	X	X	X	X	

Enhance reliability and reach of ICT Services to RACs, DACs, RMOs, DMOs, RCH coordinators and other HIV related MOHSW employees to have access to core services required for HIV service management and planning email, CTC, DHIS, eLMIS, HRHIS	Development of local processes and expertise to manage and use the new information system component. ICT Infrastructure plan developed for proper management and documentation of financial resources inputted into improving ICT infrastructure in health sector by various stakeholders.		71,319	71,319	RTI/ Data Warehouse	12728	Epidemiological & Health Data Score: Yellow	X	X	X	X	X
			75,000	75,000	MOHSW - Follow On	16887						
			37,500	37,500	*[REDACTED]*	*[REDACTED]*						
Support site level electronic information systems for medical records. Conduct systems analysis and reviews. Link site level C&T systems to national program monitoring systems.	Urgent upgrades to existing CTC system including automated reporting to DHIS and automated submission of patient level data to CTC macro via web connection, linkages with SMS reminder systems, and consideration of linkages with PMTCT implemented. System software upgrades to support improved PMTCT indicator reporting in DHIS	Expanded use of CTC upgrades. Next generation EMR system to high volume CTC sites deployed.	460,000	550,000	MDH/ HIS - UCC follow on	16899	Performance Data Score: Yellow		X			X
Data Use												
Produce Specific Data Use Plans, Decision Support Tools. Update decision processes requiring use of data. Build capacity to understand data. Advocate for data use, analysis, dissemination.	DDU Strategy implemented. Specific Data Use Plans. Decision Support Tool produced.		71,319	71,319	RTI/ Data Warehouse	12728	Performance Data Score: Yellow	X	X	X	X	
			42,500	42,500	MOHSW - Follow On	16887						
			31,875	31,875	*[REDACTED]*	*[REDACTED]*						

Increase the use of data for decision making and programming for OVC initiatives	Availability of data for decision making for epidemic control, DQA reports, and integrated PEPFAR indicators OVC module into GOT's DHIS2 improved. Survey reports for nine MER output indicators and related studies made available.		871,644	1,200,000	MEASURE Associate Award 16569	Epidemiological & Health Data Score: Yellow	X	X	X	X	
Implementation Science											
Combination Prevention Bukoba study (impact evaluation), including: regular support to VMMC Bukoba program; community mobilization during VMMC campaigns, referral to VMMC from other services; outreach VMMC registration; VMMC escort services; training and supervision for HTC counselors to refer men for VMMC; use iof community leaders as advocates of VMMC during campaigns.	80% VMMC coverage among men 18-49. At least one mobile VMMC campaign. Sustained, robust VMMC program in Bukoba. Report of results from heightened M&E program. VMMC baseline data disseminated		500,000	TBD	ICAP Combination Prevention and TA 17975	Epidemiological & Health Data Score: Yellow		X		X	X
Combination Prevention Bukoba study (impact evaluation), including: maintaining year 2 of the CP intervention scale-up, including a combination model of HTC (PITC, community HTC, venue-based HTC), linkage, retention, VMMC and other programs with targeted modalities.	Heightened M&E activities. Routinely generated M&E results. Revised protocol and questionnaires for endline survey. Project and M&E updates/ dissemination		300,000	TBD	ICAP Combination Prevention and TA 17975	Epidemiological & Health Data Score: Yellow	X	X	X	X	X

Combination Prevention Bukoba study (impact evaluation), including: providing ART to HIV pregnant or breast feeding women identified through ANC and postnatal care; supporting option B+ to all pregnant women in Bukoba Urban sites currently supported by ICAP; providing daily ART dose to infants from birth through 4-6 weeks regardless of feeding method; tracing and supporting women who default from B+; POC CD4 testing for pregnant women in at least three facilities; ensuring enhanced M&E on PMTCT program	90% of HIV+ pregnant or lactating women on ART. 90% of B+ women retained at six months. Infants born to HIV + mothers receive treatment until 4-6 weeks. Active defaulter tracing established. M&E results analyzed and disseminated		700,000	TBD	ICAP Combination Prevention and TA	17975	Epidemiological & Health Data Score: Yellow	X	X	X	X	X
Combination Prevention Bukoba study (impact evaluation), including: support tor HTC program; venue-based and community (house to house) testing as part of CP heightened intervention; targeted home based testing of sex partners and family members of positive patients in CTC/PMTCT; targeted HTC services of VMMC clients and partners; heightened M&E of HTC program elements; training and support to lay and nurse counselors	90% of resident adult population of Bukoba tested in a two year period/ M&E results collected, analyzed, and shared. Baseline HTC results disseminated		500,000	TBD	ICAP Combination Prevention and TA	17975	Epidemiological & Health Data Score: Yellow	X	X			
Combination Prevention Bukoba study (impact evaluation), including: support for PITC model and facility-based PITC lay and nurse counselors; support for facility-based linkage and retention program, ART services; test of WHO guidelines to offer treatment to the positive partner in serodiscordant couples regardless of CD4 or WHO stage; revision of general adult eligibility to 500; defaulter tracing, other CTC peer educator services; heightened M&E to track program results	80% of eligible initiated on ART within six months of diagnosis/ ART offered to all with CD4<500. ART offered to all positive partners in serodiscordant couples. Heightened M&E analyzed and shared. High achieving PITC model institutionalized		1,000,000	TBD	ICAP Combination Prevention and TA	17975	Epidemiological & Health Data Score: Yellow	X	X	X	X	X

Linkage and Retention impact evaluation: Evaluate impact of a client focused intervention led by community-based HIV/AIDS service providers on linkage to and retention in HIV care and treatment services this is a randomized trial of 20 high volume facilities in three regions. Interventions will include using community-based health workers to link newly diagnosed clients through a case-management approach, with counseling to a community support group model (either community or facility based). The support group model will be CHW-facilitated and allow for health screening, drug pick up, psychosocial support and referral to other services in one setting. Clients will visit the clinic for CD4 testing and when they have signs and symptoms requiring clinical care.	Baseline survey and participant recruitment completed. Baseline and ongoing data analysis conducted. Baseline results disseminated	Endline survey completed. Client follow-up and data extraction completed. Ongoing data analysis conducted. Results disseminated	1,550,000	TBD	Pop Council/ Supporting Operational AIDS Research Project	17357	Epidemiological & Health Data Score: Yellow		X	X	X	X
Linkage and Retention impact evaluation: Implement and supervise intervention of a client focused intervention led by community-based HIV/AIDS service providers on linkage to and retention in HIV care and treatment services, with support for staff to coordinate and conduct intervention.	Intervention fully operational in ten sites; regular monitoring, training, and mentorship activities	Intervention continues with full support during first part of year. Efforts made to transition program to local and national governments and/or other partners.	400,000	TBD	THPS/ Local FOA Follow on	16874	Epidemiological & Health Data Score: Yellow		X	X	X	X
Conduct SABER study to better understand epidemiology among military population, including infection rate, modes of transmission, etc.	Study conducted		250,000	-	*[REDACTED]*	*[REDACTED]*	Epidemiological & Health Data Score: Yellow	X	X	X	X	

6.3 Health System Strengthening

PEPFAR/T is prioritizing its Health Systems Strengthening (HSS) program according to the most pressing concerns highlighted in the Sustainability Index Dashboard (SID). In COP 2015, these programs strongly align with epidemic control and geographic program focus as articulated below.

Despite widespread recognition that HCWs are essential to controlling the epidemic, the health sector in Tanzania has been facing a 60% vacancy rate for many years. Moreover, according to Tanzania's HRH country profile for 2013/14, PEPFAR/T's Scale-Up Districts only average 16 HCW per 10,000 residents in the population. To achieve epidemic control, HCWs must be available in sufficient numbers and armed with the essential skills to provide quality care. To address these needs, COP 2015 fully aligned with the five objectives described within the recently approved PEPFAR HRH Strategy, in particular: improving recruitment, deployment and retention; establishing sustainable financing of HRH; and improving HRH performance through appropriate skills building in both public and private sectors.

Financial resources for the HIV and AIDS response in Tanzania are inadequate and overwhelmingly donor dependent. To promote sustainable financing such that Tanzania is able to achieve and maintain epidemic control, COP 2015 activities target data-driven DRM approaches as well as promote efficient use of existing funds to maximize return on PEPFAR's investment. These activities include technical support to produce analyses that better inform and link to the GOT's budgeting processes, TA for the rollout of the newly approved ATF, promotion of long-term private sector involvement, targeted advocacy of stakeholders to promote DRM, and support of the country's Results Based Financing (RBF) initiative to achieve HIV/AIDS-specific results. Support for RBF activities will target HIV and AIDS services in two regions selected because of the high burden of HIV, the overlap with GOT priority regions, and the overwhelming opportunities to leverage other USG funding, specifically for MNCH, malaria, and FP. PEPFAR/T will work closely with 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. As noted in section 5.2, the PEPFAR/T team plans to initiate negotiations with the GOT during the quarterly EC meetings with the goal of developing an agreement outlining the pace of transition for each element, including transition of government staffing and operational costs, as feasible, at local and national levels.

The availability and accessibility of life-saving commodities are the cornerstones to epidemic control. Many of the current challenges of the supply chain result from limited or poor planning. As such, HSS interventions in COP 2015 focus on strengthening supply chain performance management in all facilities in Scale-Up Districts providing HIV services, as well as national level institutions through the monitoring of key performance indicators. In addition, COP 2015 will continue to 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.

HSS activities relating to continuous quality improvement aim to achieve epidemic control through their inclusion in pre-service and in-service curricula and implementation through stepwise certification towards accreditation programs in Scale-Up Districts to improve both health worker performance and workplace conditions.

1. Brief Activity Description	Deliverables		Budget allocation		6. Implementing Mechanism		7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016	Name	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Adequate Supply of Health Care Workers												
Support MOHSW, NACTE, and TCU to adapt HIV competencies and training modalities into all pre-service education in-person and distance for cadres providing the majority of HIV-related services, having direct management responsibility for cadres providing these services, or providing the data needed to ensure delivery of high quality HIV-related services. Target: nursing university, mid, lower level Twinning; mid-level, lower level clinical cadres I-TECH, allied health, public health managers MUHAS SPH, M&E UCSF, and epidemiology cadres FELTP	HIV learning modules continuously reviewed and updated as needed within existing pre-service education curricula in-person and distance for: nursing, mid-level clinical, allied health, public health managers, M&E, and epidemiology cadres	HIV learning modules continuously reviewed and updated as needed within existing pre-service education curricula in-person and distance for: nursing, mid-level clinical, allied health, public health managers, M&E, and epidemiology cadres	252,000	400,000	I-TECH	13359	HRH Score: Red SIMS CEE 25.3 PEPFAR HRH Strategy Obj 3	X		X	X	X
			300,000	400,000	MUHAS SPH Follow On 17102	17102						
			400,000	400,000	AIHA/ Twinning Follow On	17305						
			500,000	300,000	African Field Epidemiology Network/ FELTP	13555						
			150,000	200,000	*[REDACTED]*	*[REDACTED]*						
Provide TA to universities in the lake zone to ensure utilization of curricula with adapted HIV competencies.	HIV learning modules adapted to MD and AMO curricula		370,000	-	Touch Foundation PPP	9618	HRH Score: Red Tech Cons p.271 PEPFAR HRH Strategy Obj 2	X		X	X	X
Strengthen ZHRCs' and health training institutions' capacity to effectively train nurses and midwives to deliver HIV/AIDS services in high priority regions	Teaching skills of tutors strengthened in health training institutions and ZHRCs; student performance assessment workshop established to ensure achieved competency in providing HIV/AIDS services	Teaching skills of tutors strengthened; Competencies of graduates assessed through student performance assessment workshop	200,000	800,000	JHPIEGO/ MCSP	17409	HRH Score: Red		X	X	X	
Support deployment and placement of HCW graduates to high priority sites.	Bonding framework and policy guidelines	Bonding policy guidelines rolled out to support	217,000	300,000	AIHA/ Twinning Follow On	17305	PEPFAR HRH Strategy Obj 3 HRH development	X		X	X	X

Cadres supported: nursing Twinning, public health MUHAS, field epidemiologists FELTP follow on	developed to support deployment of HCW graduates to priority sites	deployment of HCW graduates to priority sites and link implementation of policy to HRHIS planning	150,000	200,000	MUHAS SPH Follow On 17102	17102	section of HSSP IV					
Institutionalize CHW cadre	Benefits package and career track for CHWs finalized	Effective supervision structure developed and utilized	210,000	300,000	PS3	14693	HRH Score: Red Tech Cons p.240 PEPFAR HRH Strategy p.4		X			X
	Standardized CHW and social welfare curricula approved for nationwide rollout; CHWs and social welfare workers trained and providing services in Scale-Up Districts		630,000	630,000	JSI/CHSSP	14692	HRH Score: Red Planning & Coordination Score: Yellow Quality Mgmt Score: Yellow		X			X
	System developed to link CHW and pregnant girls and young women at risk of HIV to upgraded maternal facility care	Effective and sustainable referral system established from community to upgraded maternal facility	280,000	400,000	Vodafone Foundation PPP	12854	HRH Score: Red Tech Cons p.284		X			
Implement task shifting/ task sharing through MOHSW as an alternative model of service delivery to expand the supply of existing health workers that can provide HIV services at Scale-Up Districts, and to strengthen the referral linkages from OVC and HBC to improve pediatric treatment rates	Task sharing guidelines for clinical, nursing, and community health cadres approved by MOHSW and disseminated to districts	Competencies needed for quality task sharing amongst clinician and nurses reflected in in-service and pre-service training and in-service training rolled out	70,000	100,000	I-TECH	13359	HRH Score: Red Planning & Coordination: Score: Yellow PEPFAR HRH Strategy Obj 2	X	X	X	X	X
		Revised legislation for key health professions engaged in task sharing	42,208	200,000	MOHSW - Follow On	16887		X	X	X	X	X
		Scopes of practice for mid-level and allied health cadres revised	200,000	200,000	AIHA/ Twinning Follow On	17305		X	X	X	X	X
Implement task shifting/task sharing as an alternative model of service delivery to support Scale-Up Districts	# of nurses trained with HIV/AIDS skills based on new SOP	# of nurses trained with HIV/AIDS skills based on new SOP	70,000	100,000	TBD/ SHOPS Tz	18058	HRH Score: Red Tech Cons pgs. 42 and 47	X		X		X

	Task shifting guidelines implemented at the district level		100,000	TBD	PS3	14693	HRH Score: Red Tech Cons p.234 PEPFAR HRH Strategy p.4					
Strengthen use of HRHIS data at MOHSW to inform HRH recruitment, deployment, and retention to ensure there is adequate HRH capacity at high priority sites	MOHSW, RHMTs, and CHMTs able to use HR information systems to assess and project HRH and service delivery needs in Scale-Up Districts		141,461	-	RTI/ Data Warehouse	12728	HRH Score: Red PEPFAR HRH Strategy Obj 3	X	X	X	X	X
	Baseline assessment of HRH capacity needs completed for Scale-Up Districts	Recruitment, deployment, and retention developed and implemented	140,000	200,000	*[REDACTED]*	*[REDACTED]*		X	X	X	X	X
	Framework developed to harmonize the training institution information system TIIS to HRHIS	MOHSW capacitated to use HR information systems	70,000	100,000	I-TECH	13359		X	X	X	X	X
Support distribution of HRH to Scale-Up Districts	National and district level HRH planning improved to better distribute HRH to and within Scale-Up Districts.	More equitable distribution of HRH in Scale-Up Districts.	200,000	200,000	PS3	14693	HRH Score: Red Tech Cons p.233 PEPFAR HRH strategy p.4-5	X		X	X	X
	MD and AMO graduates to Mwanza, Mbeya, Geita, Mara and Shinyanga regions.	MD and AMO graduates to Scale-Up Districts.	250,000	490,000	Touch Foundation PPP	9618						
Establish sustainable financing for HCWs to support the transition of PEPFAR salary support	Framework and terms of conditions developed by PEPFAR and MOHSW to transition HCW salary support		140,000	200,000	Northrup Grumman/ PROMIS	13351	HRH Score: Red	X	X	X	X	X
Quality of Service Delivery												
Institutionalize in-service training to standardize, diminish number of trainings over time, and ensure capacity gaps at high priority sites are addressed	Framework and strategy developed to institutionalize all HIV-related training into an integrated MOHSW training plan	Strategy implemented and all PEPFAR trainings captured in MOHSW HRHIS	333,000	400,000	I-TECH	13359	HRH Score: Red PEFFAR HRH Strategy Objective 5 HRH Tech Cons 1.5.2 SIMS CEE 21.6	X	X	X	X	X

Improve professional regulatory frameworks and standards to ensure clinical teams providing HIV services at high priority sites are providing quality care	Standards established and implemented by professional associations for continuous professional development for nursing cadre		77,000	200,000	I-TECH	13359	HRH Score: Red PEPFAR HRH Strategy Obj 5 HRH development section of TZ HSSP IV	X	X	X	X	X
Support CQI activities intended to improve quality of HIV services in high priority sites. Develop strategies to strengthen CQI reporting and data use at various levels District, Region, National. Adapt CQI competencies and content for inclusion in pre-service and in-service curricula.	CQI competencies and content revised for pre-service training. QI Collaborative implemented to coordinate and share QI best practices.	CQI reporting and data use system established. Key staff trained at district, region and national to improve supportive supervision to Scale-Up Districts.	70,000	-	I-TECH	13359	Data Use Score: Yellow			X		
			70,000	100,000	*[REDACTED]*	*[REDACTED]*						
Support HRH performance and quality	Increased effectiveness of supportive supervision for HIV/AIDS services	Increased effectiveness of supportive supervision for HIV/AIDS services	200,000	200,000	PS3	14693	HRH Score: Red Tech Cons p.237 PEPFAR HRH Strategy p.6	X		X	X	
	HRH and health management teams incentivized to provide high quality HIV/AIDS services through targeted performance payments	HRH and health management teams incentivized to provide high quality HIV/AIDS services through targeted performance payments	500,000	500,000	RBF	18072	HRH Score: Red Tech Cons p.271 PEPFAR HRH Strategy Obj 5	X	X	X	X	X
	Clinical mentorship programs established to improve HRH performance in Mwanza, Mbeya, Geita, Mara and Shinyanga regions.	#MDs and AMOs mentored through clinical mentorship program in targeted geographic areas	359,500	495,000	Touch Foundation PPP	9618	HRH Score: Red Tech Cons p.271 PEPFAR HRH Obj 5	X		X	X	

Commodity Security and Supply Chain Management												
Improve supply chain performance management by strengthening forecasting, budgeting, and product availability.	FDA capacity built to improve drug registration process. A minimum of two visits per year to all facilities in VMMC saturation regions providing HIV services. Waste management and reverse logistics for VMMC products		1,760,000	2,350,000	SCMS	7234	Supply Chain Score: Yellow	X		X	X	
Strengthen Supply Chain Planning	Annual quantification and quarterly supply plan updates completed.		350,000	-	SCMS	7234	Supply Chain Score: Yellow	X		X	X	X
Provide technical assistance to MSD procurement unit to Improve MSD Operations	Contract management training for fleet and storage. Viral load logistics design. Improved supply chain management		460,000	460,000	SCMS	7234	Supply Chain Score: Yellow	X		X		X
Promote eLMIS application at facility level to ensure availability of HIV/AIDS commodities	Project management team formed. Application development begun. Hardware procured.		1,315,000	315,000	SCMS	7234	Supply Chain Score: Yellow	X		X		X
Data Use for Decision Making, Planning & Coordination												
Enhance management and planning for HIV service delivery by ensuring MOH staff working in HIV e.g., facility managers, RACs, DACs, RMOs, DMOs, RCH coordinators, etc. have access and can utilize key HIV information systems e.g., CTC, DHIS, eLMIS, HRHIS, etc.	Development of local processes and experts to manage and use the new information system component. ICT Infrastructure plan developed for proper management and documentation of financial resources.	Development of local processes and experts. Formal management and monitoring of availability of ICT infrastructure and core health information systems or services. Operating Procedures for supporting and managing e-health infrastructure	42,207	150,000	MOHSW - Follow On	16887	Planning & Coordination Score: Yellow Tech Cons p.- 272-273	X	X	X	X	X
			140,000	-	RTI/ Data Warehouse	12728						
			70,000	310,000	*[REDACTED]*	*[REDACTED]*						

Train HCWs at different levels to plan, collect, analyze and use data for decisions on program management to improve quality and cost-effectiveness of PEPFAR program services.	At least 60% of FELTP graduates employed within MOHSW units where they generate data, analyze it and assure its use in decision-making for HIV program strategic planning and management	At least 60% of FELTP graduates employed within MOHSW units	200,000	200,000	African Field Epidemiology Network/ FELTI	13555	Epidemiological & Health Data Score: Yellow		X			
Strengthen of key government public health institutions in coordination and management of the national HIV AIDS response	Coordinating mechanisms related to HIV, reviewed and updated. Combined operational plans that cover all inputs to health sector HIV/AIDS, staff requirements for support efforts. Use of available staff and financial resources. Mentorship or support for key HIV leaders or managers. HIV activities of CSO, private sector, donor partners coordinated by Host country government	Central leadership and oversight of HIV response strengthened. Inputs and activities coordinated, duplications and gaps addressed, joint operational plans developed by Host country government. Staffing Actual vs Needs monitored for key positions related to HIV response within MOHSW, NACP, and RHMTs.	420,000	650,000	*[REDACTED]*	*[REDACTED]*	Planning & Coordination Score: Yellow	X	X	X	X	X
Healthcare Financing												
Support GOT to roll out Results-based Financing activity in high burden HIV regions.	Roll out of incentives for PMTCT, HIV testing, HIV treatment, and VMMC in two high burden HIV regions	Continued implementation in two high burden HIV regions	6,031,593	TBD	RBF	18072	Performance Data Score: Yellow HRH Score: Red Quality Mgmt Score: Yellow Tech Cons pgs. 33, 106, 161, 165, 169	X		X	X	
Support GOT to conduct costing analyses to monetize efficiency gains that will benefit HIV	Costing analyses to assess allocative and technical efficiency for HIV/AIDS completed.	Costing analyses to assess allocative and technical efficiency for HIV/AIDS completed.	140,000	TBD	*[REDACTED]*	*[REDACTED]*	Allocative Efficiency Score: Red Technical Efficiency Score: Yellow	X		X		
			100,000	600,000	PS3	14693						

Support GOT to establish arrangements to sustain HIV/AIDS Trust Fund	Trust fund institutional arrangements established. Long term strategic plan established.	Trust fund comprises x% of total HIV/AIDS expenditures	140,000	600,000	*[REDACTED]*	*[REDACTED]*	Resource Commitments Score: Yellow Tech Cons pgs. 270, 311	X		X		
			100,000	600,000	PS3	14693						
Expand health insurance to cover HIV/AIDS services, including HIV/AIDS treatment and treatment for opportunistic infections	#PLHIV insured #OVC insured #single mothers insured	#PLHIV insured #OVC insured #single mothers insured	70,000	100,000	Advancing Partners and Communities	18059	Access & Demand Score: Yellow Resource Commitments Score: Yellow	X		X	X	x

6.4 Above Site Level activities in Other Technical Areas

1. Brief Activity Description	Deliverables		Budget allocation		6. Implementing Mechanism		7. Relevant Sustainability Element and Score	Impact on Epidemic Control				
	2. 2015	3. 2016	4. 2015	5. 2016	Name	ID		8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Voluntary Medical Male Circumcision												
Support use of the Decision-Makers' Program Planning Tool DMPPT to enable decision-makers to understand potential cost and impact of various options for VMMC scale-up.			150,500	-	Pop Council/ SOAR	17357	Financial /Expenditure Data Score: Yellow				X	
Infection Prevention and Injection Safety												
Facilitate IPC supportive supervision for R/CHMTs members HMTs in four new regions Geita, Katavi, Njombe and Simiyu	Supportive supervision at the health facility level conducted by R/CHMT teams	Training and supportive supervision at the health facility level by R/CHMT teams	112,553	112,553	MOHSW - Follow On	16887	HRH Score: Red	X	X		X	
Blood Safety												
Support accreditation of all zonal centers and satellites by African Society for Blood Transfusion AfSBT standards	Three zonal centers to attain at least level one AfSBT accreditation	Seven zonal centers to attain at least level one AfSBT accreditation	105,000	105,000	MOHSW Blood Follow On	17343	Quality Mgmt Score: Yellow	X	X			
			25,000	25,000	*[REDACTED]*	*[REDACTED]*						
			120,000	120,000	AABA/ Blood TA	13013						
			50,000	50,000	*[REDACTED]*	*[REDACTED]*						
Build capacity through TA to the government entities on blood safety operations in eight regions (Rukwa, Katavi, Shinyanga, Simiyu, Manyara, Singida, Pwani, and Kagera)	Meeting with stakeholders to plan capacity building framework and implementation. Orientation for management. Training and mentorship of regional staff and management teams. Quarterly supportive supervision.	Quarterly supportive supervision conducted. Periodic assessment of capacity and mentorship conducted. Training on gaps conducted. Exit plan and stakeholders meeting.	100,000	100,000	TRCS	14544	Quality Mgmt Score: Yellow	X	X			

Support connectivity of Blood Electronic Computer System BECS connectivity to Satellite and hospital information system HIMS.	Two of seven blood satellites connected to BECS	All seven satellites connected by September 2017 to BECS; hemovigilance system for big transfusion hospitals in place	205,000	205,000	MOHSW Blood Follow On	17343	Quality Mgmt Score: Yellow	X	X			
			65,000	65,000	*[REDACTED]*	*[REDACTED]*						
			80,000	80,000	AABA/ Blood TA	13013						
Counseling and Testing												
TA to the faith-based organizations on HIV testing and counseling	Tools and guidelines developed to integrate HTC services using a faith-based platform	Policies and guidelines developed to integrate HTC services	280,000	TBD	Balm in Gilead/ FBO TA Provider	13553	Planning & Coordination Score: Yellow	X	X	X		
Orphans and Vulnerable Children												
Build capacity, organizational strengthening, establish national trainers and develop curriculum through the Twining DSW and ISW program	Curriculum developed for social welfare worker cadres. Social welfare training institutes and associations strengthened.		660,000	1,100,000	AIHA/ Twinning Follow On	17305	Planning & Coordination Score: Yellow	X	X	X	X	X
Lead evidence-based QI program to optimize functional bi-directional linkages of OVC from community to health facilities to improve care and treatment	Tools and standardized guidance to prevent and address LTFU along the continuum of care developed		175,000	100,000	URC/ ASSIST	17082	Access & Demand Score: Green		X		X	X
Support LGAs to improve public financial management and planning; support national level on systemic HR issues that affect the placement, retention, and benefits packages for CHWs.	LGA retention and benefits packages for CHWs developed. Increased number of the CHW deployed at the LGA level.		210,000	200,000	PS3	14693	Planning & Coordination Score: Yellow				X	

Integrate nutrition into HIV programming through various program strengthening initiatives. Conduct policy and guideline reviews, training for HCW and CHW on NACS. Develop and disseminate nutrition and HIV tools and job aids to facilities and community programs.	TOTs in nutrition and subsequent trainings for volunteers and community para social workers conducted. Rapid nutritional screening conducted. Referral reports produced. Community NACS toolkit finalized as a part of scaling up infant feeding counselling services.		280,000	300,000	FHI 360/ FANTA III 14685	Quality Mgmt Score: Yellow		X	X	X	X
Provide TA to MOHSW and IPs on child protection to develop national parenting guidelines to ensure harmonization of HIV management and management of severe acute under nutrition among vulnerable children.	Life-saving essential nutrition commodities procured for severely undernourished HIV-exposed and positive children. IP capacity strengthened to manage programs on severe acute malnutrition among vulnerable children. National child protection training manual and guidance standardized. National communication package on child protection developed.		280,000	300,000	UNICEF Follow On 17316			X	X		
Provide support to strengthen community HRH among CHWs and para social workers; and build the capacity of CSOs and supporting networks	HRH strengthened. CSO capacity built		1,000,000	500,000	JSI/CHSSP 14692	Supply Chain Score: Yellow		X			

Work with relevant ministries, departments and stakeholders to facilitate, support, and strengthen the Gender and Children's Desks justice system	Harmonized and functional child justice system		210,000	300,000	UNICEF Follow On	17316	Enabling Environment: 15. Planning & Coordination: 7.0	X				
Increase access to insurance services among OVC	Increased proportion of OVC with access to insurance services		70,000	TBD	Advancing Partners and Communities	18059			X	X	X	
Support demand creation and integrated communication activity	Increased uptake of HIV services through demand generation. Increased awareness of HIV-related information		210,000	TBD	*[REDACTED]*	*[REDACTED]*		X	X	X	X	
Build evidence on the impact of community owned and run economic strengthening interventions on sustainable OVC care	Economic strengthening assessment, study, and impact report conducted. Increased evidence on the impact of economic strengthening interventions on OVC care in community		280,000	100,000	FHI 360/ ASPIRES	17151			X		X	X
Create enabling environment to advance youth access to HIV services through strengthening of the Ministry of Information, Youth, Culture and Sports	Revised policies, increased advocacy for youth rights. Barriers to HIV services among youths aged 15-18 years addressed. Other USAID programs leveraged to empower adolescents, women and children empowered to transition into adulthood		350,000	TBD	YouthPower	18057		X	X	X	X	
Home Based Care												

Work with NACP to strengthen workforce policies, and processes for task shifting to increase community level HRH (Health Aides and CHWs)	Standard Guidelines, SOPs, job aids in Kiswahili developed. Training needs identified and trainings delivered for community level HRH in line with task sharing policy guidelines	Trainings delivered for community level HRH in line with task sharing policy guidelines	800,000	1,100,000	AIHA/ Twinning Follow On	17305	Enabling Environment 15. Planning & Coordination: 7.0 Score: Yellow	X	X	X		X
Support national DMS development, rollout to regions, training and support to implementing partners	Database for HBC services developed and standardized CBHS reports from regions obtained	Data base maintenance and trouble-shooting conducted	280,000	200,000	URC/ ASSIST	17082	Performance Data Score: Yellow	X	X	X	X	X
Provide TA to MOHSW QI Directorate to institutionalize QI standards through the Stepwise Certification towards Accreditation (SWCA) initiatives in primary health facilities	Training of HCWs/RHMTs/CHMTs to become Safe Care Facilitators. Baseline assessment of high priority sites conducted to identify quality gaps and prioritize improvement.	Recognition of progressive improvements made towards accreditation status and safe care step awarded.	490,000	TBD	CDC PPP Management	17296		X	X	X	X	X
Provide TA to task force secretariat to formalize and develop of curricula for community health aid cadre	Harmonized CHW cadre, CHA curricula		700,000	1,000,000	JSI/CHSSP	14692	HRH Score: Red	X	X	X	X	X
Provide national TA support for integration of HIV implementation into nutrition assessment counseling and support	TOT training, printing of tools and job aids		140,000	200,000	FHI 360/ FANTA III	14685	Planning & Coordination: Score: Yellow		X	X		X
Conduct HIV Community care study to better understand cost of HIV/AIDS community based care treatment and support services, aiming at determining the unit cost per clients served.	Study protocols developed and submitted for approval.	Study report completed and available for use.	315,000	TBD	ICF Macro	17982					X	
Provide national support to improve HBC data, study and reporting system	Updated national HBC data base and tools, Study report	Training on the data base and roll out tools for data collection. Dissemination of the study reports	210,000	200,000	MEASURE Associate Award	16569	Enabling Environment Planning & Coordination		X			

Provide TA to MOHSW to strengthening the workforce, policies and processes for health aides and CHWs through MAT	Training needs identified and trainings delivered for Community level HRH in line with task sharing policy guidelines. Quality indicators for facilities providing MAT established	Trainings delivered for Community level HRH in line with task sharing policy guidelines. National tool for supportive supervision of MAT and integrated services rolled out	93,028	250,000	MOHSW - Follow On	16887	HRH Score: Red	X	X	X	X	X
Provide TA to develop national guidelines development for KP and MAT	Revised policies and guidelines to incorporate MAT. National trainers, standardized and service packages coordinated	MAT package dissemination and service roll-out completed	225,000	300,000	MUHAS-TAPP	16885	Planning & Coordination: Score: Yellow	X	X	X	X	X
Strengthen organizational capacity and regional coordination of PLHIV groups through policy advocacy and strengthening networks for Greater Involvement of People Living with HIV/AIDS GIPA	PLHIV policies, functional district HIV clusters and reporting system in place	Coordinated and functional district HIV clusters and reporting system	1,118,842	1,000,000	NACOPHA	14691	Planning & Coordination: Score: Yellow	X	X	X	X	X
PMTCT												
Develop and communicate government orders, guidelines and policies, update M&E tools and training material for LLAPLA implementation.	Guideline and policies developed and disseminated to regions, districts and facilities. Improved district and regional capacity to plan monitor and deliver quality services. Completed data quality assessment, data abstraction from PCR lab. Data triangulation from various data sources completed.	Implementation of PMTCT guidelines.	818,910	1,680,000	NACP Follow-on	14573	Planning & Coordination: Score: Yellow	X	X	X		X

Establish training for nursing and midwives at private medical training institutes to build practical skills in HIV and health to advance implementation of new task shifting policy, particularly in adult HIV treatment and prevention of MTCT.	Nursing and Midwives training established for private medical training institutes.	Nursing and Midwives training established for private medical training institutes.	350,000	-	SHOPS Tz	18058	HRH Score: Red	X		X		
Provide TA to MOHSW PMTCT unit to develop training curriculum and support scale-up of the integration of pediatric ART services in RCH services in the context of Option B+.	Training curriculum for integration of pediatric ART in RCH developed. Best practices shared during the quarterly regional and district meetings.	Improve retention of pediatric HIV patient through the use of expert mother model.	140,000	500,000	BIPAI-PPP	17103	Access & Demand Score: Green	X	X	X		
Provide national level technical support to develop and implement strategies, guidelines, and policies for PMTCT B+ integration and pediatric HIV services into maternal, newborn, and child health MNCH services.	PMTCT B+ and pediatric HIV services integrated into MNCH services. Improved national PMTCT/EID monitoring systems. Costed PMTCT action plan in place.	PMTCT B+ and pediatric HIV services integrated into MNCH services. Improved national PMTCT/EID monitoring systems.	350,000	500,000	UNICEF Follow On	17316	Planning & Coordination: Score: Yellow	X	X	X		
Strengthen governance at the district level to use resources transparently and increase citizen engagement in the planning and monitoring of resources.	Improved accountability and transparency in resource management. Strengthened coordination of HR management and appropriate commodity procurement and distribution. Implementation of a national task-sharing policy supported.	Improved accountability and transparency in resource management. Strengthened coordination of HR management and appropriate commodity procurement and distribution. Implementation of a national task-sharing policy supported.	280,000	TBD	PS3	14693	Public Access to Information Score: Yellow				X	

Reduce vacancy rates at dispensaries and health centers. Expand task sharing for HIV service delivery. Support integration of CHWs into overall health system. Support GOT rollout of results-based financing initiative, HIV/AIDS trust fund, and efficiency strengthening activities. Support GOT to enhance data use for decision-making through support to eHealth strategy.	District and national level HRH planning improved to better distribute HRH to and within Scale-Up Districts. CHWs integrated in health system. Results based financing rolled out. Support to the GOT on data use and decision making.	More equitable distribution of HRH in Scale-Up Districts	945,000	TBD	PS3	14693	HRH Score: Red Public Access to Information Score: Yellow			X		
Support the national eMTCT agenda and uptake of Option B+ nationwide through communication TA to MOHSW and IPs, materials development and production, working in an integrated fashion by supporting safe motherhood campaigns that addresses early and complete antenatal care attendance, PMTCT, couples HIV testing and counseling, malaria prevention, individual birth planning, and safe delivery.	Communication material for Option B+ developed. Improved ART adherence. Safe motherhood campaign conducted. PMTCT integrated into Green Star family planning campaign.		350,000	TBD	*[REDACTED]*	*[REDACTED]*	Access & Demand Score: Green		X	X		X
Provide TA to IPs in Family planning/PMTCT integration as part of comprehensive service delivery and support of PMTCT prong 2.	Family planning/ PMTCT integration at service delivery level		400,000	600,000	Engender Health/ RESPOND	16820	Access & Demand Score: Green		X	X		X
Provide TA at the national level on implementation and monitoring of PMTCT, including focus on: national plans and tools; national M&E systems to assess progress and improve quality and outcomes of LLAPLA services; scaled-up EID training for RCH workers. Manage and market national PMTCT resource center website and social media components, including using the website as a platform for online learning,. Support partner coordination and communication to promote successful scale-up of high impact PMTCT interventions.	National eMTCT plan developed, printed, disseminated. National PMTCT tools reviewed, printed, and disseminated. Scaled up PMTCT interventions in Zanzibar. Improved M&E systems, including increased use of PMTCT dashboard. RCH workers trained on EID. Increased uptake of improved media on PMTCT.		415,750	415,750	THPS/ Local FOA Follow on	16874	Access & Demand Score: Green		X	X		X

Adult and Pediatric Treatment												
Provide technical support to monitoring requirements and tracking development and deployment of upgraded information systems to support medical records across HIV continuum of care.	National management and coordination strengthened. Documentation of use cases and requirements improved to guide evaluation and selection of system solutions.		210,000	TBD	*[REDACTED]*	*[REDACTED]*	Performance Data Score: Yellow		X	X		X
Integrate HIV competencies into MD, AMO, and nursing program curricula	# of MDs and AMOs trained # of Nurses trained		200,000	TBD	Touch Foundation PPP	9618	HRH Score: Red			X		X
Coordinate national HIV/AIDS response through the Zonal HIV/AIDS Response Framework in Mbeya, Rukwa, Ruvuma and Katavi	Redefined accountability and reporting structures in four regions (Mbeya, Ruvuma, Rukwa and Katavi) in place. Political and local government administrative mechanisms and structures enlisted for accountability and impact.		225,000	225,000	TACAIDS-M&E	12234	Planning & Coordination Score: Yellow			X		
Support policy advocacy and development/updates for national HIV guidelines	Policy in place and updated national HIV guidelines incorporated in the new HIV Care and Treatment guidelines. National ART M&E tools reviewed and updated to facilitate pediatric HIV services monitoring		140,000	TBD	WHO Follow-on	16886	Performance Data Score: Yellow				X	
Support RHMT/CHMT leadership and management capacity-building on data management and dissemination, M&E. Conduct performance based incentives schemes. Establish and establish functional QA teams in facilities to	Targets achieved. Supportive Supervision and mentorship conducted. Improved documentation,		50,000	50,000	Kagera RHMT	14551	Quality Mgmt Score: Yellow				X	
			50,000	50,000	Mtwara RHMT	14552						
			50,000	50,000	Mwanza RHMT	14553						
			50,000	50,000	Pwani RHMT	14554						

improve HIV/AIDS services.	R&R at regional, district and facility levels. LGA ownership of care and treatment services. Funds for HIV/AIDS services available at LGA level. HCWs updated on care and treatment services		50,000	50,000	Tanga RHMT	14555						
Support revision of pediatric training package to implement new WHO guidelines.	Better coordinated, government-led pediatric HIV response with national monitoring tools, training materials, and SOPs in place.		310,979	TBD	NACP Follow-on	14573	Access & Demand Score: Green		X	X	X	
Support for systems analysis and requirements for site level electronic information systems to support medical records, including promotion of documentation of requirements, analysis and review of system or design options to support evolution of patient level data systems. Linkage of site level C&T systems to national program monitoring systems including automated collection, aggregation and transmission of core indicator data from service delivery, district and national levels to inform clinic and program management decisions at all levels, including USG and other donors.	Technical Support to MOHSW, NACP on efforts to strengthen HIV C&T facility level patient record systems. Coordinates learning process to improve understanding of benefits and issues related to next generation of HIV EMR. Documentation of use cases and requirements, and use of these to guide evaluation and selection of system solutions.		200,000	TBD	RTI/ Data Warehouse	12728	Performance Data Score: Yellow				X	

Institute QI methodologies in all Scale-Up and some Sustained Districts with high rate of LTFU, including use QI teams at ART sites to implement strategies to prevent LTFU, monitor adherence, and plan adherence sessions for clients with poor adherence, and capacity-building of regional QI focal person to coordinate regional QI activities.	Scaled up QI teams at ART sites in Scale-Up Districts. Addition of two beneficiaries to QI teams to bring in client perspective. Community QI teams among CHWs established. QI dashboard and database developed to monitor and report on QI nationwide. Adherence, treatment retention and sustained viral of suppression among adult ART clients improved		175,000	TBD	URC/ ASSIST	17082	Quality Mgmt Score: Yellow			X		X
Provide TA and capacity building to strengthen service provision by local IPs, focusing on five critical technical areas: 1. PMTCT 2. Care and Treatment Clinical Services for adults and children; 3. Pediatric Care and Treatment 4. Surveillance and SI 5. Laboratory Work will include assessing HIV service delivery quality and developing TA plans and strategies for local IPs.	WHO care and treatment guidelines adopted. Scaled up quality HIV care and treatment programs for adults and children to reach targets. Increased HR capacity in PMTCT, ART, TB/HIV service delivery, program management and supervision, and SI. Commodity security and supply chain management strengthened.		2,500,000	TBD	*[REDACTED]*	*[REDACTED]*	Access & Demand Score: Green		X	X		X

Provide leadership and coordination on provision of quality HIV care and treatment services for Zanzibar, including guidance and oversight of policy and guideline implementation. Build regional capacities for coordination, commodities management, and operationalization of national guidelines, and promote inclusion of community based services funding in Council plans. Implement supportive supervision and mentorship of providers at regional, district and facility levels. Ensure availability of quality, reliable HIV data.	Guidelines and policies updated and available. Funds for HIV/AIDS services at LGA level available. Functional M&E system. Standardized and coordinated service packages, and R&R tools developed. HCW trained and updated; Quality of HIV services improved.		621,693	TBD	*[REDACTED]*	*[REDACTED]*	Planning & Coordination Score: Yellow		X	X		
Provide leadership and coordination on provision of quality HIV care and treatment services for Mainland, including guidance and oversight of policy and guideline implementation. Build regional capacities for coordination, commodities management, and operationalization of national guidelines, and promote inclusion of community based services funding in Council plans. Implement supportive supervision and mentorship of providers at regional, district and facility levels. Ensure availability of quality, reliable HIV data.	Guidelines and policies updated and available. Improved community based HIV services. Funds for HIV/AIDS services at LGA level available. Functional M&E system. Standardized and coordinated service packages, and R&R tools developed. HCW trained and updated; Quality of HIV services improved.		855,191	TBD	NACP Follow-on	14573	Planning & Coordination Score: Yellow		X	X		
Provide TA on development, review and adaptation of national HIV policies and guidelines. Provide technical guidance to MOHSW to develop and ensure implementation of program-specific regional strategic scale-up plans. Build capacity of MOHSW and regional authorities to deliver and monitor quality pediatric HIV services at scale.	Updated national pediatric policies, strategies, guidelines, SOPs and job aids. Regional pediatric program strategies in place.		360,000	TBD	UNICEF Follow On	17316	Quality Mgmt Score: Yellow	X	X	X		
TB/HIV												

Coordinate TA to ensure stronger collaboration between NACP and NTLP, and improved management of TB/HIV co-infected patients	100% implementation of national policy on management of co-infected patients. Collaborative TB/HIV program coordination		70,000	TBD	WHO Follow-on	16886	Planning & Coordination Score: Yellow			X	X	
Support NTLP to develop and implement a QI Collaborative and institutionalize QI capacity at the national, regional, and district levels.	Increased percentage of TB patients co-infected with HIV receiving ART in targeted TB clinics through evidence- based CQI approaches		70,000	TBD	I-TECH	13359	Access & Demand Score: Green		X	X		X
Provide technical assistance in TB, MDR TB to MOHSW/NTLP and Kibongoto National TB reference hospital	95% of registered TB patients screened for HIV. 90% linked for ART services. 100% of co-infected patients started on ART.		420,000	TBD	*[REDACTED]*	*[REDACTED]*	Access & Demand Score: Green		X	X		X
			1,000,000	TBD	KNCV TB Foundation	17420						

7.0 Staffing Plan

The COP 2015 development process required staff to systematically use data to develop targets, budgets, and programming that support sustained epidemic control through the efficient use of PEPFAR funds. As a result, there has been an increase in data use and analysis among both program and management staff, for both SI and EA analysis.

Each implementing agency in PEPFAR/T conducted a 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. The main increases in management and operations costs in COP 2015 are to support increased programmatic data use and performance monitoring, including the full implementation of SIMS.

The implementation of SIMS in FY 2016 has led to a 54.6% increase in management and operations costs, which is also influenced to a smaller extent by a global rise in ICASS and Capital Security Cost Sharing rates. The SIMS contribution to this significant increase takes into account all funding requirements from the SIMS Action Planner. It also incorporates plans for additional support secured through a contractor to meet the gap remaining after a 25% Level of Effort (LOE) of existing staff.

USAID requests two new positions, one of which is a Data Analyst at USAID to serve as an agency lead for SIMS as well as support analysis and data use of both financial (EA) and programmatic (SI) data. The second request for USAID is for a Senior Clinical Specialist to lead the USAID Clinical Team and supplement the technical expertise for core efforts to reach epidemic control. USAID has also requested the use of an institutional contractor to meet the SIMS reporting requirements.

In addition, in COP 2015, USAID has consolidated its program evaluation and M&E capacity building through a third-party contractor, entitled the Monitoring, Evaluation and Learning Program (MELP). MELP will provide continuous, on-demand and systematic support to USAID/Tanzania on performance monitoring, data verification, environmental compliance, impact and performance evaluations, research and studies, organizational learning, and knowledge management. The contract will include: evaluations, studies, and assessments; capacity building on M&E and data analysis for USAID staff, our implementing partners, and other key local partners; and collaboration, learning and adapting support, which includes GIS services, learning plans, learning events, and regional coordinator representatives. The additional support from MELP will liberate time for program staff to redirect toward the intense data analysis and SIMS activity expected as part of the PEPFAR pivot.

The PEPFAR Coordination Office requests a new Central Initiatives Coordinator hired as a personal services contractor through USAID located in the PEPFAR Coordination Office to oversee the planning and implementation of the numerous central initiatives for which Tanzania receives funding.

DOD requests four new positions, including two Site Monitoring/Linkage and Retention Monitoring Specialists to ensure retention of patients throughout out the clinical cascade; and to enhance and systematize site monitoring for improvement, and quality assurance processes to positively impact epidemic control and outcomes of PEPFAR's investments in high HIV burden Scale-Up Districts in the Southern Highlands. DOD also requests a Technical Program Manager to provide strategic planning and project management in the Southern Highlands, including day-to-day technical direction and supervision to other technical members of the WRAIR-Tanzania team. The Technical Program Manager will manage communications and coordination involving Implementing partners, Regional/District Health Management teams, Ministry of Health and other key stakeholders. DOD also requests the addition of a Quality Improvement Advisor to enhance and systematize quality improvement and assurance processes

to positively impact epidemic control and PEPFAR's investments in high HIV burden Scale-Up Districts supported by WRAIR-Tanzania Implementing partners. The Quality Improvement Advisor will provide comprehensive technical guidance in building capacity for quality assurance, quality improvement, laboratory accreditation, and ensuring retention throughout the clinical cascade to achieve 90/90/90 goals.

CDC and Peace Corps are not requesting new positions in COP 2015.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for 2015 COP

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	Provision of high quality behavioral, biomedical, and structural interventions for key and carefully selected priority populations in Scale-Up Districts that reduce the likelihood of HIV acquisition and onward HIV transmission; Surveillance and mapping interventions to ensure appropriate targeting. Continuum of facility and community health services, including treatment failure detection, clinical monitoring, and demand creation, in Scale-Up Districts and populations. Monitoring of program outputs, outcomes and quality; Health management information systems to support HIV prevention, care and treatment. Implementation of evidence-based quality interventions for PLHIV & OVC support that enhance bi-directional referral and linkages between core community and facility programs and promote retention and adherence to promote viral suppression.	Support quarterly supervision.	Provision of behavioral, biomedical, and structural interventions for general (non-priority) populations and support in non-priority geographic locations Demand creation, in Sustained Districts and populations Constructions/renovations for health facilities and training institutes. Provision of interventions for legal services and direct subsidies for scholarships, transport, health insurance to the OVC and PLHIVs. Support basic and refresher training in Pain Management and palliative care.
Sub-national level	In strategic locations, provision of high quality behavioral, biomedical, and structural interventions for key and priority populations that reduce the likelihood of HIV acquisition and onward HIV transmission; Surveillance and mapping interventions to ensure appropriate targeting Coordination and monitoring of HIV services at regional and district levels. Monitoring of program outputs, outcomes and quality; Health management information systems to support HIV prevention, care and treatment Capacity-building of the local government authorities, CSO and PLHIV clusters to provide TA on service provision and supportive supervision.	Capacity-building for interpreting and using data for decision-making; Health Information Systems inclusive of HIV/AIDS Implementation of the interventions that will support district monitoring and reporting, mapping of services to facilitate referrals linkages and coordination of services, dissemination of the policy and guidelines to harmonize service provision. Allowance and top ups for health care providers.	In low burden areas, provision of behavioral, biomedical, and structural interventions for the general population Surveys for Sustained Districts Support monthly council meetings and ToTs
National level	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 Policy and guideline development, printing and dissemination.	Capacity-building for interpreting and using data for decision-making; Health Information Systems inclusive of HIV/AIDS Procurement of selected commodities and supplies to cover needs above GFATM	Routine procurement of male and female condoms as well as HIV rapid test kits Routine procurement of commodities such as HBC kits, and water treatment tablets. Subsidized ITN procurement & residual

Table A.1 Program Core, Near-core, and Non-core Activities for 2015 COP

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	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. 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	and MOHSW coverage (gap filling for PEPFAR scale-up) Revision of national policies and guidelines. National data management system and Community human resource development to ensure sustainability of programs. Technical assistance for blood safety and infection prevention and control	spraying, Surveys for non-essential areas

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
Key and vulnerable populations			
Key populations (SW, MSM, 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.	
Priority populations (Adolescent and young women ages 15-24 yrs; clients of sex workers; men in mobile occupations; uniformed services; prisoners)	Geographically-targeted continuum of behavioral, biomedical, and structural interventions 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
Prevention			
Prevention of Mother to Child Transmission, Option B+	PMTCT option B+ in Scale-Up Districts		
EID	EID, geographically targeted to follow PMTCT	EID commodity procurement	
HIV testing and counseling	In Scale-Up Districts, 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 Districts, PITC in ANC and TB settings when 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.	Community-based HTC to key and vulnerable populations in non-identified hot spots in Sustained Districts	Rapid test kit procurement (GFATM Procured)
Voluntary medical male circumcision	Service delivery, demand creation, and commodity procurement for 10-29 year old males	TA and service delivery, including commodity procurement, for early infant male circumcision	

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
		in regions that have achieved or are approaching 80% coverage of 10-29 year old males	
Behavior change communication	Targeted health communications, focused on key and carefully selected priority populations 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 Procurement/packaging of lubricant for key populations	Bulk procurement of condoms, both socially marketed and public sector for general population (GFATM/other procured)	
Infection prevention and control		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 program activities, and advocate incorporation of IPC-IS in service training into Comprehensive Council Health Plans (CCHPs). Provide TA to implementing partners to integrates IPC-IS Into their programs	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 MOHSW, MOHZ and RALG ministries
Blood safety		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	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

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
		eight regions	supplies.
Care and treatment			
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 Districts 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 MOHSW coverage	Demand creation, in Sustained Districts 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 MOHSW 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) CHW support -adherence counseling and referral services	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	Screening; case finding, infection control; referral, ART, INH; HTC in areas and populations with highest number of HIV infections	OI Procurement to cover needs above GFATM and MOHSW coverage (gap filling for PEPFAR scale-up)	Routine TB Drug Procurement (GFATM Procured)
Cervical cancer		Client screening, treatment & referral support; in-service training of TOTs and providers, procurement of commodities (e.g. CO2), supplies, equipment; QA and performance monitoring, reporting and QI	
Health systems strengthening			
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.	

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
		Procurement of lab commodities for gap filling beyond GFATM and MOHSW 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 MOH 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+, VMMC. Support task sharing implementation as an alternative 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 zonal health resource centers to conduct and manage HCW, CHMT, RHMT and faculty trainings in the regions	
Institutional capacity-building (units/ organizations/ GOT institutions)		Support sustainability approaches in order for GOT to effectively deliver HIV/AIDS services. These components are outlined in the Sustainability Index: 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	
Supply chain	Supply Chain Management TA 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

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
	Population-based HIV impact assessments (PHIA) HMIS at the facility level Key populations surveillance;	Support (software, application and infrastructure) for interoperability between facility and above site levels of Health Information Systems inclusive of HIV/AIDS	
Health financing	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 Districts	Constructions/renovations for health facilities and training institutes.

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in 2015 COP	Estimated Funding in COP 2016	# of IMs	Transition End date	Notes
Rapid test kit procurement	N/A	$0	$0	0	N/A	Already GFATM supported
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 MOHSW, 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
Surveys for non-essential areas	n/a	50,000	0	1	n/a	COP 2015 has a one-off activity (TBD/Regionalization Study) aimed at identifying the impact of PEPFAR geographic shift in terms of availability of HIV/AIDS related services. No plan to transition this discrete activity.

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 Districts remain near-core. PEPFAR/T will spend down current pipeline for any remaining infrastructure activity in previously approved COPs.
Procurement of Commodities such as HBC Kits, Water treatment tablets and condoms. Subsidizing ITN procurement & residual spraying,	Transition to government	$0	$0	0	2016	Revision of the HBC kit Contents is ongoing, prior transitioning to the government 2016
Support monthly council's meetings and the training of ToTs.	Transition to local government	$0	$0	0	2015	
Volunteer incentives	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 machines.	Service contracts with manufacturers as machines are placed	$1,700,000	$1,500,000	1	2017	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.

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$9,717,849	**$412,049,754**	**$421,767,603**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$41,805,561
HVAB	Abstinence/Be Faithful Prevention	$0
HVOP	Other Sexual Prevention	$15,320,270
IDUP	Injecting and Non-Injecting Drug Use	$1,831,911
HMBL	Blood Safety	$1,376,648
HMIN	Injection Safety	$579,238
CIRC	Male Circumcision	$28,118,698
HVCT	Counseling and Testing	$17,549,586
HBHC	Adult Care and Support	$45,871,674
PDCS	Pediatric Care and Support	$8,495,586
HKID	Orphans and Vulnerable Children	$36,457,183
HTXS	Adult Treatment	$129,005,027
HTXD	ARV Drugs	$31,256,795
PDTX	Pediatric Treatment	$10,759,106
HVTB	TB/HIV Care	$9,727,858
HLAB	Lab	$4,207,010
HVSI	Strategic Information	$10,771,484
OHSS	Health Systems Strengthening	$12,747,648
HVMS	Management and Operations	$15,886,320
TOTAL		**$412,049,754**

B.2 Resource Projections

PEPFAR/T used the Expenditure Analysis (EA) data throughout the COP process. In the early phases of COP development, Interagency Technical Teams (ITTs) conducted an outlier analysis. Although there were some implementing partners/sub-national unit combinations that had extremely high Unit Expenditures (UEs), it was decided that these outliers should not be removed when calculating the unit cost. However, the application of those average unit costs in the PBAC tool will lead to the relevant implementing partners needing to adjust their support to be more in line with the national average. All UEs were derived in consultation with the Finance and Economic Working Group representative.

Among target driven ITTs, all but one ITT used the EA unit costs and the PBAC tool for budgeting purposes. Individual ITTs derived budget code amounts through the PBAC with district level targets with national UEs and then used partner UEs to determine partner budgets.

PEPFAR/T decided to budget for health commodities separately. Thus, the cost of all commodities (ARVs, non-ARV drugs/reagents, HIV test kits, and condoms) was removed from the unit cost in each ITT's unit expenditure with the exception male circumcision. To budget for commodities, PEPFAR calculated the additional number of patients to be served above the Global Fund cap of 657,000 patients. UEs (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.

The Health Systems ITT did extensive analysis of EA data. By first filtering for target driven partners, PEPFAR/T was able to provide information to each ITT, how much of their expenditures had been on health systems activities. ITTs used this information to inform how much of their budget should be for non-target (or non-unit expenditure) driven activities. The HSS ITT also used the balance budget of HSS expenditures as a guideline for their approximate budget for COP 2015.

HTC

Facility-based testing (FBTC), largely PITC, will be supported by clinical partners who also receive HTXS funding. The unit cost of $5.50 was applied to FBTC in Scale-Up Districts and $3.00 in Sustained Districts. For community-based HTC, various unit costs (ranging from $6 to $20) have been used depending on the modality, target population, geography such as islands and mining areas, as well as package of services being offered. 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 Districts in line with the scale-up trajectory in those areas.

Care and Treatment

PEPAR/T used the average national unit expenditures to allocate resource across all districts i.e. Scale-Up and Sustained Districts. 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 Districts. The UEs used excluded ARVs, Non-ARV Drugs/Reagents, HIV test kits and Condoms as these activities are not expected to be carried out at district or facility level. The regional level IM unit expenditures were used as a proxy for the district UE to allocate districts' IM level budgets. A product of district's targets and unit expenditures was summed up to come up with individual IM budget for all districts supported by the respective mechanism. It is worth noting that an outlier analysis was done to identify IM unit expenditures that

exceeded the three times threshold above and below average national unit expenditure. All outlier UEs were adjusted to the three times thresholds both ways. Below are the national unit expenditures used:

Adult ART	$118.86
Adult Pre ART	$49.90
Pre ART Pediatrics	$65.80
ART pediatrics	$127.79

For community care, the UE used was $76 for all districts. This UE established in consultation with the FEWG group and differed from the UE calculated in the EA Data Navigation, which did not account for all indicators that were included in the denominator (number of beneficiaries (C1.1D)). The FEWG team re-calculated using TZ_CARE and TZ_HBC, from the FY 14 APR as the denominator excluding the following categories from the UE breakdown: ARV, HIV test kits and food supplements.

PMTCT

For PMTCT PEPFAR/T used the EA Data Navigation tool. The team used SNU UEs excluding expenditures for ARVs, Non-ARVS, HIV test kits and condoms and applied them to the respective district 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	The SNU UEs reported by regionalized partners were used. For UEs that were more than 5 times the average (upper limit), the region was assigned the highest UE below the upper limit. For UEs that were less than the lower limit (average divide by 5) the region was assigned the lowest UE that is above the lower limit. Higher limit (Average x 5) = $18.70 Average = $3.74 Lower limit = (Average divide by 5) = $0.74
# of women receiving ART as Option B+ (PMTCT_ARV disaggregate Life-long ART (Option B+)	The SNU UEs reported by regionalized partners were used. For UEs that were more than 5 times the average (upper limit), the region was assigned the highest UE below the upper limit. For UEs that were less than the lower limit (average divide by 5) the region was assigned the lowest UE that is above the lower limit. Higher limit (Average x 5) = $643.28 Average = $128.66 Lower limit = (Average divide by 5) $25.73
# of infants tested (PMTCT_EID Numerator)	The SNU UEs reported by regionalized partners were used. For UEs that were more than 5 times the average (upper limit), the region was assigned the highest UE below the upper limit. For UEs that were less than the lower limit (average divide by 5) the

	region was assigned the lowest UE that is above the lower limit. Higher limit (Average x 5) = $829.18 Average = $165.84 Lower limit = (Average divide by 5) $33.16
# infants receiving care (TX_CURR (<1 year old)	The SNU UEs reported by regionalized partners were used. For UEs that were more than 5 times the average (upper limit), the region was assigned the highest UE below the upper limit. For UEs that were less than the lower limit (average divide by 5) the region was assigned the lowest UE that is above the lower limit. Higher limit (Average x 5) = $9288.26 Average = $1857.65 Lower limit = (Average divide by 5) $371.53 For districts within regions where SNU UE was missing, we used average UE from Navigation Tool.

VMMC

Various unit costs (ranging from $90-$105) have been used across the VMMC Scale-Up Districts based on expenditure data, geographic location and program maturity. Budgets for TA, research, and coordination partners were based on expenditure information and program needs. VMMC commodities have been budgeted at approximately 75% of the adult VMMC target with the remainder of commodities coming from the existing stock. Early Infant Male Circumcision was projected at $65 per circumcision based on program expenditures to date and the required scale-up in FY2016.

Key and Priority Population Prevention

Unit expenditures for key and vulnerable populations were calculated after conducting a literature search on the unit cost of individual components of a minimum package of services for each population. For MSM, SW, and PWID, PEPFAR/T used unit expenditures ranging from $62-$165.32, $42-$92, and $45-90, respectively. A unit expenditure ranged from $25-43 was used for all priority populations, which includes adolescent girls and young women. The unit costs were set based on the APR14 reported costs while considering other factors such new packages and establishment of new program in new prioritized districts.

OVC

The OVC program reviewed its geographical coverage to align with the clinical cascade. As part of the OVC shift, the investment efforts in the Sustained Districts were reduced and the UE was reduced to $34 from the current revised national UE of $41.27 for Scale-Up Districts. The OVC program reviewed its geographical coverage to align with the clinical cascade. Regional UEs were used and adjusted by 72.7% (the national UE was $55 and adjusted submitted to PBAC was to $40, thus 40/55 x regional UE) was used for all districts because the service package is the same.

Tanzania COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Arusha City Council	110,389	2,737	12,440	2,541	12,199
Arusha DC	7,943	621	2,731	587	1,975
Babati DC	754	532	1,680	506	1,557
Babati TC	391	419	1,322	398	1,223
Bagamoyo DC	24,025	1,625	6,479	2,106	6,007
Bahi DC	454	359	1,234	342	1,146
Bariadi DC	9,754	606	2,432	580	2,250
Bariadi TC	12,172	613	2,434	584	2,266
Biharamulo DC	8,260	711	2,835	676	2,453
Buhigwe DC	-	78	310	102	287
Bukoba DC	38,852	1,376	4,696	1,371	4,876
Bukoba MC	89	1,926	7,674	1,831	6,312
Bukombe DC	19,396	2,334	5,567	2,218	5,157
Bumbuli DC	-	-	-	-	-
Bunda DC	2,441	1,748	5,511	1,661	5,106
Busega DC	4,184	976	3,893	925	3,611
Busokelo DC	5,907	1,067	4,247	1,014	3,942
Butiama DC	1,682	540	1,701	509	1,577
Chake Chake	53	57	226	54	210
Chamwino DC	653	705	2,424	670	2,246
Chato DC	12,912	1,153	4,594	1,096	4,260
Chemba DC	163	102	352	98	327
Chunya DC	17,930	2,505	12,118	2,467	11,315
Dodoma MC	17,801	2,191	10,221	2,139	9,543
Gairo DC	550	216	740	205	686
Geita DC	99,531	2,681	10,524	2,592	9,808
Geita TC	1,147	206	823	196	762
Hai DC	6,441	1,079	3,026	1,025	2,814
Hanang DC	213	264	832	251	773
Handeni DC	1,809	486	1,532	463	1,422
Handeni TC	3,041	736	2,317	700	2,152
Igunga DC	92,406	3,644	9,415	3,538	8,851
Ikungi DC	800	341	1,174	324	1,089
Ilala MC	194,069	9,058	52,718	8,755	49,596
Ileje DC	7,146	652	4,180	644	2,417
Ilemela DC	-	-	-	-	-
Ilemela MC	13,033	1,340	5,299	1,260	4,902
Iramba DC	503	749	2,795	727	2,598
Iringa DC	1,299	2,174	7,466	2,065	6,924
Iringa MC	28,404	1,954	10,989	1,863	10,189
Itilima DC	8,669	464	1,833	442	1,704
Kahama DC	110,534	2,219	5,965	2,196	5,596
Kahama TC	112,688	1,628	8,903	1,578	8,301
Kakonko DC	1,533	140	556	182	515
Kalambo DC	-	-	-	-	-
Kaliua DC	13,032	902	2,538	857	2,350
Karagwe DC	12,917	1,031	4,112	980	3,570
Karatu DC	5,429	377	1,060	360	982
Kaskazini A	1,158	75	317	75	296
Kaskazini B	380	-	-	-	-
Kasulu DC	1,923	167	663	217	614
Kasulu TC	4,199	347	1,383	453	1,285
Kati	497	-	-	-	-
Kibaha DC	12,087	521	2,075	680	1,923
Kibaha TC	12,894	1,356	5,409	1,771	5,013
Kibondo DC	4,347	342	1,358	446	1,256
Kigoma DC	120	1	3	1	3
Kigoma Ujiji MC	247,597	2,774	5,780	3,283	5,419
Kilindi DC	1,127	277	874	264	808

Tanzania COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Kilolo DC	1,552	1,776	6,112	1,692	5,660
Kilombero DC	9,180	2,448	8,411	2,327	7,799
Kilosa DC	1,921	1,633	5,617	1,553	5,208
Kilwa DC	2,143	734	2,060	696	2,053
Kinondoni MC	339,133	10,224	48,165	9,921	45,363
Kisarawe DC	8,188	917	3,656	1,197	3,387
Kishapu DC	23,284	1,459	5,800	1,387	5,383
Kiteto DC	581	471	1,484	447	1,374
Kondoa DC	744	485	1,666	462	1,546
Kongwa DC	717	760	2,616	722	2,421
Korogwe DC	5,339	726	2,287	691	2,124
Korogwe TC	5,996	1,307	4,600	1,249	4,259
Kusini	-	23	91	22	84
Kwimba DC	17,533	1,376	5,375	1,281	4,981
Kyela DC	95,567	2,358	11,634	2,290	10,843
Kyerwa DC	8,520	696	2,775	662	2,416
Lindi DC	3,030	936	2,640	892	2,662
Lindi MC	6,612	805	3,205	770	3,334
Liwale DC	959	343	963	326	938
Longido DC	8,002	171	480	163	436
Ludewa DC	412	2,032	6,977	1,927	6,473
Lushoto DC	1,680	1,121	3,537	1,065	3,275
Mafia DC	197	205	817	267	757
Mafinga TC	2,278	1,270	4,672	1,213	4,455
Magharibi	2,787	-	-	-	-
Magu DC	19,244	2,231	8,705	2,075	8,068
Makambako TC	391	1,677	5,757	1,594	5,342
Makete DC	430	2,610	8,964	2,480	8,309
Manyoni DC	1,019	1,013	3,481	964	3,227
Masasi DC	3,079	1,335	5,329	1,744	4,937
Masasi TC	2,675	810	3,227	1,057	2,991
Maswa DC	12,870	1,375	5,479	1,315	5,082
Mbarali DC	115,373	4,792	14,348	4,681	13,416
Mbeya City Council	125,165	3,441	26,897	3,389	25,239
Mbeya DC	84,585	2,132	9,157	2,081	8,550
Mbinga DC	87,543	3,616	7,970	2,535	7,467
Mbongwe DC	16,435	886	3,529	842	3,273
Mbozi DC	40,365	2,284	12,766	2,207	11,788
Mbulu DC	279	456	1,438	433	1,331
Meatu DC	11,855	1,102	4,366	1,047	4,058
Meru DC	13,120	1,639	4,771	1,646	4,259
Micheweni	558	35	102	33	129
Missenyi DC	-	1,136	4,530	1,079	3,935
Misungwi DC	16,567	1,318	5,158	1,227	4,771
Mjini	3,754	1,946	4,167	1,850	3,773
Mkalama DC	463	503	1,509	464	1,389
Mkinga DC	2,819	535	1,686	509	1,564
Mkoani	-	13	92	13	90
Mkuranga DC	11,004	2,069	8,232	2,454	7,820
Mlele DC	6,538	528	2,249	506	2,056
Momba DC	15,310	1,477	5,861	1,915	7,713
Monduli DC	9,134	748	2,563	717	2,496
Morogoro DC	4,327	657	2,312	626	2,142
Morogoro MC	11,448	3,239	10,165	3,117	9,459
Moshi DC	78,790	1,904	5,598	1,860	5,232
Moshi MC	35,825	3,793	10,631	3,605	9,897
Mpanda DC	2,098	150	374	145	432
Mpanda TC	12,724	1,231	5,122	1,167	4,668
Mpwapwa DC	740	668	2,290	634	2,124
Msalala DC	12,906	1,094	2,235	872	2,110

Tanzania COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Mtwara DC	738	413	1,645	539	1,525
Mtwara Mikindani MC	2,627	1,145	4,571	1,484	4,236
Mufindi DC	28,146	2,180	16,239	2,083	14,979
Muheza DC	16,542	1,997	5,660	1,914	5,255
Muleba DC	27,021	2,801	8,959	2,740	9,719
Musoma DC	1,472	306	968	291	897
Musoma MC	20,130	4,189	8,315	4,005	7,717
Mvomero DC	6,022	936	3,217	888	2,981
Mwanga DC	4,162	717	2,025	682	1,871
Mwanza CC	-	-	-	-	-
Nachingwea DC	2,109	1,166	3,278	1,107	3,147
Namtumbo DC	11,572	535	2,137	505	1,976
Nanyumbu DC	1,275	413	1,644	539	1,527
National	-	-	-	-	-
Newala DC	2,262	720	2,873	940	2,662
Ngara DC	9,638	723	2,877	687	2,519
Ngorongoro DC	140	-	-	-	-
Njombe DC	371	1,015	3,826	965	3,548
Njombe TC	31,838	933	10,585	906	9,844
Nkasi DC	-	-	-	-	-
Nsimbo DC	4,179	185	600	171	579
Nyamagana MC	35,847	1,790	21,898	1,569	20,418
Nyang'hwale DC	3,125	322	1,283	306	1,188
Nyasa DC	4,073	626	2,496	592	2,314
Nzega DC	128,777	2,534	10,107	2,467	9,451
Pangani DC	1,739	582	1,835	553	1,701
Rombo DC	9,517	1,305	3,678	1,241	3,410
Rorya DC	81,261	2,535	7,395	2,473	6,931
Ruangwa DC	2,724	852	2,395	810	2,402
Rufiji DC	14,400	938	3,736	1,224	3,464
Rungwe DC	103,639	2,456	9,989	2,448	9,354
Same DC	13,263	1,260	3,536	1,197	3,284
Sengerema DC	83,639	2,313	8,805	2,254	8,209
Serengeti DC	1,402	646	2,042	613	1,886
Shinyanga DC	20,943	1,676	6,670	1,591	6,177
Shinyanga MC	64,935	1,021	7,827	995	7,284
Siha DC	18,217	662	1,864	629	1,725
Sikonge DC	3,675	1,114	3,132	1,061	2,905
Simanjiro DC	286	324	1,022	308	947
Singida DC	519	181	623	172	578
Singida MC	2,855	926	3,184	880	2,949
Songea DC	7,288	1,390	5,544	1,321	5,138
Songea MC	105,968	3,128	13,701	3,068	12,775
Sumbawanga DC	15,446	-	-	-	-
Sumbawanga MC	15,759	-	-	-	-
Tabora MC	121,518	8,702	6,538	8,304	6,118
Tandahimba DC	2,130	493	1,970	644	1,824
Tanga City Council	24,979	2,041	11,778	1,954	10,938
Tarime DC	2,123	941	2,968	894	2,751
Temeke MC	257,508	12,570	46,642	11,950	43,911
Tunduru DC	11,572	753	3,167	754	2,937
Ukerewe DC	10,497	876	3,441	819	3,186
Ulanga DC	928	819	2,814	778	2,606
Urambo DC	8,361	888	2,497	844	2,320
Ushetu DC	12,430	771	2,226	879	2,021
Uvinza DC	3,119	275	1,101	360	1,022
Uyui DC	13,910	1,055	2,967	1,002	2,749
Wanging'ombe DC	39,386	740	5,894	721	5,487
Wete	-	46	219	44	170
Other_ Tanzania	90,123	4,313	19,259	4,160	17,923
Total	**4,111,641**	**236,139**	**906,142**	**231,298**	**846,266**

Tanzania COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Arusha City Council	2,052	2,361	10,594
Arusha DC	-	-	2,816
Babati DC	-	-	-
Babati TC	-	-	-
Bagamoyo DC	-	-	5,544
Bahi DC	-	-	5,763
Bariadi DC	-	-	4
Bariadi TC	-	-	4
Biharamulo DC	-	-	-
Buhigwe DC	-	-	-
Bukoba DC	790	243	1,714
Bukoba MC	-	-	-
Bukombe DC	-	-	-
Bumbuli DC	-	-	-
Bunda DC	-	-	824
Busega DC	-	-	128
Busokelo DC	-	-	-
Butiama DC	-	-	-
Chake Chake	-	-	1,370
Chamwino DC	-	-	4,808
Chato DC	-	-	-
Chemba DC	-	-	1,786
Chunya DC	2,258	875	6,980
Dodoma MC	2,121	1,597	10,477
Gairo DC	-	-	-
Geita DC	4,738	2,189	40,406
Geita TC	-	-	-
Hai DC	-	-	-
Hanang DC	-	-	-
Handeni DC	-	-	-
Handeni TC	-	-	-
Igunga DC	3,704	936	18,324
Ikungi DC	-	-	1,760
Ilala MC	3,888	8,652	46,188
Ileje DC	-	-	-
Ilemela DC	-	-	-
Ilemela MC	-	-	-
Iramba DC	-	-	1,884

Tanzania COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Iringa DC	-	-	11,456
Iringa MC	633	877	14,462
Itilima DC	-	-	-
Kahama DC	24,185	2,170	36,186
Kahama TC	1,886	1,149	14,015
Kakonko DC	-	-	1,053
Kalambo DC	-	-	2,716
Kaliua DC	-	-	-
Karagwe DC	-	-	-
Karatu DC	-	-	10,024
Kaskazini A	-	-	920
Kaskazini B	-	-	1,226
Kasulu DC	-	-	1,345
Kasulu TC	-	-	1,345
Kati	-	-	1,214
Kibaha DC	-	-	6,640
Kibaha TC	-	-	6,044
Kibondo DC	-	-	639
Kigoma DC	-	-	806
Kigoma Ujiji MC	728	383	6,676
Kilindi DC	-	-	-
Kilolo DC	-	-	11,548
Kilombero DC	-	-	4,046
Kilosa DC	-	-	1,987
Kilwa DC	-	-	777
Kinondoni MC	4,301	12,863	74,844
Kisarawe DC	-	-	5,062
Kishapu DC	-	-	127
Kiteto DC	-	-	-
Kondoa DC	-	-	2,650
Kongwa DC	-	-	2,860
Korogwe DC	-	-	6,210
Korogwe TC	804	742	2,850
Kusini	-	-	422
Kwimba DC	-	-	-
Kyela DC	4,709	667	10,257
Kyerwa DC	-	-	-
Lindi DC	-	-	140
Lindi MC	331	167	2,884
Liwale DC	-	-	332

Tanzania COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Longido DC	-	-	-
Ludewa DC	-	-	6,979
Lushoto DC	-	-	6,004
Mafia DC	-	-	1,678
Mafinga TC	-	-	-
Magharibi	-	1,880	1,680
Magu DC	-	-	-
Makambako TC	-	-	-
Makete DC	-	-	7,688
Manyoni DC	-	-	3,481
Masasi DC	-	-	-
Masasi TC	-	-	-
Maswa DC	-	-	9
Mbarali DC	1,313	1,097	6,540
Mbeya City Council	14,390	1,910	24,429
Mbeya DC	1,336	1,303	11,802
Mbinga DC	1,746	1,207	14,880
Mbongwe DC	-	-	-
Mbozi DC	1,008	145	15,498
Mbulu DC	-	-	-
Meatu DC	-	-	-
Meru DC	-	-	-
Micheweni	-	-	171
Missenyi DC	-	-	952
Misungwi DC	-	-	-
Mjini	-	2,788	720
Mkalama DC	-	-	2,417
Mkinga DC	-	-	84
Mkoani	-	-	406
Mkuranga DC	-	-	8,644
Mlele DC	-	-	2,632
Momba DC	-	20	-
Monduli DC	-	-	56
Morogoro DC	-	-	2,046
Morogoro MC	3,416	1,690	24,115
Moshi DC	646	883	29,828
Moshi MC	-	-	-
Mpanda DC	-	-	1,941
Mpanda TC	-	-	1,707
Mpwapwa DC	-	-	5,536

Tanzania COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Msalala DC	-	-	-
Mtwara DC	-	-	-
Mtwara Mikindani MC	-	-	-
Mufindi DC	799	1,143	9,542
Muheza DC	765	1,058	9,938
Muleba DC	1,566	862	9,932
Musoma DC	-	-	-
Musoma MC	740	272	8,852
Mvomero DC	-	-	2,605
Mwanga DC	-	-	-
Mwanza CC	-	-	-
Nachingwea DC	-	-	385
Namtumbo DC	-	-	514
Nanyumbu DC	-	-	-
National	-	-	-
Newala DC	-	-	-
Ngara DC	-	-	-
Ngorongoro DC	-	-	1,238
Njombe DC	-	-	10,560
Njombe TC	409	926	7,997
Nkasi DC	-	-	2,894
Nsimbo DC	-	-	-
Nyamagana MC	2,316	1,488	12,112
Nyang'hwale DC	-	-	222
Nyasa DC	60	35	560
Nzega DC	5,042	1,196	20,760
Pangani DC	-	-	-
Rombo DC	-	-	-
Rorya DC	1,300	472	1,092
Ruangwa DC	-	-	484
Rufiji DC	-	-	5,180
Rungwe DC	1,483	803	6,708
Same DC	-	-	8,356
Sengerema DC	3,052	1,785	9,826
Serengeti DC	-	-	-
Shinyanga DC	-	-	6,235
Shinyanga MC	9,046	676	8,374
Siha DC	-	-	6,982
Sikonge DC	-	-	-
Simanjiro DC	-	-	298

Tanzania COP15 Targets by District: Key, Priority, Orphan and Vulnerable Children Indicators

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Singida DC	-	-	2,688
Singida MC	-	-	2,732
Songea DC	-	-	3,686
Songea MC	954	888	12,436
Sumbawanga DC	2,336	450	10,806
Sumbawanga MC	2,336	520	7,748
Tabora MC	2,664	620	25,272
Tandahimba DC	-	-	-
Tanga City Council	1,340	1,188	11,756
Tarime DC	-	-	-
Temeke MC	10,756	9,552	9,660
Tunduru DC	-	-	1,504
Ukerewe DC	-	-	-
Ulanga DC	-	-	4,646
Urambo DC	-	-	-
Ushetu DC	-	-	-
Uvinza DC	-	-	712
Uyui DC	-	-	-
Wanging'ombe DC	3,889	715	4,630
Wete	-	-	2,208
Other_ Tanzania	1,200	-	1,070
Total	**133,036**	**73,443**	**840,260**

Tanzania COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Arusha City Council	21,860	838
Arusha DC	2,109	145
Babati DC	-	-
Babati TC	47	2
Bagamoyo DC	1,634	77
Bahi DC	456	6
Bariadi DC	5,854	201
Bariadi TC	5,926	567
Biharamulo DC	1,854	36
Buhigwe DC	-	-
Bukoba DC	8,261	378
Bukoba MC	3,718	261
Bukombe DC	7,556	160
Bumbuli DC	-	-
Bunda DC	1,627	53
Busega DC	4,324	240
Busokelo DC	2,423	254
Butiama DC	842	18
Chake Chake	-	-
Chamwino DC	657	9
Chato DC	1,803	46
Chemba DC	163	1
Chunya DC	15,179	1,124
Dodoma MC	18,013	673
Gairo DC	553	8
Geita DC	25,688	811
Geita TC	1,069	36
Hai DC	1,530	89
Hanang DC	-	-
Handeni DC	1,206	24
Handeni TC	2,027	62
Igunga DC	18,028	1,751
Ikungi DC	804	9
Ilala MC	69,037	4,251
Ileje DC	378	10
Ilemela DC	-	-

Tanzania COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ilemela MC	9,165	392
Iramba DC	506	8
Iringa DC	903	55
Iringa MC	6,736	686
Itilima DC	5,522	79
Kahama DC	16,293	188
Kahama TC	17,830	208
Kakonko DC	147	5
Kalambo DC	-	-
Kaliua DC	4,565	29
Karagwe DC	1,589	42
Karatu DC	1,585	41
Kaskazini A	-	-
Kaskazini B	33	-
Kasulu DC	555	19
Kasulu TC	754	27
Kati	142	1
Kibaha DC	1,378	53
Kibaha TC	3,567	120
Kibondo DC	305	11
Kigoma DC	120	11
Kigoma Ujiji MC	10,596	506
Kilindi DC	564	5
Kilolo DC	973	78
Kilombero DC	9,345	372
Kilosa DC	1,952	70
Kilwa DC	1,521	116
Kinondoni MC	83,583	5,086
Kisarawe DC	2,312	78
Kishapu DC	3,416	278
Kiteto DC	-	-
Kondoa DC	748	8
Kongwa DC	722	11
Korogwe DC	4,493	149
Korogwe TC	3,362	164
Kusini	128	1

Tanzania COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Kwimba DC	1,838	45
Kyela DC	10,396	942
Kyerwa DC	1,349	24
Lindi DC	2,112	111
Lindi MC	1,928	129
Liwale DC	680	23
Longido DC	1,078	26
Ludewa DC	428	37
Lushoto DC	1,120	15
Mafia DC	197	7
Mafinga TC	1,467	183
Magharibi	8,840	76
Magu DC	7,265	308
Makambako TC	415	53
Makete DC	453	51
Manyoni DC	1,028	19
Masasi DC	2,182	119
Masasi TC	1,826	187
Maswa DC	5,835	265
Mbarali DC	16,146	1,530
Mbeya City Council	19,781	1,808
Mbeya DC	11,329	681
Mbinga DC	9,109	518
Mbongwe DC	4,725	104
Mbozi DC	19,326	927
Mbulu DC	-	-
Meatu DC	5,269	257
Meru DC	4,216	194
Micheweni	-	-
Missenyi DC	4,983	247
Misungwi DC	1,629	68
Mjini	12,520	100
Mkalama DC	465	5
Mkinga DC	1,879	68
Mkoani	-	-
Mkuranga DC	6,158	235

Tanzania COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Mlele DC	871	37
Momba DC	870	40
Monduli DC	1,566	61
Morogoro DC	4,406	185
Morogoro MC	11,586	620
Moshi DC	9,490	491
Moshi MC	5,074	307
Mpanda DC	261	48
Mpanda TC	2,514	195
Mpwapwa DC	745	10
Msalala DC	4,682	78
Mtwara DC	490	31
Mtwara Mikindani MC	1,878	216
Mufindi DC	9,523	1,197
Muheza DC	7,198	285
Muleba DC	17,924	565
Musoma DC	735	15
Musoma MC	8,650	378
Mvomero DC	6,124	229
Mwanga DC	416	59
Mwanza CC	-	-
Nachingwea DC	876	73
Namtumbo DC	743	28
Nanyumbu DC	906	84
National	-	-
Newala DC	1,605	74
Ngara DC	635	8
Ngorongoro DC	26	4
Njombe DC	391	45
Njombe TC	4,437	617
Nkasi DC	-	-
Nsimbo DC	559	19
Nyamagana MC	19,250	1,242
Nyang'hwale DC	667	14
Nyasa DC	3,012	297
Nzega DC	29,943	2,424

Tanzania COP15 Targets by District: Breastfeeding and Pregnant Women

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Pangani DC	1,160	57
Rombo DC	1,921	188
Rorya DC	11,979	694
Ruangwa DC	1,105	145
Rufiji DC	964	33
Rungwe DC	9,259	648
Same DC	1,710	123
Sengerema DC	22,390	922
Serengeti DC	701	9
Shinyanga DC	5,491	413
Shinyanga MC	5,467	748
Siha DC	501	23
Sikonge DC	2,614	40
Simanjiro DC	-	-
Singida DC	522	6
Singida MC	2,898	98
Songea DC	3,680	387
Songea MC	8,617	856
Sumbawanga DC	-	-
Sumbawanga MC	-	-
Tabora MC	11,201	1,548
Tandahimba DC	1,439	62
Tanga City Council	13,968	759
Tarime DC	1,564	35
Temeke MC	80,855	4,921
Tunduru DC	1,203	60
Ukerewe DC	1,767	41
Ulanga DC	938	23
Urambo DC	1,395	75
Ushetu DC	7,170	206
Uvinza DC	1,149	39
Uyui DC	5,430	81
Wanging'ombe DC	5,100	380
Wete	-	-
Other_ Tanzania	12,768	944
Total	**972,987**	**54,939**

Tanzania COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Arusha City Council	1,036	250
Arusha DC	92	45
Babati DC	-	-
Babati TC	-	-
Bagamoyo DC	353	129
Bahi DC	-	-
Bariadi DC	135	14
Bariadi TC	64	16
Biharamulo DC	-	-
Buhigwe DC	-	-
Bukoba DC	-	-
Bukoba MC	-	-
Bukombe DC	145	106
Bumbuli DC	-	-
Bunda DC	-	-
Busega DC	-	-
Busokelo DC	71	34
Butiama DC	-	-
Chake Chake	23	6
Chamwino DC	-	-
Chato DC	192	156
Chemba DC	-	-
Chunya DC	225	112
Dodoma MC	-	-
Gairo DC	37	18
Geita DC	9	4
Geita TC	45	17
Hai DC	348	110
Hanang DC	-	-
Handeni DC	61	30
Handeni TC	88	43
Igunga DC	229	112
Ikungi DC	201	51
Ilala MC	2,448	471
Ileje DC	42	22
Ilemela DC	-	-
Ilemela MC	351	5
Iramba DC	177	43

Tanzania COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Iringa DC	83	46
Iringa MC	216	88
Itilima DC	136	266
Kahama DC	153	35
Kahama TC	494	149
Kakonko DC	-	-
Kalambo DC	-	-
Kaliua DC	58	29
Karagwe DC	-	-
Karatu DC	86	37
Kaskazini A	26	37
Kaskazini B	26	92
Kasulu DC	-	-
Kasulu TC	-	-
Kati	-	-
Kibaha DC	110	42
Kibaha TC	313	110
Kibondo DC	-	-
Kigoma DC	-	-
Kigoma Ujiji MC	-	-
Kilindi DC	35	18
Kilolo DC	79	39
Kilombero DC	415	203
Kilosa DC	227	135
Kilwa DC	102	50
Kinondoni MC	2,118	1,127
Kisarawe DC	155	76
Kishapu DC	241	52
Kiteto DC	-	-
Kondoa DC	-	-
Kongwa DC	-	-
Korogwe DC	90	44
Korogwe TC	167	82
Kusini	5	-
Kwimba DC	163	224
Kyela DC	214	105
Kyerwa DC	-	-
Lindi DC	114	58

Tanzania COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Lindi MC	147	72
Liwale DC	46	24
Longido DC	39	17
Ludewa DC	168	51
Lushoto DC	135	66
Mafia DC	34	17
Mafinga TC	70	34
Magharibi	-	-
Magu DC	211	11
Makambako TC	132	38
Makete DC	202	59
Manyoni DC	400	128
Masasi DC	317	81
Masasi TC	163	49
Maswa DC	547	149
Mbarali DC	263	128
Mbeya City Council	386	187
Mbeya DC	230	70
Mbinga DC	261	55
Mbongwe DC	174	139
Mbozi DC	283	88
Mbulu DC	-	-
Meatu DC	270	65
Meru DC	319	155
Micheweni	40	92
Missenyi DC	-	-
Misungwi DC	151	86
Mjini	-	-
Mkalama DC	97	34
Mkinga DC	68	33
Mkoani	-	-
Mkuranga DC	315	113
Mlele DC	-	-
Momba DC	181	54
Monduli DC	163	62
Morogoro DC	90	44
Morogoro MC	550	268
Moshi DC	276	200

Tanzania COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Moshi MC	205	384
Mpanda DC	-	-
Mpanda TC	-	-
Mpwapwa DC	-	-
Msalala DC	36	8
Mtwara DC	244	57
Mtwara Mikindani MC	249	65
Mufindi DC	230	119
Muheza DC	281	138
Muleba DC	-	-
Musoma DC	-	-
Musoma MC	-	-
Mvomero DC	158	77
Mwanga DC	52	73
Mwanza CC	-	-
Nachingwea DC	113	82
Namtumbo DC	172	39
Nanyumbu DC	100	31
National	-	-
Newala DC	432	125
Ngara DC	-	-
Ngorongoro DC	19	10
Njombe DC	64	15
Njombe TC	256	71
Nkasi DC	-	-
Nsimbo DC	-	-
Nyamagana MC	1,160	365
Nyang'hwale DC	202	37
Nyasa DC	82	23
Nzega DC	271	133
Pangani DC	72	35
Rombo DC	74	136
Rorya DC	-	-
Ruangwa DC	120	59
Rufiji DC	351	76
Rungwe DC	703	164
Same DC	71	139
Sengerema DC	101	168

Tanzania COP15 Targets by District: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Serengeti DC	-	-
Shinyanga DC	315	83
Shinyanga MC	665	191
Siha DC	134	74
Sikonge DC	151	36
Simanjiro DC	-	-
Singida DC	201	58
Singida MC	117	36
Songea DC	178	49
Songea MC	573	172
Sumbawanga DC	-	-
Sumbawanga MC	-	-
Tabora MC	232	128
Tandahimba DC	274	77
Tanga City Council	584	285
Tarime DC	-	-
Temeke MC	2,229	1,089
Tunduru DC	209	61
Ukerewe DC	161	169
Ulanga DC	140	69
Urambo DC	48	46
Ushetu DC	64	15
Uvinza DC	-	-
Uyui DC	79	32
Wanging'ombe DC	65	15
Wete	-	-
Other_ Tanzania	-	-
Total	**31,163**	**12,921**

Tanzania COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Arusha City Council	-
Arusha DC	-
Babati DC	-
Babati TC	-
Bagamoyo DC	-
Bahi DC	-
Bariadi DC	-
Bariadi TC	-
Biharamulo DC	-
Buhigwe DC	-
Bukoba DC	9,285
Bukoba MC	-
Bukombe DC	-
Bumbuli DC	-
Bunda DC	-
Busega DC	-
Busokelo DC	2,636
Butiama DC	-
Chake Chake	-
Chamwino DC	-
Chato DC	-
Chemba DC	-
Chunya DC	6,530
Dodoma MC	-
Gairo DC	-
Geita DC	39,193
Geita TC	-
Hai DC	-
Hanang DC	-
Handeni DC	-
Handeni TC	-
Igunga DC	8,126
Ikungi DC	-
Ilala MC	-
Ileje DC	2,423
Ilemela DC	-
Ilemela MC	-

Tanzania COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Iramba DC	-
Iringa DC	2,443
Iringa MC	2,082
Itilima DC	-
Kahama DC	6,786
Kahama TC	4,386
Kakonko DC	-
Kalambo DC	-
Kaliua DC	-
Karagwe DC	-
Karatu DC	-
Kaskazini A	-
Kaskazini B	-
Kasulu DC	-
Kasulu TC	-
Kati	-
Kibaha DC	-
Kibaha TC	-
Kibondo DC	-
Kigoma DC	-
Kigoma Ujiji MC	-
Kilindi DC	-
Kilolo DC	2,647
Kilombero DC	-
Kilosa DC	-
Kilwa DC	-
Kinondoni MC	-
Kisarawe DC	-
Kishapu DC	-
Kiteto DC	-
Kondoa DC	-
Kongwa DC	-
Korogwe DC	-
Korogwe TC	-
Kusini	-
Kwimba DC	-
Kyela DC	4,594
Kyerwa DC	-
Lindi DC	-
Lindi MC	-

Tanzania COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Liwale DC	-
Longido DC	-
Ludewa DC	-
Lushoto DC	-
Mafia DC	-
Mafinga TC	2,934
Magharibi	-
Magu DC	-
Makambako TC	-
Makete DC	-
Manyoni DC	-
Masasi DC	-
Masasi TC	-
Maswa DC	-
Mbarali DC	6,340
Mbeya City Council	9,446
Mbeya DC	2,616
Mbinga DC	24,426
Mbongwe DC	-
Mbozi DC	9,618
Mbulu DC	-
Meatu DC	-
Meru DC	-
Micheweni	-
Missenyi DC	-
Misungwi DC	-
Mjini	-
Mkalama DC	-
Mkinga DC	-
Mkoani	-
Mkuranga DC	-
Mlele DC	-
Momba DC	4,447
Monduli DC	-
Morogoro DC	-
Morogoro MC	-
Moshi DC	-
Moshi MC	-
Mpanda DC	-
Mpanda TC	-

Tanzania COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Mpwapwa DC	-
Msalala DC	-
Mtwara DC	-
Mtwara Mikindani MC	-
Mufindi DC	765
Muheza DC	-
Muleba DC	17,599
Musoma DC	-
Musoma MC	-
Mvomero DC	-
Mwanga DC	-
Mwanza CC	-
Nachingwea DC	-
Namtumbo DC	-
Nanyumbu DC	-
National	-
Newala DC	-
Ngara DC	-
Ngorongoro DC	-
Njombe DC	-
Njombe TC	6,500
Nkasi DC	-
Nsimbo DC	-
Nyamagana MC	8,503
Nyang'hwale DC	-
Nyasa DC	9,524
Nzega DC	10,340
Pangani DC	-
Rombo DC	-
Rorya DC	-
Ruangwa DC	-
Rufiji DC	-
Rungwe DC	6,691
Same DC	-
Sengerema DC	14,585
Serengeti DC	-
Shinyanga DC	-
Shinyanga MC	2,948
Siha DC	-
Sikonge DC	-

Tanzania COP15 Targets by District: Voluntary Male Medical Circumcision (VMMC)

	Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program
Simanjiro DC	-
Singida DC	-
Singida MC	-
Songea DC	-
Songea MC	10,388
Sumbawanga DC	-
Sumbawanga MC	-
Tabora MC	5,142
Tandahimba DC	-
Tanga City Council	-
Tarime DC	-
Temeke MC	-
Tunduru DC	19,082
Ukerewe DC	-
Ulanga DC	-
Urambo DC	-
Ushetu DC	-
Uvinza DC	-
Uyui DC	-
Wanging'ombe DC	4,500
Wete	-
Other_ Tanzania	8,981
Total	**276,506**

HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural Sustainability Index and Dashboard (SID) during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Table 1: Sustainability Element Score Criteria

Dark Green Score (sustainable and requires no additional investment at this time)
Light Green Score (approaching sustainability and requires little or no investment)
Yellow Score (emerging sustainability and needs some investment)
Red Score (unsustainable and requires significant investment)

Sustainability Analysis for Epidemic Control: Tanzania

Epidemic Type: Generalized
Income Level: Low Income
PEPFAR Categorization: Long-term Strategy
COP 15 Planning Level: $425 million (incl. $30 million 1-time top-up)

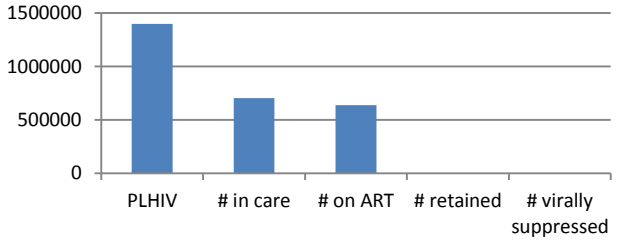
UNSUSTAINED → SUSTAINED

SUSTAINABILITY DOMAINS and ELEMENTS

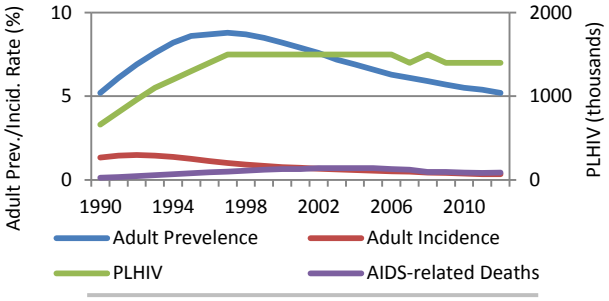
	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	8.3
2. Financial/Expenditure Data	9.3
3. Performance Data	12.5
Domestic Program and Service Delivery	
4. Access and Demand	13.8
5. Human Resources for Health	2.5
6. Commodity Security and Supply Chain	7.7
7. Quality Management	9.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	3.0
9. DRM: Resource Commitments	0.0
10. Allocative Efficiency	0.0
11. Technical Efficiency	7.5
Accountability and Transparency	
12. Public Access to Information	8.0
13. Oversight and Stewardship	12.0
Enabling Environment	
14. Policies, Laws, and Regulations	8.0
15. Planning and Coordination	7.0

CONTEXTUAL DATA

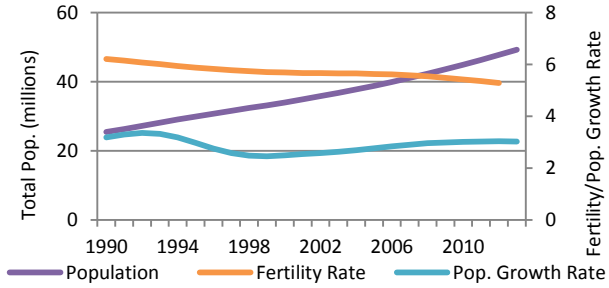
Care and Treatment Cascade



Epidemiological Data

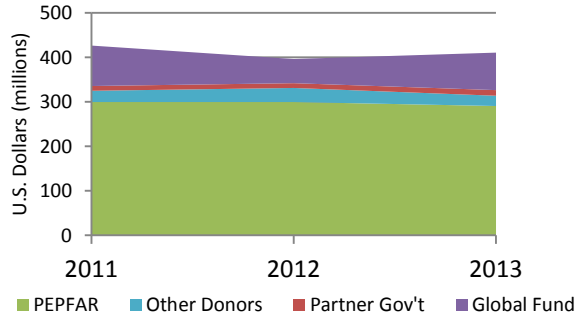


Population and Fertility

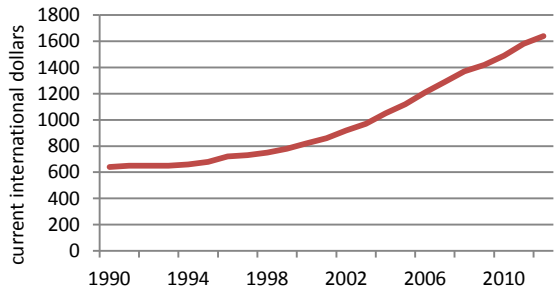


CONTEXTUAL DATA

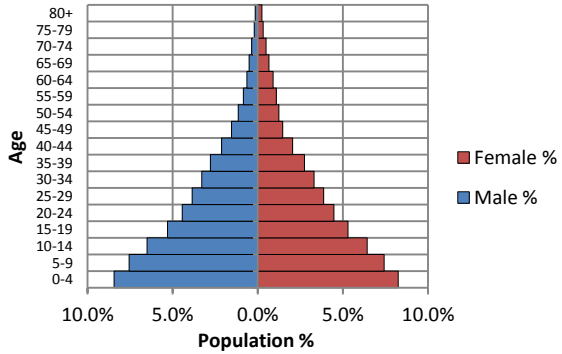
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1.Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.			**Source of data**	**Notes/Comments**
Q1. **Who leads**: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?	◉ A. Host Country Government/other domestic institution ○ B. External agency with host country government ○ C. External agency, organization or institution ○ D. Not conducted	4.5	Meeting minutes, TACAIDS Coordination meeting on HIV Indicator Surveys, July 17, 2013. National research agenda.	SI ITT verified. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
Q2. **Who finances**: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?	○ A. 80-100% of the total cost of latest survey was financed by Host Country Government ○ B. 60-79% of the total cost of latest survey financed by Host Country Government ○ C. 40-59% of the total cost of latest survey financed by Host Country Government ○ D. 20-39% of the total cost of latest survey financed by Host Country Government ○ E. 10-19% of the total cost of latest survey financed by Host Country Government ◉ F. 0-9% of the total cost of latest survey financed by Host Country Government	0	Survey budget by funding sources document	SI ITT verified. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
Q3. **Comprehensiveness of Prevalence and Incidence Data**: Does Host Country Government collect HIV prevalence and or incidence data?	○ No, the government does not collect HIV prevalence or incidence data ◉ Yes, the government collects (check all that apply): ☑ A. HIV prevalence ☑ Collected by age ☐ Collected for children ☑ Collected by sex ☐ Collected by key population ☑ Sub-national data ☐ Collected every 3 years ☑ Data analyzed for trends ☑ Data made publicly available ☐ B. HIV incidence ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed for trends ☐ Data made publicly available	2.2	Tanzania Commission for AIDS (TACAIDS), Zanzibar AIDS Commission (ZAC), National Bureau of Statistics (NBS), Office of the Chief Government Statistician (OCGS), and ICF International 2013, Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2011/12	SI ITT verified. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
	◉ No, the government does not collect viral load data	0	Not applicable.	SI ITT comment: There is a National draft strategic plan for viral load testing. Neema

Q4. **Comprehensiveness of Viral Load Data**: Does Host Country Government collect viral load data?	○ Yes, the government collects viral load data (check all that apply): ☐ Collected by age ☐ Collected for children ☐ Collected by sex ☐ Collected by key population ☐ Sub-national data ☐ Collected every 3 years ☐ Data analyzed to understand trends			strategic plan for viral load testing. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
Q5. **Key Populations**: Does the Host Country Government conduct size estimation studies for key populations?	○ No, the host country government does not conduct size estimation studies for key populations ◉ Yes, the government conducts key population size estimates (check all that apply): ☑ Men who have sex with men (MSM) ☑ Female sex workers ☐ Transgender ☑ People who inject drugs (PWID) ☐ Government finances at least 50% of the size estimation studies ☑ Government leads and manages the size estimation studies	1.6	National AIDS Control Programme, "Consensus Estimates on Key Population Size and HIV Prevalence in Tanzania" (July 2014)	SI ITT comment: Limitations: Generalizability of results to whole country or to specific Regions because size estimation studies were conducted in few selected geographical locations using different methods resulting in wide-range of estimated sizes of KP. The National consensus report on size estimates of the 3 KP (MSM, FSW, and PWID) is qualitatively sound and may be good for policy issues. Quantitatively method used may require additional scientific rigor and caution should be used when using these estimates for target setting. Prevention ITT concurred. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
	Epidemiological and Health Data Score:	8.3		

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.			**Source of data**	**Notes/Comments**
Q1. **Expenditure Tracking**: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	○ No, it does not have a national HIV/AIDS expenditure tracking system ◉ Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): ☑ A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☐ B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening ☐ C. Collected sub-nationally ☐ D. Collected annually ☑ E. Data is made publicly available	2	1) Ministry of Health and Social Welfare. Health Sector Strategic Plan III (July 2009-June 2015). 2) Dr. Flora Kessy (University of Dar Es Salaam), Dr. Jehovaness Aikaeli (University of Dar es Salaam), and Mariam Ally (Ministry of Health and Social Welfare).September 2010. Draft Institutionalization Plan for reporting health expenditures using National Health Accounts Framework in Tanzania.	HSS ITT: Note, there is a system for collecting health expenditures which is now broken down by disease including for HIV/AIDS (the most recent NHA tool incorporated NASA categories); that said further harmonization to streamline data collection and analysis (incl. for PER) for health and HIV/AIDS is warranted. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q2. **Quality of Expenditure Tracking**: Is the Host Country Government tracking expenditures based on international standards?	○ No, they are not using any international standards for tracking expenditures	5	Ministry of Health and Social Welfare. November 5, 2014. National Health Accounts 2011/12, Public Expenditure Review 2013/14. Presented at Joint	Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.

What type of expenditure data are available in the country, i.e. NHA, NASA, others: _____	◉ Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.		Annual Health Technical Review meeting. November 4, 2014. Full reports for previous years on http://www.tzdpg.or.tz/	
Q3. **Transparency of Expenditure Data:** Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?	○ No, they do not make expenditure data available to the public Yes, check the one that applies: ○ A. Annually ○ B. Bi-annually ◉ C. Every three or more years	1	1) Tanzania Commission for AIDS. July 2012. Public Expenditure Review, 2011 HIV/AIDS Tanzania Mainland. Dar es Salaam, Tanzania and Health Systems 20/20 project, Abt Associates Inc. 2) National Health Accounts 2011/12, Public Expenditure Review 2013/14. Presented at Joint Annual Health Technical Review meeting. November 4, 2014.	Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q4. **Economic Studies:** Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?	○ No, they are not conducting special health economic studies for HIV/AIDS ◉ Yes, check all that apply: ☑ A. Costing studies or analyses ☐ B. Cost-effectiveness studies or analyses ☐ C. Efficiency studies or analyses ☐ D. Cost-benefit studies or analyses	1.25	1) Costing the NMSF. Dr. R Kalinga TACAIDS, Dr. Arin Dutta HPP. November 11, 2014 presented at Joint Annual HIV/AIDS review. 2) Chris James, Mark Bura, Tim Ensor. 2013. The Costs of Delivering Health Services In Tanzania; Findings from a comprehensive costing analysis. Ministry of Health and Social Welfare.	HSS ITT: while some costing studies are done, they are few and not routinely updated. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
	Financial/Expenditure Data Score:	**9**		

3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.			**Source of data**	**Notes/Comments**
Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?	○ No, the government does not have an HIV/AIDS service delivery data collection system ◉ Yes, service delivery data are collected/reported for (check all that apply): ☑ A. For HIV Testing ☑ B. For PMTCT ☑ C. For Adult Care and Support ☑ D. For Adult Treatment ☑ E. For Pediatric Care and Support ☑ F. For Pediatric Treatment ☐ G. For AIDS-related mortality	6	National Care and Treatment reporting System.	SI ITT: Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?	○ No, the government does not routinely analyze service delivery data to measure performance ◉ Yes, service delivery data are being analyzed to measure (check all that apply): ☐ A. Continuum of care cascade, including testing, care, treatment, retention and adherence ☑ B. Results against targets ☐ C. Coverage ☐ D. Site specific yield for HIV testing (HTC and or PMTCT) ☐ E. AIDS-related death rates	1	National Care and Treatment report Number 3; PMTCT annual Report. May 2013	SI ITT verified. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
	○ No ◉ Yes, service delivery data are being: (check all that apply):	4	NACP Quarterly report and PMTCT annual report,Care and Treatment report number 3, May 2013	SI ITT: Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.

Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	☑ A. Collected at least quarterly ☑ B. Collected by age ☑ C. Collected by sex ☐ D. Collected from all clinical sites ☐ E. Collected from all community sites ☑ F. Data quality checks are conducted at least once a year		Report number: 3. May 2013	Sr. Data Manager (NACP) verified.
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	○ No, they do not make program performance data available to the public Yes, check the one that applies: ○ A. At least annually ◉ B. Bi-annually ○ C. Every three or more years	1.5	Annual Statistical Bulletin; Tanzania Natioal Care and Treatment Report version 3. May 2013	SI ITT: Other routine service delivery data is available on a more frequent basis than Bi-annually from the PMTCT and NACP websites. Neema Makyao, Acting Head of Epidemiology (NACP) and Verhey Sambu, Sr. Data Manager (NACP) verified.
	Performance Data Score:	**13**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIVAIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.			**Source of data**	**Notes/Comments**
Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?	○ This information is not available Check the one answer that best describes the current situation: ◉ A. More than 80% of facilities in high prevalence/burden locations are providing ART. ○ B. 50-79% of facilities in high prevalence/burden locations are providing ART. ○ C. 21-49% of facilities in high prevalence/burden locations are providing ART. ○ D. 20% or less of facilities in high prevalence/burden locations are providing ART.	Q1 Score: 4	NACP quarterly report May 2013. PEPFAR APR 2014	Clinical SRU: Denominator is the number of facilities accredited to provide ART,Numerator is the number of facilities that are providing ART. Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at NACP
Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?	○ This information is not available Check the one answer that best describes the current situation: ◉ A. More than 80% of facilities in high prevalence/burden locations are providing Option B+. ○ B. 50-79% of facilities in high prevalence/burden locations are providing Option B+. ○ C. 21-49% of facilities in high prevalence/burden locations are providing Option B+. ○ D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.	Q2 Score: 3	NACP-PMTCT report (May 2013) and APR 14 data	Clinical SRU: Option B+ started in october 2013,by APR 14 over 80% of PMTCT facilities were providing option B+. Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at NACP
Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ This information is not available Check the one answer that best describes the current situation: ◉ A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites ○ D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites	Q3 Score: 3	NACP quarterly report May 2013. PEPFAR APR 2014	Clinical SRU: All the facilities are under Government, Faith based or private owned. Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at NACP
Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services (i.e. those sites	◉ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites	Q4 Score: 0	Not available	Clinical SRU: Information is not available because the current national tools cannot capture the disaggregates by key population. Refer to the prevention team to give us the effort made to key population in Zanzibar. Prevention SRU concurs with response. % of

faith based operated services). (i.e. those sites that receive commodities from the government and/or follow government protocols).	○ C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites ○ D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites			PLHIV: national number/total PLHIV in TZ= 549,000/1,400,000=42%
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%	○ This information is not available Check the one answer that best describes the current situation: ○ A. 80% or more of PLHIV are currently receiving ART ○ B. 50-79% of PLHIV are currently receiving ART ◉ C. 20-49% of PLHIV are currently receiving ART ○ D. Less than 20% of PLHIV are currently receiving ART	Q5 Score 2	UNAIDS 2013,NACP Quarterly report (May 2013).	Clinical SRU: Denominator is UNAIDS 2013 number of PLHIV 1.4 m,Numerator is NACP quartely report(Oct -Dec 2013). Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at NACP
Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?	Check the one answer that best describes the current situation: ○ No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. ◉ Yes, there are efforts by the government (check all that apply): ☑ educates PLHIV about their legal rights in terms of access to HIV services ☐ educates key populations about their legal rights in terms of access to ☑ National policy exists for de-stigmatization in the context of HIV/AIDS ☑ national law exists regarding health care privacy and confidentiality protections ☐ government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score 1.8	1. Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013 – 2017 2. National Guideline for Comprehensive package of Interventions for Key Populations 3. National HIV/AIDS policy, LAW OF THE CHILD ACT 2009, NMSF	Clinical SRU verified. However, Prevention SRU adjusted some of the responses -- took out "educates key pop. About legl rights.." and took out "government provides financial support.." Given the domain area, went with Prevention responses.
		Access and Demand Score	**13.8**	

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.			**Source of data**	**Notes/Comments**
Q1. **HRH Sufficiency**: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	Check the one answer that best describes the current situation: ◉ This information is not available ○ A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand ○ B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) ☐ HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand	Q1 Score: 0	Not available.	HSS ITT verified

	☐ HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites			
Q2. **HRH Transition**: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	Check the one answer that best describes the current situation: ◉ A. There is no inventory or plan for transition of donor-supported health workers ○ B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date ○ C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date. ○ D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan ○ E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated	Q2 Score: 0	Not available.	HSS ITT: Rather, an inventory has been conducted but is not yet complete as there are some key partners who have not entered information. A plan has also not yet been developed. While there are no options in this regard, we opted for Option A (also confirmed with call to OGAC). It should be noted, that while there is no inventory or national plan to formally transition PEPFAR and other donor supported health workers, there has been limited progress in discrete areas (blood safety, lab) -- but there has not been a formal process to engage MOHSW.
Q3. **HRH Financial reform:** Has financial reform been undertaken in the last 5 years to address government financing of health workers?	Check the one answer that best describes the current situation: ○ A. No financial reform has been undertaken in the last 5 years to address government financing of health workers ◉ B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply): ☐ Wage reform to increase salaries and or benefits of health workers ☑ Increase in budget allocation for salaries for health workers	Q3 Score: 1	PE budget for Health. Rapid Budget Analysis 2013 (http://www.tzdpg.or.tz/). Rapid Budget Analysis 2014.	HSS ITT verified.
	Check the one answer that best describes the current situation: ◉ A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE ○ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☐ content updated for all HIV/AIDS services ☐ updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☐ updated curriculum is problem based/competency based ☐ updated curriculum includes practicums at high volume clinical/ social services sites	Q4 Score: 0	Pre-Service Curricula for Nursing; Clinical Cadres, Labs, FELTP. 1. Bridging Course for Rural Medical Aides and Clinical Assistants trained under Knowledge-Based Education and Training Curriculum Module 6: Fundamentals of HIV and AIDS Management August 2012 2. United Republic of Tanzania Ministry of Health and Social Welfare Curriculum for Basic Technician Certificate in Clinical Medicine NTA LEVEL 4 Department of Human Resource Development Ministry of Health and Social Welfare Revised April 2009 3. United Republic of Tanzania Ministry of Health and Social Welfare Curriculum for Technician Certificate in Clinical Medicine NTA LEVEL 5 Department of Human Resource Development Ministry of Health and Social Welfare Revised April 2009 4. United Republic of Tanzania Ministry of Health and Social Welfare	HSS ITT verified. HIV/AIDS content is being updated for certain vertical programs (GBV/VAC, FP/HIV, VMMC, Option B+).

Q4. **Pre-Service**: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	☐ institutions that track students after graduation		Curriculum for Ordinary Diploma in Clinical Medicine NTA LEVEL 6 Department of Human Resource Development Ministry of Health and Social Welfare Revised April 2009 5. The United Republic of Tanzania Ministry of Health and Social Welfare Curriculum Information for Ordinary Diploma (NTA Level 6) in Nursing In-service Programme Department of Human Resource Development December 2009 6. The United Republic of Tanzania Ministry of Health and Social Welfare Curriculum Information for Ordinary Diploma Programme in Nursing (NTA Level 4 - 5) Department of Human Resource Development Reviewed July 2008 7. The United Republic of Tanzania Ministry of Health and Social Welfare Curriculum Information for Ordinary Diploma Programme in Nursing (NTA Level 4 - 6) Department of Human Resource Development Reviewed July 2008	
Q5. **In-Service**: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?	Check the one answer that best describes the current situation: ○ A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training. ○ B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented. ○ C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date. ◉ D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.	Q5 Score: 0	Country Team Knowledge: USG only with confirmation from our HRH in-country partners and MOHSW.	HSS ITT verified
Q6. **HRIS**: Does the government have a functional Human Resource Information System (HRIS) for the health sector?	Check the one answer that best describes the current situation: ○ A. No, there is no HRIS ◉ B. Yes, the government does have a HRIS (check all that apply) ☑ The HRIS is primarily funded by host country institutions ☐ There is a national interoperability strategy for the HRIS ☑ The government produces HR data from the HRIS at least annually ☑ The government uses data from the HRIS for HR planning and management	Q6 Score: 1.5	USG/Tz Country Team Knowledge (USG only with confirmation from our HRH in-country partners and MOHSW). Mid-term Review of Health Sector Strategic Plan III 2009-2015 HRH Report October 2013 - MOHSW, GOT	HSS ITT: *Note, while there are HRIS systems -- the information needs to be better streamlined and consistent
	Check the one answer that best describes the current situation:	Q7 Score: 0	Not available. As we don't have information on	HSS ITT verified. Emma to

Q7. **Domestic funding for HRH**: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?	◉ This information is not known ○ A. Less than 20% ○ B. 20-49% ○ C. 50-79% ○ D. 80% or more			the denominator -- total health worker salaries including public and private sectors.	determine if this can be calculated from annual report.
		Human Resources for Health Score	**2.5**		

6. **Commodity Security and Supply Chain:** The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.				**Source of data**	**Notes/Comments**
Q1. **ARV domestic financing**: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q1 Score:	0	Pending Procurements Quarterly Report December 2014	HSS ITT verified.
Q2. **Test Kit domestic financing:** What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ◉ A. 0-9% obligated from domestic public sources ○ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q2 Score:	0	Pending Procurements Quarterly Report December 2014	HSS ITT verified.
Q3. **Condom domestic financing**: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?	Check the one answer that best describes the current situation: ○ This information is not known ○ A. 0-9% obligated from domestic public sources ◉ B. 10-29% obligated from domestic public sources ○ C. 30-79% obligated from domestic public sources ○ D. 80% or more obligated from domestic public sources	Q3 Score:	1	Contraceptive Procurements Table January 2015	HSS ITT verified. Though more than 30% of future male condom shipments will be supported by GOT, if one factors in the value of male and female condoms currently in stock, 10-29% is correct.
Q4. **Supply Chain Plan:** Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?	○ A. No, there is no plan or thoroughly annually reviewed supply chain SOP ◉ B. Yes, there is a Plan/SOP. It includes these components: (check all that apply) ☑ Human resources ☐ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system	Q4 Score:	3.7	National supply chain plan/SOP: PHARMACEUTICAL SECTOR ACTION PLAN 2020 2014 – 2020	HSS ITT verified

	☑ Procurement ☑ Forecasting ☑ Supply planning and supervision			
Q5. **Stock:** Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?	◉ A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time ○ B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time ☐ Both public and (if they exist in the country) private storage facilities at central level ☐ Both public and (if they exist in the country) private storage facilities at intermediate level	Q5 Score: 0	Pending Procurements Quarterly Report December 2014	HSS ITT verified. According to cited report, more than 10% of all products are currently not stocked according to plan.
Q6. **Assessment**: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment? (If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)	○ A. No assessment has been conducted nor do they have a system to oversee the supply chain ○ B. Yes, an assessment was conducted but they received below 80% ◉ C. No assessment was conducted, but they have a system to oversee the supply chain that reviews: ☑ Commodity requirements ☑ Commodity consumption ☑ Coordinates procurements ☑ Delivery schedules ○ D. Yes, an assessment was conducted and they received a score that was 80% or higher	Q6 Score: 3	Tanzania: USG Funded - Strategic Review of the National Supply Chain for Health Commodities. April 2013	The Supply Chain Strategic Review included what they are asking for here. But it was not scored in the same way. So difficult to say the 80% threshold has been met.
	Commodity Security and Supply Chain Score	**7.7**		

7. **Quality Management:** Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.			**Source of data**	**Notes/Comments**
Q1. **Existence of System**: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?	○ A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH ◉ Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply): ☑ Routinely reviews national HIV/AIDS performance and clinical outcome data ☐ Routinely reviews district/regional HIV/AIDS performance and clinical outcome data ☐ Prioritizes areas for improvement	Q1 Score: 2	National Health and Social welfare quality improvement strategic plan 2013 -2018, National guidelines of quality improvements of HIV/AIDS, Comprehensive supportive supervision and mentorship participant manual	HSS ITT: There is a Directorate of Health Quality Assurance, which houses a Health Services Inspectorate and Quality Assurance Section (among others) at ministry of health ans social welfare; and Qulity Improvement Unit at National Aids Control Program

Q2. **Strategy:** Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?	○ No, there is no HIV/AIDS-related QM/Q strategy ○ B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years) ◉ C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. Yes, there is a current HIV/AIDS program specific QM/QI strategy	Q2 Score: 3	National health and social welfare Quality Improvement Strategic plan 2013-2018	HSS ITT verified.
Q3. **Guidelines:** Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?	○ A. No, the national practice does not follow current WHO guidelines for PMTCT or ART ◉ B. Yes, the national practice does follow current WHO guidelines for: ☑ PMTCT (option B+) ☑ Adult ART ☑ Pediatric ART ☑ Adolescent ART ☑ Test and treat for specific populations	Q3 Score: 4	National PMTCT guidelines (Revised third edition April 2013), The country is revising ART guinelines to meet WHO recommendation	HSS ITT verified.
Q4. **QI Data use**: Does the host country government monitor and use data for HIV/AIDS quality improvement?	◉ A. No, there is no monitoring for HIV/AIDS quality improvement ○ B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes: ☐ All sites ☐ Use of data to determine quality of program or services ☐ Making recommendations and action plan for mid-course corrections	Q4 Score: 0	Use of quarterly and annual HIV/AIDS reports to identify national QI indicators at national level. 2014 APR report and National Annual report 2014 by NACP. Some regions and district meet quarterly to monitor and use HIV/AIDS data to identify areas of improvements.	There is a need of national database to collect QI data from the site to the national level
Q5. **Post-transition:** Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?	◉ A. No, there is no quality monitoring at sites post-transition ○ B. Yes, there is quality monitoring at transition sites. Monitoring includes: ☐ All transition sites ☐ Review of service outcomes ☐ Client feedback on changes in quality ☐ Quality improvement action plan ○ C. PEPFAR/other donors have never supported direct service delivery in the country	Q5 Score: 0	No transition has occurred.	HSS ITT verified: Although there is no post -transition that has occured. The national comprehensive supportive supervision and mentorship tools used by regional and district health teams during regular supportive supervision and mentorship are assessing the quality of HIV/AIDS service. They also guides how to make action plan to improve the quality of the poor perfoming areas.
		Quality Management Score	**9**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.			**Source of data**	**Notes/Comments**
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	◉ A. No, there is no budget line item for HIV/AIDS in the national budget ○ B. Yes, there is an HIV/AIDS budget line item under the Health budget ○ C. Yes, there is an HIV/AIDS program-based budget across ministries ○ D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 0	Medium Term Expenditure Framework Objective 1.	HSS ITT: While there may be a separate budget line item classification, hardly anything is funded through this account- rendering this line item effectively non-existent. Verified through conversation with Y. Abbas, Acting Director of Finance and Administration, TACAIDS. Chose Option A also following dialogue with OGAC -- as the option closest to reality.
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	○ A. No ◉ B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program ○ C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 3	In country source, i.e. national budget, budget summary or report for 2014: Medium Term Expenditure Framework FY 2013, FY 2014	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)	○ Yes ◉ No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/selection/scorecards	
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic	Check the appropriate box for your country's income category: FOR LOW INCOME ○ A. More than 16.4% (i.e. surpasses category mean) ○ B. 14.8%-16.4%, (i.e. 90-100% of category mean) ◉ C. Less than 14.8%, (less than 90% of category mean) FOR LOW MIDDLE INCOME ○ D. More than 22.3% (i.e. surpasses category mean)	Q4 Score: 0	OGAC-provided data sheet (follows tab E) Note, USAID Economic bureau in HQ provided provisional estimates (12.6%) given that the GDP was revised Dec. 19th 2014. This approach was agreed to by OGAC.	HSS ITT verified.

revenue excludes external grants)	◯ E. 20.1-22.3% (i.e. 90-100% of category mean) ◯ F. Less than 20.1% (less than 90% of category mean) FOR UPPER MIDDLE INCOME ◯ G. More than 27.8% (i.e. surpasses category mean) ◯ H. 25.0%-27.8% (i.e. 90-100% of category mean) ◯ I. Less than 25.0% (less than 90% of category mean)			
Score for Domestic Resource Mobilization: Resource Generation:		**3**		

9. **Domestic Resource Mobilization: Resource Commitments:** Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.			**Source of data**	**Notes/Comments**
Q1. Benchmarks for health spending: **African countries:** Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? **Non-African countries:** Is government health expenditure at least 3 percent of GDP?	◯ A. Yes ◉ B. No	Q1 Score: 0	OGAC-provided data sheet (follows tab E) Original sources: WHO and World Bank. NHA 2012--shows it is actually 7%	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	◉ A. Less than 10% ◯ B. 10-24% ◯ C. 25-49% ◯ D. 50-74% ◯ E. 75% or Greater	Q2 Score: 0	NASA or NHA data: NHA 2012latest draft (April 1st 2015 version) (5% of national HIV response is domestically financed excluding OOP)	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q3. Key population spending: What percent of key population-specific interventions are financed	◉ A. None or information is not available ◯ B. 1-9% ◯ 10-24%	Q3 Score: 0	In country source, i.e., NASA data, national expenditure analysis report: Expenditure reporting is not broken down by key pop.	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.

with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	◯ 25-49% ◯ 50-74% ◯ 75% or Greater			
Score for Domestic Resource Mobilization: Resource Commitments:		**0**		
10**. Allocative Efficiency:** The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).			**Source of data**	**Notes/Comments**
Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?	◉ A. No, data are not used annually ◯ B. Yes, data are used annually. Check all that apply: ☐ Epidemiological data are used ☐ Health/service delivery data are used ☐ Financial data are used ☐ There is integrated analysis across data streams ☐ Multiple data streams are used to model scenarios	Q1 Score: 0	(NMSF III (Nov 2013), GF HIV/TB Concept Note 2014, and GF HSS Round 9 proposal (2013)– targeting 70 hard-to-reach districts with multiple interventions). Not annually provided.	HSS ITT/ Clinical SRU verified. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS. Donor financed activities Involve data driven allocations (GFATM and PEPFAR).
Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?	◉ A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites ◯ B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients ◯ E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	Q2 Score: 0	National HIV/AIDS Strategic planning	Clinical SRU: Government consider accessibility and equity when deciding on the number and location of HIV/AIDS services

Q3.Data driven reprogramming: Do host country government policies/systems allow for reprograming investments based on new or updated program data during the government funding cycle?	◉ A. No, there is no system for funding cycle reprogramming ○ B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used ○ C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data	Q3 Score: 0	Note that GOT budget reprogramming does happen -- often time from one sector to another (it is not clear what drives this) as learned from 2014 Rapid Budget Analysis. TACAIDSverified that there is no system cycle for reprogramming. Note it may be more articulated with GFATM funds	HSS ITT verified. Note, Y. Abbas, Acting Director of Finance and Administration, TACAIDS -- marked "No, there is no system for funding cycle reprogramming."
		Allocative Efficiency Score: **0**		

11. **Technical Efficiency:** Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.			**Source of data**	**Notes/Comments**
Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	○ A. No ◉ B. Yes (check all that apply): ☐ Annually ☑ For HIV Testing ☑ For Care and Support ☑ For ART ☑ For PMTCT ☑ For VMMC ☑ For OVC Service Package ☑ For Key population Interventions	Q1 Score: 5	GFATM concept note submission (October 15, 2014). Investment Case Analysis for HIV program	Clinical SRU verified. Prevention ITT verified.Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at NACP
	Check all that apply: ☐ Using findings from cost-effectiveness or efficiency studies to modify operations or interventions	Q2 Score: 0.5	In country sources for each checked: Use of Pooled procurement (see attached PQR)	Clinical SRU verified. Prevention ITT verified. Based on consultations with Dr Bonita Kilama, Head of SI Unit at NACP; Dr Robert Josiah, Deputy PM at

Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?	☐ Streamlining management to reduce overhead costs ☑ Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling ☐ Improving procurement competition ☐ Integration of HIV/AIDS into national or subnational insurance schemes (private or public) ☐ Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact ☐ Geographic targeting in high burden/high yield sites to increase impact ☐ Analysis of expenditure data to establish appropriate range of unit costs			Dr Robert Josiah, Deputy PM at NACP
Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?	◉ A. No ○ B. Yes	Q3 Score: 0	Not applicable.	HSS verified. Difficult to disentangle HIV/AIDS health service delivery from PE and OC budget.
Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?	Check boxes that apply: ☐ They are not paying for any ARVs ☐ They are not paying for any test kits ☑ They are paying no more than 5% above the international benchmark price for first line ARVs ☐ They are paying no more than 5% above the international benchmark price for test kits	Q4 Score: 2	http://apps.who.int/hiv/amds/price/hdd/Default.aspx	Prevention ITT. Most test kits and ARVs are procured through PPM.
Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years? Unit cost 2 years ago: $ _____ Current unit cost: $ _____	◉ A. No ○ B. Yes	0	WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/	
		Technical Efficiency Score: **7.5**		

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.			**Source of data**	**Notes/Comments**
Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)	○ A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) ○ B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) ◉ C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) ○ D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) ○ E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) ○ F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget	Q1 Score: 6.0	OGAC-provided data sheet (follows tab E) Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org)	HSS ITT: Note, for future this may not be the best index to use. A presentation was made to Tanzanian Donors (Feb 4) on PEFA and noted that it focused largely on legal and instituitonal framework; however, it does not give as much insight into how well those frameworks are being operationalized. For this, a sectoral specific analysis was recommended.
Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?	○ A. No, the national HIV/AIDS program progress report or presentation of results is not made public ◉ B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): ☐ On Website ☐ Through any type of media ☑ Disseminate print report or presentation of results	Q2 Score: 2.0	November 11-13 2014 Biennial AIDS review (Agenda and related conference documents)	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS	◉ A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically ○ B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:	Q3 Score: 0.0	In country source, i.e., last HIV/AIDS audit report:	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.

government make an annual national HIV/AIDS program audit report publically available?	☐ On website ☐ Through any type of media ☐ Disseminate print report			
		Public Access to Information Score: **8**		

13. **Oversight and Stewardship**: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.			**Source of data**	**Notes/Comments**
Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.	○ A. PEFA assessment never conducted, or data unavailable ○ B. PEFA was conducted and score was below C ◉ C. PEFA was conducted and score was C ○ D. PEFA was conducted and score was B ○ E. PEFA was conducted and score was A	Q1 Score: 1.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	HSS ITT
Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment. Actual scores are ____	Check A or B; if B checked, select appropriate disaggregates: ○ A. PEFA assessment never conducted, or data unavailable ◉ B. PEFA was conducted and score was C or higher for: ☑ (i) Completeness of the financial statements ☑ (ii) Timeliness of submission of the financial statements ☑ (iii) Accounting standards used	Q2 Score: 5.0	OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)	HSS ITT Actual scores are B, A, B
	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. No, there are no formal channels or opportunities ○ B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback	Q3 Score: 3.0	In country source, i.e., reports indicating CSO engagement, policies or SOPs: The State of Civil Society Organisations in Tanzania Annual	Note that CSO engagement meeting -- most leaned towards saying "no there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and

Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?	◉ C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply: ☐ During strategic and annual planning ☑ In joint annual program reviews ☐ For policy development ☑ As members of technical working groups ☐ Involvement on evaluation teams ☐ Giving feedback through social media ☐ Involvement in surveys/studies ☐ Collecting and reporting on client feedback		Report 2009, Foundation for Civil Society	feedback." That said, USG/Tz chose option C to recognize the official existence of channels for CSO engagement but also recognize stakeholder comments that these channels are weak and need to be strengthened.
Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society? If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?	○ A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role ◉ B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government ○ C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight	Q4 Score: 3.0	OGAC-provided data sheet (follows tab E) Data derived from Civicus Enabling Environment Index (civicus.org/eei/)	HSS ITT
		Oversight and Stewardship Score:	**12**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. **Policies, Laws, and Regulations:** Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.			**Source of data**	**Notes/Comments**
Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?	○ A. No, there are no such laws or policies ◉ B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): ☐ Criminalization of HIV transmission ☑ HIV testing disclosure policies or age requirements ☐ Non-disclosure of HIV status laws ☑ Anti-homosexuality laws ☑ Anti-prostitution legislation ☑ Laws that criminalize drug use, methadone use or needle exchange	Q1 Score: 2.0	HIV and AIDS Prevention and Control Act (HAPCA) No. 28 (2008), Provision 15 (2) sets testing age of consent at 18 and Section 150 of the Zanzibar Penal Act No. 6 (2004) Laws against same-sex marriage/union: Section 158 of the Zanzibar Penal Act No. 6 (2004) and in Tanzania mainland Laws against consensual same-sex intercourse: of 1945 (as revised by the Sexual Offences Special Provisions Act, 1998) Section 138A Laws against prostitution: Section 145 of the Tanzania Penal Code of 1945 (as revised by the Sexual Offences Special Provisions Act, 1998 and Section 141 (1) (2) of the Zanzibar Penal Act No. 6 (2004) Laws that criminalize drug use: Drugs and Prevention of Illicit Traffic Drugs Act, No. 9 (2009, amended in 2012)	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated? (note: full score of six points possible without checking all boxes)	○ A. No, there are no such policies or laws ◉ B. Yes, there are such policies and laws. Check all that apply: ☑ For people living with HIV ☐ For men who have sex with men ☐ For transgendered persons ☐ For sex workers ☐ For people who inject drugs ☐ For children orphaned or affected by HIV/AIDS	Q2 Score: 1.0	HAPCA (2008) Section 31 prevents discrimination for PLHIV ; in Zanzibar this is covered under Section 23 of an Act to Provide for the Prevention and Management of HIV and AIDS in Zanzibar, Act No.18 of 2014. National HIV and AIDS Policy 2012	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.

	☐ For young girls and women vulnerable to HIV ☐ For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	○ A. No, there are no special provisions or advantages for CSOs ◉ B. Yes, there are special provisions and advantages for CSOs. Check all that apply: ☑ Significant tax deductions for business or individual contributions to not-for-profit CSOs ☑ Significant tax exemptions for not-for-profit CSOs ☐ Open competition among CSOs to provide government-funded services ☐ Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 2.0	Income Tax Act of 2004, Value Added Tax Act, 1997 . CSO consultation notes (Feb. 2015)	CSO consultation: While there may be some provisions for CSOs, there are quite a few nuances that should be factored in -- e.g. while there may be tax exemptions for CSOs that get donor funded monies, tfor those CSOs who access own-generated funds, they have to pay taxes... therefore not much incentive to find more domestic sustainable sources of funds. Also, CSOs with limited org. structures and systems do not ordinaril qualify for waivers.
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	○ A. No ◉ B. Yes, there are. Check all below that are included: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 3.0	National HIV/AIDS Policy 2012	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
	Policies, Laws, and Regulations Score:	**8**		

15. **Planning and Coordination:** Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			**Source of data**	**Notes/Comments**
Q1. National Strategy: Does the country have a	○ A. No, there is no national strategy for HIV/AIDS ◉ B. Yes, there is a national strategy. Check all that apply: ☑ It is multiyear	Q1 Score: 4.0	Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14-2017/18). November 2013 www.tacaids.go.tz	HSS ITT.Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.

multi-year, costed national strategy to respond to HIV?	☑ It is costed ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy			
Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?	○ A. No data-driven prioritization approach was used ◉ B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources ○ C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources	Q2 Score: 2	Global Fund Joint Concept Note; TNCM Member knowledge	HSS ITT. Verified By Y. Abbas, Acting Director of Finance and Administration, TACAIDS.
Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?	○ A. No or there is no CCM ◉ B. Yes, with conditions ○ C. Yes	Q3 Score: 1	Global Fund Eligibility List 2014. CCM Performance spreadsheet	HSS ITT.
Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?	◉ A. No, it does not track or map all HIV/AIDS activities ○ B. the host country government coordinates all HIV/AIDS activities. Check all that apply: ☐ Of Civil Society Organizations ☐ Of private sector ☐ Of donor implementing partners ☐ Activities are tracked or mapped ☐ Duplications and gaps are addressed ☐ Joint operational plans are developed that include key activities of all implementing agencies	Q4 Score: 0.0	TACAIDS public reporting is incomplete and inconsistent (see: TACAIDS Digital Reponsitory at http://repo.tacaids.go.tz:8080/tacaids_repo/handle/123456789/26) andthere is not much to report on private sector engagement. It has an extensive database on CSOs providing data through its TOMSHA tool (see http://www.tacaids.go.tz/csomis/). CSO consultation (Feb. 2015)	CSO consultation-- majority of CSOs stated that there is tracking and mapping. However, the host country government does not 'coordinate' all HIV/AIDS activities. Option A is the closest to reality.
	◉ A. No	Q5 Score: 0.0	In country source for each checked: The Foundation for Civil	CSO consultation confirmed response --

Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?	○ B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders and/or networks representing affected populations) are actively engaged. Check all that apply: ☐ In advocacy ☐ In programmatic decision-making ☐ In technical decision-making ☐ In service delivery		Society site (http://fcsis.net/grantweb/index.php/app/appdetails/199) shows minor CSO involvement in HIV/AIDS by non-PEPFAR donors. CSO consultation Feb 2015.	namely that there is a lack of active or meaningful engagement.
		Planning and Coordination Score:	**7**	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN