



THE UNITED REPUBLIC OF TANZANIA
**MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER,
ELDERLY AND CHILDREN**



NATIONAL AIDS CONTROL PROGRAMME

NATIONAL ACCELERATED ACTION PLAN ON HIV TESTING SERVICES

Ministry of Health, Community Development Gender Elderly and Children

National AIDS Control Programme (NACP)

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FOREWORD

In the last fifteen years, our HIV response has undergone a remarkable evolution. The introduction of Antiretroviral therapy has converted HIV infection from a deadly illness to a chronic controllable disease. The tone of public health messages has changed from that of instilling distress to that of promoting acceptance and support. The proactive involvement of key stakeholders has broadened the coverage and strengthened the scope of HIV programs in meeting the needs of more diverse populations.

In contrast, however, there are more than 546,000 of People Living with HIV who are undiagnosed in the community and that cause a grave concern towards the control of the epidemic by 2020. It is evident that HIV testing services (HTS) serves as a critical gateway for treatment and prevention services, which reduces HIV transmission.

While it is clear that diagnosis of HIV is a critical intervention, the selection of strategy for HTS is not straight forward as it depends on several factors including: the nature of the HIV epidemic in different geographical areas, the socio-cultural context, gender, current services for different population groups, structures, and resources available. In this Accelerated Plan for HTS, a mix of HTS strategies are presented that can increase the number of people who test and receive care and treatment services, including approaches that reach more clandestine populations or those that may not identify themselves as at-risk for HIV. The Plan further accentuates on quality, efficiency, yield and linkages as these are prerequisite for the country to attain stated targets. Moreover, the Plan consolidates existing and new guidance for HTS for all population and settings and for various approaches while considering the National and Sub National targets for different population groups.

We thank all our stakeholders as we mark the progress made in our AIDS response and call upon their continued support to achieve the targets set out in this Accelerated Action Plan as well as those of the 2020 global fast track targets.



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PERMANENT SECRETARY (HEALTH)

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This Accelerated Action plan for HTS 2018, is as a result of a participatory process involving numerous stakeholders including International Agencies, Implementing Partners and Non-Governmental Organizations.

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Special thanks go to Consultative Task Team members involved in thinking through the idea for development of the Accelerated plan. This include; Ms. Peris Urasa (NACP), Ms. Bahati Mfaki (NACP), Mr. James Juma (NACP), Mr. Pavel Mtango (NACP), Dr. Bhavin Jani (WHO Tanzania), Mr Koech Rotich (UNAIDS Tanzania), Dr. Sajida Kimambo (UNICEF Tanzania), Dr. Nyagonde Nyagonde (CDC Tanzania) and Dr. Ramadhani Gongo (CDC Tanzania). The MoHCDGEC would like to thank Dr. Stella Kasindi for facilitating the whole process including review of the literature surrounding HIV testing strategies. The MoHCDGEC is also grateful for financial support offered by WHO and UNAIDS during the process of developing this Accelerated plan.

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Finally, this effort brought together many individual and institutional capacities and experiences, and the MOHCDGEC is very grateful to all individuals and institutions for their dedication and commitment towards the content and finalization of this document.



Prof. Muhammad Bakari Kambi
Chief Medical Officer

ACRONYMS

AFS	Adolescent Friendly Services
AGYW	Adolescent Girls & Young Women
AIDS	Acquired Immuno-Deficiency Syndrome
CDC	Center for Disease Control
CHW	Community Health Workers
COP	Country Operational Plan
EID	Early Infant Diagnosis
EQA	External Quality Assurance
HIV	Human Immuno-Deficiency Virus
HSHP	Health Sector HIV Strategic Plan
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
IDU	Injecting Drug Users
IEC/BCC	Information Education Communication & Behavior Change Communication
IQC	Internal Quality Control
KVP	Key Vulnerable Population
M&E	Monitoring & Evaluation
MOHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
MSM	Men Who Have Sex with Men
MTCT	Elimination of Mother to Child Transmission
NACP	National Aids Control Program
NMSF	National Multi-Sectoral Framework
OVC	Orphans and Vulnerable Children
PEPFAR	Presidential Emergency Plan for Aids-Relief
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV

PWID	People Who Injects Drugs
PWUD	People Who Use Drugs
STI	Sexually Transmitted Infections
TB	Tuberculosis
THIS	Tanzania HIV Impact Survey
TWG	Technical Working Group
UNAIDS	Joint United Nations Program on HIV/Aids
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

Executive Summary

The Accelerated Action Plan has been designed to respond to challenges in reaching the 90, 90, 90 targets by 2018 that were observed from previous experience of the HIV Program, and respond to the identified gaps as stipulated in prior National guidance, therefore presenting a need for a comprehensive, rapid, targeted and focused implementation plan that will be practical in responding to guidance from HSHSP IV and NMSF IV in achieving HTS targets in Tanzania,

The following priority strategies were narrated in the HSHSP IV as guide for implementation:

- Community-based HTS and mobile HTS targeting hotspots, prisons, orphanages and selected workplaces.
- Voluntary Assisted Partner Notification (VAPN) will also be scaled up to support index client testing as part of a comprehensive package for testing and care.
- Strengthen and scale up integration of HTS into other health services (TB, STI, OPD, ANC, FP, BTS, etc.).
- In addition, male involvement promoted through couple/partner testing, targeted combination prevention (CP) and workplace HIV testing campaigns.
- Demand creation activities (e.g. use of index clients and peers) implemented to promote HTS uptake, promotion of HIV testing for adolescents through youth-friendly services.
- Strengthen health systems to support HTS: monitoring the quality of HTS, strengthening the supply chain for HTS commodities to eliminate stock outs of test kits and accountability for test kits at all levels, strengthening M&E system for HTC and improving data utilization at all levels.
- Address human resource needs for the scaling up HTS while improving quality of HIV testing: In this effort, capacity building of providers on HTS will be enhanced, improve linkage to care, treatment and support through task-sharing using community health care workers, community development officers and social welfare officers, a framework for sustainable stepwise improvement and certification for these testers and testing points established.
- The HIV rapid testing quality improvement initiative (RTQII) will also be expanded.
- Link clients who are identified positive from testing centers to those who are enrolled to care (completed referral)
- Voluntary medical male circumcision and early infant male circumcision provided in priority regions with low coverage and high HIV burden as one of the entry point in HIV Testing.
- It has also clearly identified that targeted services for adolescent girls and young women (AGYW) need to be expanded to provide tailored services for this vulnerable group in terms of HIV incidence and prevalence.
- Scale up provision of comprehensive HIV prevention, care and support services to KVP groups implementers and to track interventions for KVP
- Strengthen M&E system and operational research so as to inform policy makers.

The services need to be prioritized, targeted and coordinated in terms of resources allocation, data reviews and analysis using an effective monitoring and evaluative system and re-planning for quality and efficiency as they are supported at all levels from National, Sub-National up to community levels.

While the National Multi-Sectoral Framework IV Guidance, clearly states that there are strategies to address factors / bottlenecks that prevent Tanzania from achieving the optimal level HIV and AIDS programmes efficacy.

The identified bottlenecks include;

- *Weak Procurement and Supply Chain Management (PSCM) systems*
- *Poor linkages between health facilities and communities*
- *Shortages of human resources*
- *Inadequate funding and use of appropriate technologies to support implementation*
- *High numbers of people lost to follow-up*
- *Weak monitoring and evaluation (M&E) system*

The NMSF IV and HSHSP IV recommend strengthening of the socio-policy and legal environment, strategic partnerships and alliances necessary to support and complement community efforts including sustained demand creation and social protection, as well as stigma and discrimination reduction.

The Accelerated Action Plan for HIV Testing Services (HTS), in summary, aim to increase HIV testing in high-burden regions and targeted and focused HIV testing in low burden regions. There will be review of targets and data quality, review of geographical status through regional targets and HIV burden of disease, prioritization of men, KVP and adolescents. There will be community-based outreach for hot-spots and KVP while ensuring linkage and retention to care. All HTS facilities will aim to be linked electronically to the National data system such as DHIS 2.

Chapter 1: Overview of HIV Identification for PLHIV

1.1 Introduction

Aligning to the WHO Global strategy of 2016 to 2021, continued support of the health sector response is needed to build on universal health coverage, potentiating people-centered approach addressing human rights and equity, with radical decline in new HIV infections and reducing deathsⁱ.

UNAIDS 2015, stipulates a fast-track combination strategy to reduce new infections to less than 500,000 by 2020 as a global target, and end HIV as a public health threat by 2030ⁱⁱ.

UNAIDS has stipulated on focusing on pockets of high-transmission rates, expanding the dimension of service delivery to community levels for demand creation and treatment adherence support, while PEPFAR 3.0 enhances data-driven approaches, targeting geographical areas and populations so as to reach the highest impact for the 90, 90, 90 targetsⁱⁱⁱ.

The Global Fund strategy 2017 – 2020, clearly directs on investing to end epidemics, maximizing impact against TB, HIV and Malaria by building resilient and sustainable health systems, promoting and protecting human rights and gender equality while mobilizing resources to support countries to achieve Sustainable Development Goals (SDGs)^{iv}.

These initiatives focus the health sector response for HIV services, HTS inclusive, and in Tanzania, the government's expectations by 2020 is envisaged that the coverage of the national response to HIV and AIDS will have improved to ensure that 90% of all people living with HIV know their HIV status, and 100% of pregnant women with HIV receive anti-retroviral treatment for prevention of mother to child HIV transmission (PMTCT).

1.2 Tanzania HIV Strategic Scenario Over the Implementation Years

Tanzania is the biggest country in East Africa with a total of 31 regions, whereby 26 are in the mainland and a total of 169 districts. The population is skewed to young people whereby the under 24 contribute to 63% of the total population. In the country 68% of the population live in rural areas.

New infections in Tanzania occur in the context of stable heterosexual relationships (38.8%), casual heterosexual sex (28.9%), sex workers (1.3%) clients of sex workers (8.7%), partners of sex worker's clients (3.3%), partners of people engaged in casual sex (7.6%), PWID (2.1%) and MSM (6.8%)^v.

During the implementation of HSSP III, number of health facilities with Care and Treatment Clinic (CTC) Services increased from 1,176 out of 6,342 (18.5%) health facilities in 2012 to 6,155 out of 7,494 (82%) health facilities by December 2016. These facilities provided care, treatment and support services through CTCs and RCH clinics that provide Option B+ for pregnant women.

The National Multi-Sectoral Framework IV stipulates that during the above period, effective coordination of HIV and AIDS programs at all levels continued to be critical to guide cost-effective resource allocation and planning of service delivery tailored for local epidemiology.

In Tanzania the HSHSP IV has specified that HTS are provided through a mix of modalities including Client Initiated Testing and Counselling (CITC) and Provider-Initiated Testing and Counselling (PITC) provided in both health facilities and community settings.

The Accelerated Action Plan for HTS is meant to consolidate different priority guidance for HIV services in Tanzania and include other key documents for example the National Multi-Sectoral Framework – IV, PEPFAR Country Operational Plan – 2018, Key and Vulnerable Population mapping – 2018 and Tanzania HIV Impact Survey for 2016 – 2017 to come out with a cost-effective, quality and targeted roadmap.

Different initiatives will be undertaken for regions with low HIV yield for example screening before testing and concentrating with clients with high-risk symptoms while in community HIV testing will be used in regions/locations with high HIV burden, similarly for targeted population groups will receive a package of HTS care as per need.

1.3 Justification of the Accelerated Action Plan for HIV testing in Tanzania

The country efforts have always embraced global and in-country best practices and evidence. The fourth NMSF (2018/17 to 22/23) is therefore informed by the UNAIDS Fast-Track Commitments to End AIDS by 2030 and the country is working to achieve 90-90-90 targets by 2020^{vi}; The country implementation of the 90,90,90 goals were still low particularly for the first component of HIV Testing which was at 61% by end of 2017, the linkage to ART of those identified was 90% while viral suppression rates has reached 88%. Review of this status necessitated for a targeted Accelerated Action Plan, that will consolidate evidence-based priorities for a roadmap that will define the needed interventions to reach the 90, 90, 90 goals.

The Accelerated Action Plan consolidates existing and new guidance for HTS for all populations and settings and for various approaches while taking into consideration the National and Sub National targets for different population groups to identify HIV positives efficiently. The Plan provides guidance on what needs to be undertaken for HIV testing in Tanzania (what); the responsible entities for the actions (who); the appropriate timelines for the relevant actions (when). Prioritization of services as per need will be effectively done, for equitable consideration.

The broad aim being to make sure that 90% of the people living with HIV know their status by 2020, and 95% by 2023. The targets emanate from the requirement to achieve sustainable development goals to end HIV by 2030 and eliminate new HIV infections.

Reviewing the previous trend of HIV Testing services (HTS) over the past 3 years, it has been documented that 2,891,391 were tested in 2015, whereby 157,496 (yield of 5.45%), 4,848,615 were tested in 2016, whereby 212,221 (yield of 4.38%) and in 7,362,222 people were tested in 2017 and 227,879 (yield of 3.01%) HIV Positive.

Reviewing the on-going initiatives including recent HIV Testing campaigns, it is clear that there is a decreasing yield over the years, whereby from the above figures narrated for 2018, the yield is anticipated to reach less than 2.4% seen from experience; if the total number culminates at 9,678,254 people tested out of whom 241,956 were found HIV positive (by end of December 2018).

This demonstrates that, reaching the last mile of the HIV Testing goal of 90% of people knowing their status by 2020, then, if we will continue with the current methods and yield, then large number of people will have to be tested to reach the remaining gap of more than 440,000 unidentified HIV positive. Using the same trend noted above, it will mean that 10,162,166 people will need to be tested by 2019, to get about 233,243 (yield of 2.0%) HIV Positive and test 10,670,274 to get a yield of 213,405 HIV Positive people, again a yield of 2.0%.

There is a need to conduct cost-effective, comprehensive and targeted actions to increase yield using acceptable numbers of HIV Test kits, testing in areas and population groups who have higher number of people that do not know their HIV status; this Plan aims at contributing the solution in finding the remaining unidentified PLHIV in the country.

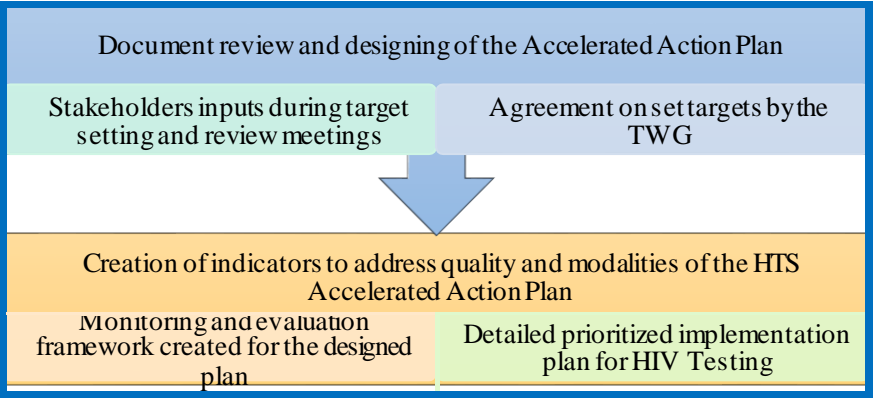
1.4 The process of developing the “Accelerated Action Plan

This is the result of activities that began with significant stakeholder consultations. The stakeholders, including government, funding partners, technical partners met to update each other on the global, regional and national HIV epidemic. The first meeting was addressing “target setting” whereby technical officers from the National AIDS Control Program, UNICEF, UNAIDS, WHO, CDC, implementing partners, Global Fund representatives/consultants met and went through the different situations observed at the country level and started to pave a way towards a comprehensive, but targeted, cost-effective accelerated action plan for Tanzania.

The follow-up review and in-depth discussions were done through a series of two focus group, in-depth discussion, first by the members of the UN (WHO, UNAIDS) followed by a technical group of implementing partners who went on in detail describing the current landscape as it is now and what have been their best practices. The partners that attended came from Health Policy Plus, JHPEIGO, ICAP, AMREF, MDH, AGPAHI, EGPAF and HQPIA.

In-puts from these round-table discussions have complimented the detailed literature review of key Tanzania Policy documents. These are the Health-Sector HIV Strategic Plan IV, the National Multi-Sectoral Framework IV, the PEPFAR Country Operational Plan 2018, The Key Vulnerable Population guiding documents and different operational plans from other countries (Zimbabwe and Ghana) and the Tanzania HIV Guideline, amongst others.

Figure 1. Development of the Accelerated Action Plan for HIV Testing



Chapter 2: Current Situation

2.1 The Health Sector HIV Strategic Plan

The HSHSP IV (2017-2022) has identified some of *the gaps observed* through prior implementation experience as;

1. Recurrent stock outs of HIV rapid test kits.
2. An inadequate health workforce for maximum coverage of HIV testing according to set standards.
3. Inadequate infrastructure to support HTS.
4. Low uptake of HTS among adolescents and children mainly constrained by the existing age of consent (18 years) which affects access to HTS especially for AGYM who are often vulnerable to HIV, stigma, and lack of appropriate community-based HTS for children and their families.
5. Low up-take of HTS among men. Despite an increase in partner testing there is still low involvement of male partners in HIV testing especially outside the PMTCT setting.
6. Lack of a reliable data collection and reporting mechanism which can provide updates on progress toward increased numbers of people with HIV who know their status
7. Poor quality of rapid HIV testing in terms of compliance to testing standards among testing points and testers.
8. HIV testing does not always reach the people at highest risk of HIV, particularly those who do not interact regularly with the health system.

The HSHSP IV has clearly stated what needs to be done, if we are to reach the targets that have been set. These include the following key areas;

- i. *Intensify existing and/or identify new alternative service delivery models for HTS:*
- ii. *Service delivery models that have proved to and/or can increase uptake of HIV testing services and improve yield will be intensified and/or introduced to meet the fast track target for HIV testing (first 90).*
- iii. *Since HIV testing services are provided in both facility and community settings, the delivery of these services will include integration of HTS into all entry points including STI, TB, FP*
- iv. *The overall quality of HIV testing is of paramount importance to ensure quality (reliable, efficient and effective) results and improve interventions.*
- v. *Scale up targeted HIV testing: The implementation of targeted HIV Testing, will be conducted by scaling up index client HIV testing either through facility and community level.*

The HSHSP IV specifies that efforts to meet the ambitious targets for coverage and uptake of HIV testing, ART enrolment, retention, adherence and viral suppression, PMTCT, VMMC, condoms and demand creation, should be reinvigorated and where necessary strategic shifts made towards achieving the 90-90-90 targets.

2.2 Regional HIV Prevalence data

Prioritization by population-group and geographical location will be critical, and will be informed by more granular data generated from the active involvement of decentralization, coordination and implementation structures of the national response.

Table 1: Regional HIV Prevalence

Regions HIV Prevalence \geq 4.7%			Regions with HIV Prevalence $<$ 4.7%	
1.	Kagera	6.5	Mara	3.6
2.	Geita	5.0	Simiyu	3.9
3.	Mwanza	7.2	Arusha	1.9
4.	Tanga	5.0	Manyara	2.3
5.	Dodoma	5.0	Kilimanjaro	2.6
6.	Pwani	5.5	Kigoma	2.9
7.	Iringa	11.3	Lindi	0.3
8.	Mbeya	9.3	Mtwara	2.0
9.	Songwe	5.8	Singida	3.6
10.	Tabora	5.1	Morogoro	4.2
11.	Katavi	5.9	Rukwa	4.4
12.	Njombe	11.4		
13.	Ruvuma	5.6		
14.	Shinyanga	5.9		
15.	Dar-es-Salaam	4.7		

Reviewing these regional prevalence, there are regions that have a prevalence equal or higher than the National average of 4.7% and the other group whose prevalence is below 4.7%. This average has been conveniently used to ease creation of targets and review the numbers reached in a systematic manner.

Table 2: Tanzania HIV Statistics' Synopses ^{vii}

	2017	Targets by 2019	By 2020 (90%)
<i>Total Population</i>	54,199,163 - 2018; 2012 projections)		
<i>Sex disaggregation of the total population (2018)</i>	Female – 27,689,068 Male – 26,510,095		
<i>Number tested (HTS)</i>	7,362,222	10,162,166	10,670,274
<i>Yield from testing</i>	241,956	233,243	213,405
<i>People Living with HIV</i>	1,500,000		

<i>HIV Prevalence – general population 15-49 years</i>	4.7%		
<i>HIV Prevalence disaggregated by sex 15 - 49 years</i>	Female – 6.2% Male – 3.1%		
<i>Population who know their HIV Status</i>	61% (65.3% females and 52.4% males)		90%
<i>PLHIV on ART</i>	93.7%		90%
<i>PLHIV Virally Suppressed</i>	87%		90%
<i>Annual Estimated Mortality</i>	33,800		50% reduction by 2020
<i>Incidence of HIV (15-49 yrs)</i>	81,000 (0.29)		75% reduction by 2020
<i>Incidence of HIV in youth (<24 years)</i>	43% of the incidence (AGYW are 70%)		
<i>Maternal to Child Transmission of HIV rate</i>	3% at 6 weeks, 7.6% after breast-feeding	< 3%	< 2% Elimination
<i>Male Partner testing</i>	58%		70%
<i>Voluntary Medical Male Circumcision</i>	2,200,000 (78.6%)		81% by 2018 to 90%
<i>Adolescent Girls and Young Women</i>	80,142		
<i>People who inject drugs (PWID)</i>	PWID - 30,000 (HIV prevalence of 36%)-	5,162	
<i>People who use drugs (PWUD)</i>	PWUD – 300,000 (HIV prevalence - 22%)	31,548	
<i>Men who have sex with men</i>	49,000 (HIV prevalence of 25%)	5,162	

Female Sex Workers	155,450 - 69% Reached (HIV Prevalence 26%)		
Prison inmates	HIV Prevalence 6.7% (Female -14.7%, Male 5.2%)		28% Reached with HIV services
Fishermen			28% Reached with HIV services
Miners	225,000		60% Reached

As the target setting process the key issue is, what are the number of clients that need to be provided services to reach the goal of 90% information by PLHIV by 2020 and 95% by 2023

2.3 Identification gaps by different population groups

Table 3: National gaps by population groups to be tested to reach 90% by 2020

<i>Population</i>	<i>HIV Prevalence</i>	<i>Population magnitude</i>	<i>Estimated Number HIV Positive</i>	<i>61% know their HIV status 2018</i>	<i>29% to reach the gap –know their HIV status</i>
<i>Adults General population</i>	4.7%	54,199,163	1,500,000	854,000	440,000
<i>Women</i>	6.2%	27,689,068	975,000	595,000	283,000
<i>Men</i>	3.1%	26,510,095	525,000	259,000	157,000
Total HIV population by gender					
<i>MSM</i>	25%	49,000	10,800	6,588	4,212
<i>FSW</i>	25%	155,465	39,000	23,790	15,210
<i>PWID</i>	36%	30,000	10,800	6,588	4,212
<i>PWUD</i>	22%	300,000	66,000	40,260	25,740
Sub-population total			126,600	77,226	49,374
<i>Pediatrics, Adolescents and youth</i>	2%	32,886,000	657,720	401,209	256,511

If the estimated 440,000 to 500,000 figures are the number to target within the coming two years to reach PLHIV who do not know their HIV Positive status, it is important to find out which population sub-group is anticipated to yield more HIV positive while the program is also giving out prevention services to those who are negative to remain negative. This is due to the fact that reaching the last mile is more challenging and calls for targeted, focused efforts.

This means that the program need to identify **150,000 – 200,000 men** who test HIV Positive, find **256,511 – 270,000 young people (including AGYW)** who are HIV Positive and about **49, 371 – 60,000 Key and Vulnerable Population** who test HIV positive to be identified by 2020.

Young people and men have to be targeted to reach the HTS goal. The key and vulnerable populations will create the low hanging fruits as through a combination of methods they will easily lead to a possible HIV Positive client than the general population. Different strategies such as a combination of PITC and Index testing will need to be employed.

2.4 Burden of disease by geographical location

Burden of disease is the clearer way to understand the HIV population load as it depicts the true number of HIV populations per region. Burden of disease also reflects the interventions that are needed to comprehensively reach the target set by the health system. Burden of disease is determined by the regional population and therefore is diluted in regions with high population groups.

By means of the burden of disease, there are regional variations in terms of the number of people who are HIV positive but do not know their HIV status. From the National data the number of people who need to receive HTS in the regions is as detailed below.

Figure 2: Using burden of disease to determine the HTS Gap

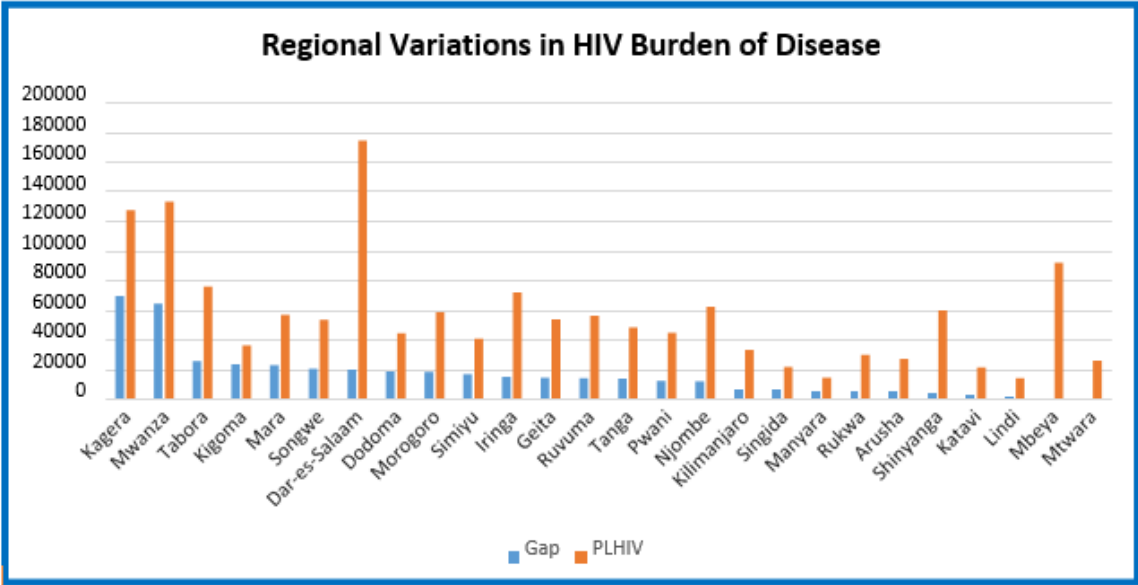


Table 4: Regional rates of HIV Burden of disease for above and below 10,000 population

	Region	Total Burden of HIV	Population who do not know (>10,000)	Region	Total Burden of HIV	Population Who do not know (<10,000)
1	Kagera	127,968	70,002	Kilimanjaro	33,510	6,661
2	Mwanza	133,647	64,815	Singida	22,470	6,458
3	Tabora	76,141	26,144	Manyara	14,909	6,031
4	Kigoma	36,861	23,928	Rukwa	30,407	5,966
5	Mara	57,417	23,468	Arusha	27,564	5,749
6	Songwe	53,917	20,945	Shinyanga	60,403	4,729
7	Dar-es-Salaam	174,839	20,350	Katavi	21,869	2,908
8	Dodoma	44,856	19,130	Lindi	14,686	2,576
9	Morogoro	59,161	18,952	Mbeya	92,413	1,541
10	Simiyu	41,320	17,425	Mtwara	26,409	1,343
11	Iringa	72,428	15,663			
12	Geita	54,071	15,064			
13	Ruvuma	56,649	14,619			
14	Tanga	48,919	14,283			
15	Pwani	45,285	12,814			
16	Njombe	62,630	12,483			
	Total		390,085	Total		43,962

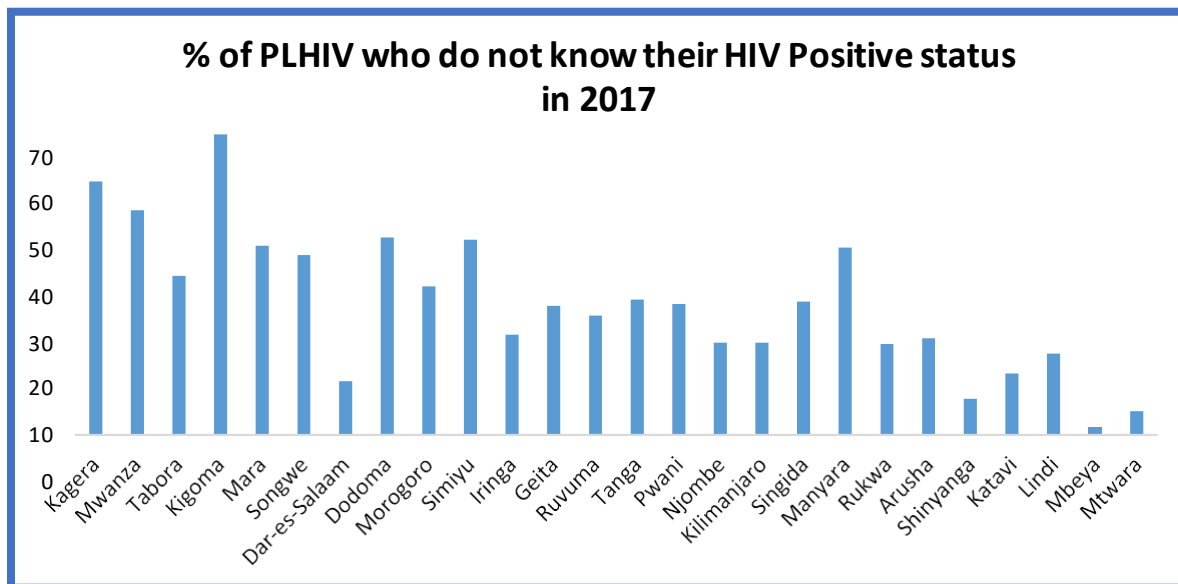
The above Figures really contrast the parameter of use of HIV prevalence, for example Mbeya region, with prevalence of 9% , has the lowest number of PLHIV who do not know their HIV status of 1,541, while Kigoma region with one of the lowest HIV prevalence at 3% has higher number of people who need to know their HIV status of 23,928. At the same time, Njombe with the highest HIV prevalence in the country of 12% has smaller number of people who do not know their HIV status of 12,483, but still this is set as higher than 10,000 people who will be prioritized in the Accelerated Action Plan to reach the 90% targets.

2.5 Awareness of HIV Positive Status in Tanzania

In the country, there are 16 regions with more than 10,000 people “*who are not aware*” that they are HIV positive. The regions are Kagera (6.5%), Mwanza (7.2%), Tabora (5.1%), Kigoma (2.9%), Mara (3.6%), Songwe (5.8%), Dar-es-Salaam (4.7%), Dodoma (5.0%), Morogoro (4.2%), Simiyu (3.9%), Iringa (11.3%), Geita (5.0%), Ruvuma (5.6%), Tanga (5.0%), Pwani (5.5%), Njombe (11.4%).

All these facts direct to a geographical and hot-spots view for a cost-effect intervention for HTS, using HIV Burden of disease in considering regional targets and for geographical analysis within these regions with high HIV disease burden. The hotspots in these regions such as fishermen, mines and targeted programs for men and the youth including AGYW.

Figure 3: Percentage of PLHIV who do not know their HIV Positive Status in 2017

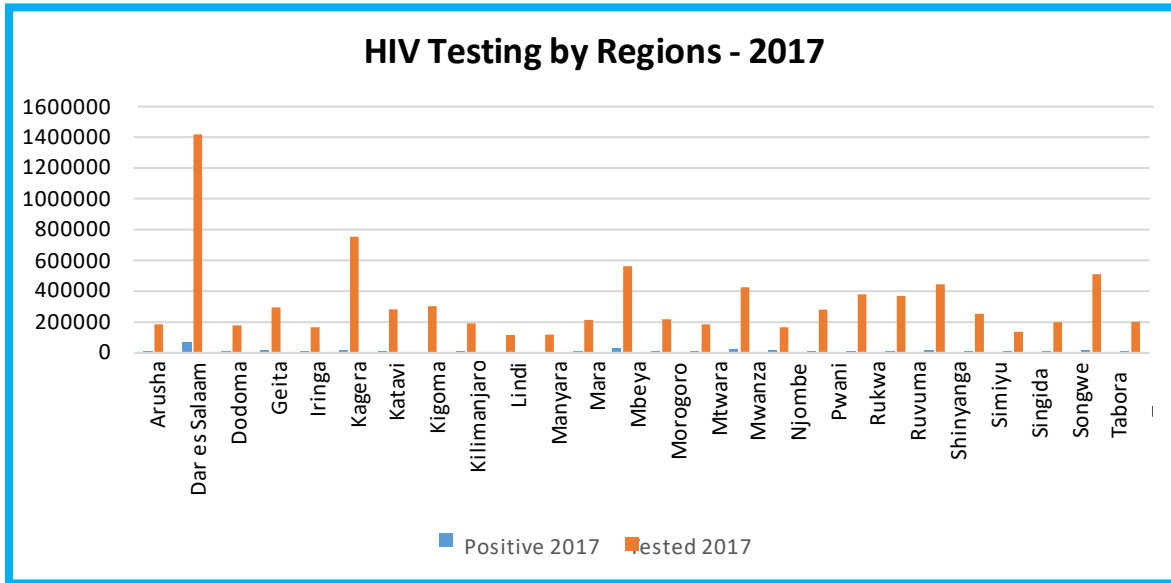


The above graph analyses the burden of HIV among the regions when you compare with the total estimated PLHIV in these regions. The highest fraction is again Kigoma at 65% of the estimated HIV prevalence not knowing their HIV status, followed by Kagera at 55%, Mwanza at 48%, Dodoma at 43%, Simiyu at 42%, Mara at 41% and Manyara at 40%.

2.6 Number of people who were tested in 2017

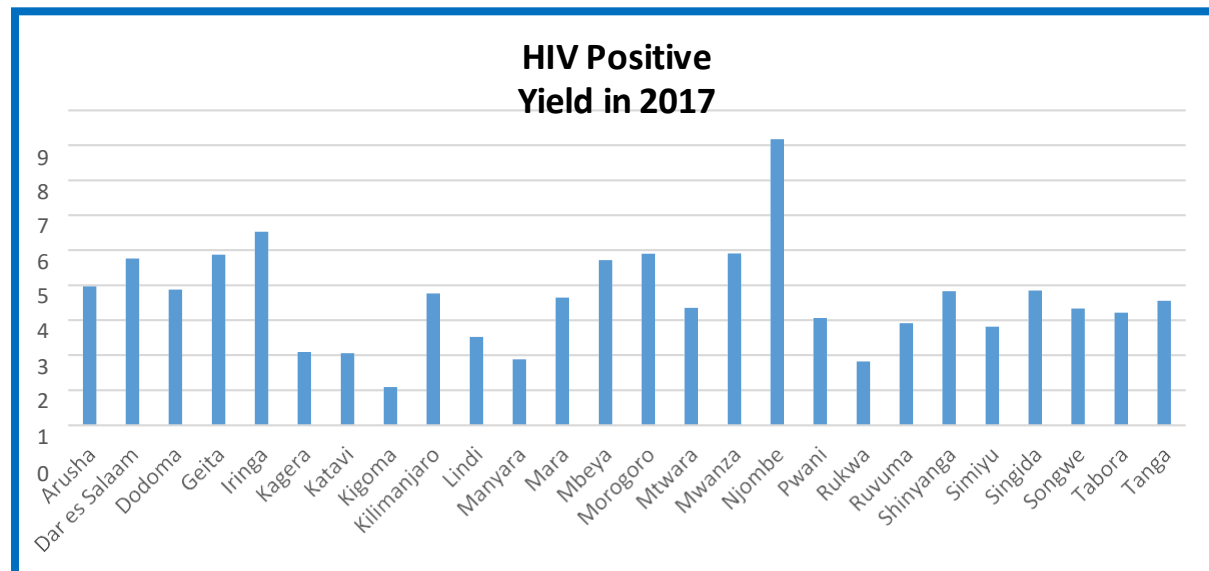
From the experience of implementation of 2017, Dar-es-Salaam has the highest numbers followed by Kagera, Mbeya, Mwanza, Tabora and Shinyanga.

Figure 4: HIV Testing by regions in 2017



From this information it was possible to determine the yield of the HIV testing for HIV Positive status and Njombe (8%) had the highest yield, followed by Iringa (6%), Mwanza (5%), Morogoro (5%) Dar-es-Salaam (5%), Geita (5%) and Mbeya (5%).

Figure 5: HIV Positive yield from HTS in 2017



Chapter 3: About Accelerated Plan for HTS

3.1 Goal, Objectives and Targets

Goal:

To design a two-year, targeted and prioritized, Accelerated Action Plan for HIV Testing Services to reach 95% of PLHIV who know their status by 2020.

Program Objective:

To integrate existing and new guidance for HTS for all populations settings and explicit modalities to improve access to HTS in Tanzania

Broad Objective:

To extend identification, linkage and retention of HIV positive clients synchronized to an efficient record-keeping system

Purpose:

Instituted targeted, prioritized and cost-effective HTS program linked to ART

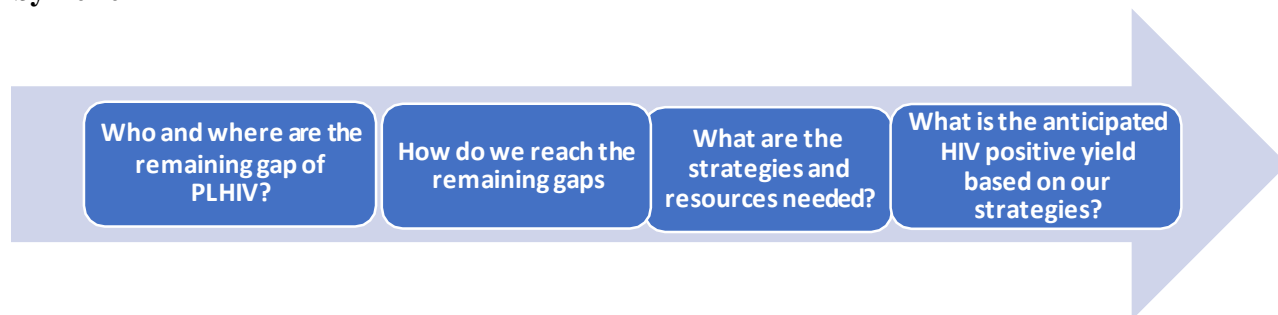
- *Efficient data and recording system for HIV Testing in place for both health facilities and communities*
- *Comprehensive, targeted HIV testing to all prioritized population groups in high HIV prevalent regions and councils*
- *Efficient and targeted demand-creation for HTS such as through use of IEC/BCC*

Specific Objectives:

1. To revise HIV testing targets and institute a program that consider age, gender, key and vulnerable populations
2. To establish efficient practice of HTC approaches (PITC, VCT, CITC, Index Testing, PMTCT, VMMC and Community outreach)
3. To monitor quality of HIV Testing and take it to scale, (repeat testing and differentiated service delivery models) oriented to HTS human resource.
4. To enable consistent supply for HIV testing kits and health system support structures in an efficient manner as per targets used to inform the quantification and procurement of HIV Test kits.

3.2 Conceptual Framework on Accelerated Plan on HTS

Figure 6: The Conceptual Framework in reaching the remaining PLHIV identification gap by 2020



3.3 The Planned Outputs on Accelerated Plan on HTS

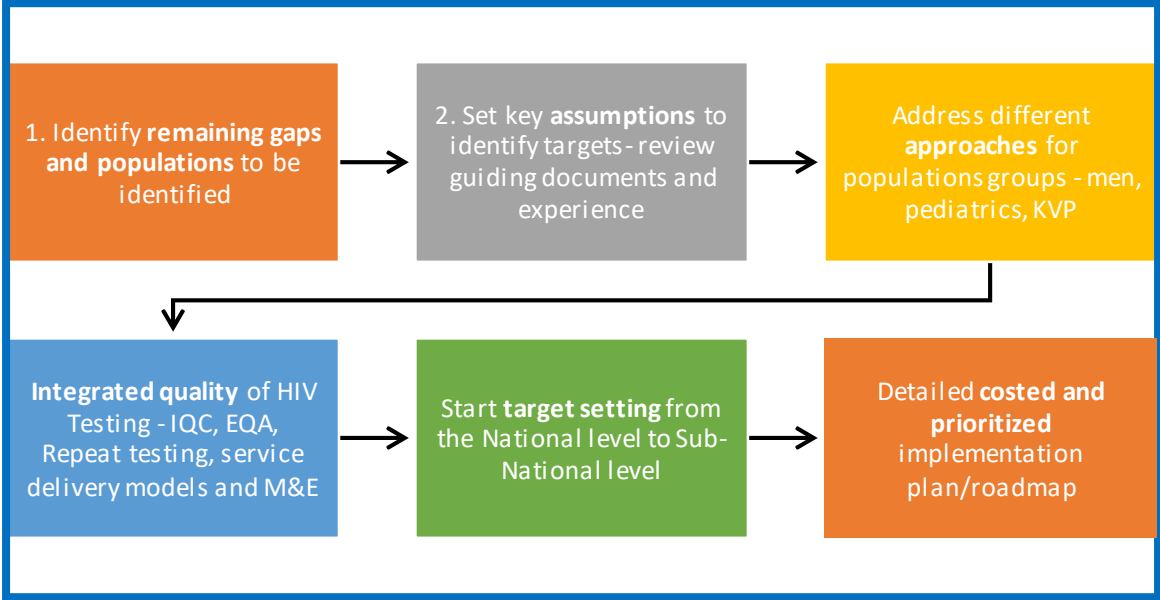
Outputs I	Low uptake of HTS by men, pediatrics and adolescents addressed.	Guidance on HTS approaches to HTS workers (PITC, VCT, CITC, Index Testing, PMTCT, VMMC, Community outreach) provided	Quality-centered (IQC and EQA), compliance to the HIV testing algorithm for HTS program instituted in all testing sites	Consistent supply of HIV testing kits to all testing sites, provided
Outputs II	Supported hot-spots for high HIV positives yield – fishermen camps, long-truck drivers’ stopovers, mining areas and prisons	Clear pre-determined targets at National, Sub-National and Community levels for testing modalities	Differentiated service delivery models of care used to provide HTS services	System support structures for HTS managed
Outputs III	Prioritized key and vulnerable population for HTS – AGYW, OVC, MSM, IDU, Prisoners and Female Sex Workers	A clear system for supportive supervision integrated within HTS	Validation mechanisms in place for true HIV Positives (sensitivity) and HIV negatives (specificity)	Integrated screening of HIV Testing clients for low yield areas such as OPD and low prevalence regions for HIV

From the above detailed objectives, different indicators will be developed aligning to identified *outcome and outputs* across key areas that will guide the implementation of the Accelerated Action Plan.

This plan will help in managing the provision of equitable HIV Testing Services (HTS) while governing consumption of HIV Test kits in a cost-effective manner, and prioritizing specific population groups and geographical locations affected by HIV using appropriate modalities.

3.4 Determining the targets to be used for HTS

Figure 7: Creating the HIV Testing targets



The HIV Testing targets have been set following the above flow of initiatives using guiding documents at the National level and integrating key components such as quality initiatives and different approaches in HTS. The process started with National level so as to set the ground for other SUB-National levels.

Targeting Considerations

- General Population, 15-64 years (Men, Women)
- Key population groups, (FSW, IDU, etc.)
- Children 0-14
- Adolescents, 10-19, (AGYW, others)
- PITC, CITC, Community (Others), Index (facility/community)
- Over-testing as it happens with testing campaigns to be factored in, as a matter of fact to be able to address campaigns in the future,
- Targets be set through top down approach; i.e. national, regional, council

Source Documents

- Global Funds gap Table, Routine Program (Government & PEPFAR) data, UNAIDS SPECTRUM PLHIV estimates, Country Performance framework, and Some key considerations in HSHSPIV, NMSF, and THIS (2016/7) report,

Key assumptions used,

- Number of PLHIV from the UNAIDS Spectrum 2018 was estimated to be constant (only insignificant variations are expected) over the next three years,
- Baseline Counts of people who had received ART by quarter four in 2017, and people who received HIV tests in 2017, were used to guide identification of the gap to reach the first 90% (global target),
- The 2% increase in successful linkages was assumed from baseline of 74% to estimate number of people to be initiated in ART yearly, towards 2020,
- Looking at data trends estimated the number of individuals to be diagnosed each year, towards 2020,

Process of target setting

- Established the structures of the HTS data outputs from DHIS2 database. This was necessary to help a team identify key trends in data structures and reports over time. On few interventions that were lacking data (e.g. index testing, information from Implementing Partners pilots were used).
- The team identified reasonable contributions of individual HIV testing modalities (testing approaches) and key interventions on populations groups (such as KVP, CBHTS etc.), from 2017/2018 routine data,
- Crude contributions of individual modalities were standardized and used for setting up the targets for similar “*HIV testing modalities*” and “*population groups*”,

National Targets, 2019 and 2020

The numbers allocated in 2018 are actual test expected by December 2018 based on current reach and testing trends over next three months. By end of September, the program had already reached approximately 11 million tests.

Table 5: Annual HTS targets, disaggregated by population groups and HIV testing modalities for 2019 and 2020.

HTS Mode and Pop GRPs	% Contribution	TOTAL TESTS		
		2018	2019	2020
PITC (Adults)	44.6%	6,289,694	4,532,319	4,758,943
CBHTS	10.5%	1,480,758	1,067,026	1,120,379
INDEX-FACILITY	6.1%	860,250	619,891	650,887
CITC	5.5%	775,635	558,918	586,865
KVP	1.6%	225,639	162,594	170,724
PEDS (Age ≤14)	1.3%	183,332	132,108	138,714
PMTCT	30.0%	4,230,736	3,048,645	3,201,083
TB/HIV	0.4%	56,410	40,649	42,681
TOTAL	100.0%	14,102,453	10,162,150	10,670,277
GENERAL POPULATION				
MEN		6,050,295	4,359,809	4,577,808
WOMEN		8,052,158	5,802,341	6,092,469
TOTAL		14,102,453	10,162,150	10,670,277

Regional Target Setting

Key Assumptions

- Number of people receiving ART as of September 2018 from the DHIS2 database,
- Estimated counts of PLHIV in each region, using the UNAIDS spectrum files,
- Estimated Regional contributions to the national first 90's gap,
- Based on data trends, estimated Number of PLHIV to be diagnosed,

Table 6: Annual regional HTS targets for 2019.

Region	Targets (Total tests)	New HIV+ to be Identified
Arusha	134,598	3,500
Dar es Salaam	476,446	12,388
Dodoma	447,900	11,645
Geita	352,696	9,170
Iringa	366,716	9,535
Kagera	1,638,959	42,613
Katavi	68,093	1,770
Kigoma	560,040	14,561
Kilimanjaro	155,951	4,055
Lindi	60,312	1,568
Manyara	141,208	3,671
Mara	549,455	14,286

Mbeya	36,079	938
Morogoro	443,724	11,537
Mtwara	31,432	817
Mwanza	1,517,517	39,455
Njombe	292,263	7,599
Pwani	300,020	7,801
Rukwa	139,690	3,632
Ruvuma	342,270	8,899
Shinyanga	110,722	2,879
Simiyu	407,969	10,607
Singida	151,195	3,931
Songwe	490,386	12,750
Tabora	612,101	15,915
Tanga	334,406	8,695
National	10,162,150	264,216

Since the country is still to introduce Unique Identifiers and the successful linkages of patients is not 100%, the target of 264,216 identified tests positives has accounted for repeat tests and linkage failure in the annual target of 233,243 PLHIV to be identified in 2019.

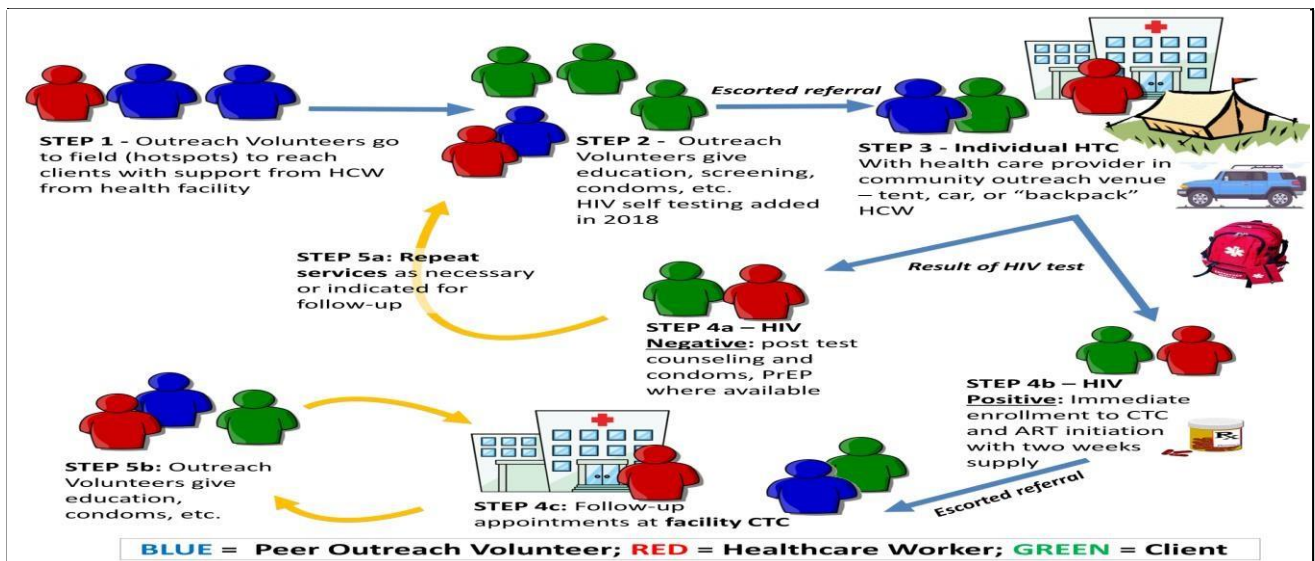
The above targets are crude for all interventions. To be more precise, these targets will be aggregated by age groups and sex to ensure close monitoring of key groups like children, Adolescents' boys and girls etc. This will be done during revision of country HIV performance frame work.

Chapter 4: Implementation

3.1 Approaches in Accelerated Plan

The plan is to increase HIV testing in high-burden with large gap of unidentified PLHIV regions and implement targeted and focused testing in low positivity with few unidentified PLHIV regions. There will be review of targets and data quality, review of geographical status through regional targets, prioritization of men, KVP and adolescents. There will be community-based outreach for hot-spots and KVP while ensuring linkage and retention to care. All HTS facilities will aim to be linked electronically to the National data system such as DHIS 2.

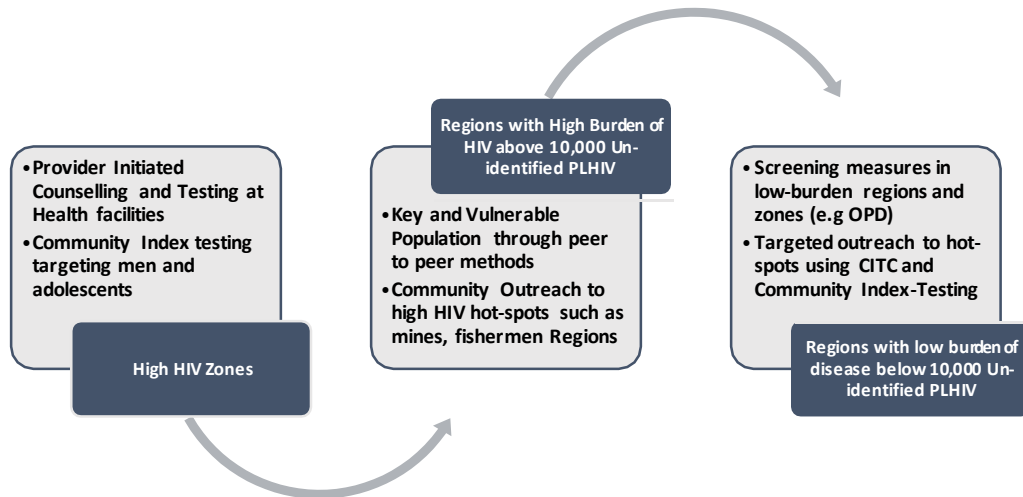
Task shifting is advocated especially for community HTS use of service delivery models to improve community and health facility testing. Such models for HTS include those used to reach key and vulnerable populations. For instance, JHPIEGO is focused on testing for high-risk population with intensified index testing and FIKIKA- ICAP using anonymous index testing using cards that has phone numbers, whereby the clients are asked to come to the health facilities. They also map all the hotspots and involve peers to identify the KVP rather than using the health care workers. Boresha Afya North and Central has a different model whereby men-friendly clinic, supported by men HCW are able to provide integrated clinics near hot-spots of high HIV prevalent areas such as fishermen camps and long-truck drivers stop-over junctions.



ICAP – Fikia model on the use of peer outreach support for HTS service delivery and linkages

The Ministry of Health, Community Development, Gender, Elderly and Children has been leading the process by setting the policy environment through a variety of policy guidelines and standard operating procedure that has enabled significant HIV testing and linkage of HIV positive to ART, while monitoring retention to HIV services. Integration of services will then account for a sustainable, cost-effective program.

4.2 Mix HTS modalities for Accelerated Plan



Combining all these analysis, automatically there are converging regions which are therefore the areas for priority when conducting the Accelerated Action plan. However, the burden of disease will be used, and the 16 regions with burden of HIV more than 10,000 are the recommended regions of priority.

4.3 Linkages

All HIV-positive clients testing positive at a facility should be escorted (with their consent) to the point for ART registration and clinical assessment. This should ideally be done by the HCW who has performed the test or by a lay worker. All clients who have tested HIV positive in the community should be linked, with their consent, with a community health nurse or other community-based lay worker.

The person who has performed community testing should link the client to their ART site of choice and, after one month, follow up to ensure that linkage has occurred. If not linked, tracing should be performed by the community-based HCW.

4.4 Different Population groups

4.4.1 Key and Vulnerable Populations

KVP are at a high risk of HIV transmission; there is a need for an aggressive scale up of targeted services tailored to the unique requirements of these groups. These services should as much as possible be integrated into the health service delivery system – both facility and community based.

Key and vulnerable population (KVPs) are defined within the World Health Organization (WHO) Global health sector strategy on HIV/AIDS 2011-2015 to include both vulnerable and populations who are at higher risk for HIV^{viii}. They often have legal and social issues related to their behaviors

that increase their vulnerability to HIV. Several vulnerable groups such as street children, long distance truck drivers, miners and fishermen remain at high risk of HIV infection and are included. In the HSHSP IV, it has been detailed that combination prevention interventions such as HTS, condom programming, STI management and ART initiation were implemented to reach KVP using both static and outreach services.

Key intervention areas for this population group will be the following;

- *Community mapping for high HIV prevalence areas for KVP*
- *KVP offered an integrated package of services, HTS as a core service, (Condom distribution, FP, STI screening and treatment, GBV services, PEP)*
- *Targeted community testing will be provided with escorted referrals and use of CHW*
- *Linkage initiatives to ART for key and vulnerable population groups while tracking retention rates through detailed data system follow-ups and review*

Key and Vulnerable populations therefore need to be provided with an aggressive, targeted, scale-up services that are integrated into the health service delivery system at the levels of the health facilities and community.

4.4.2 Adolescent Girls and Young Women

Some of the challenges and gaps in addressing AGYW population include:

- Inadequate prevention strategies focused on adolescents and young people and locations of high risk
- Age-of consent for HIV testing, (currently at 18years), affects HTS access especially for AGYW who are more vulnerable to HIV
- Inadequate integration of HIV and AIDS services in school health program interventions
- Inadequate SBCC programs focusing on young people
- Inadequate community-based HIV and AIDS interventions targeting young people
- Inadequate focus on AGYW interventions due to lack of age disaggregated data on care and treatment services for adolescents and young people
- Few health facilities offering adolescent-youth friendly HIV services
- Lack of a standard service package for adolescents and youth living with HIV Strategic outcome

The aim is for reduction of new HIV infection among adolescents and young women by 50% by 2022 and the overall goal is that 95% of adolescent living with HIV will be on ART by 2022

Key intervention areas to improve AGYW will focus on the following;

- Strengthen linkage mechanisms for facility and community-based services to increase retention in care and treatment services for adolescents and youth
- Improve coordination among stakeholders working on adolescent and youth HIV and SRH services and sensitize on HIV testing for treatment and prevention linkages.

- Provision of adolescent friendly services (AFS) integrated into all councils is recommended, and use of community health workers (CHW) to support HIV testing.
- Advocate for policy changes to include lowering age of consent and self-testing services.
- Expand access to and utilization of integrated quality HIV and AIDS services by adolescents and youth.

4.4.3 Orphans and Vulnerable Children

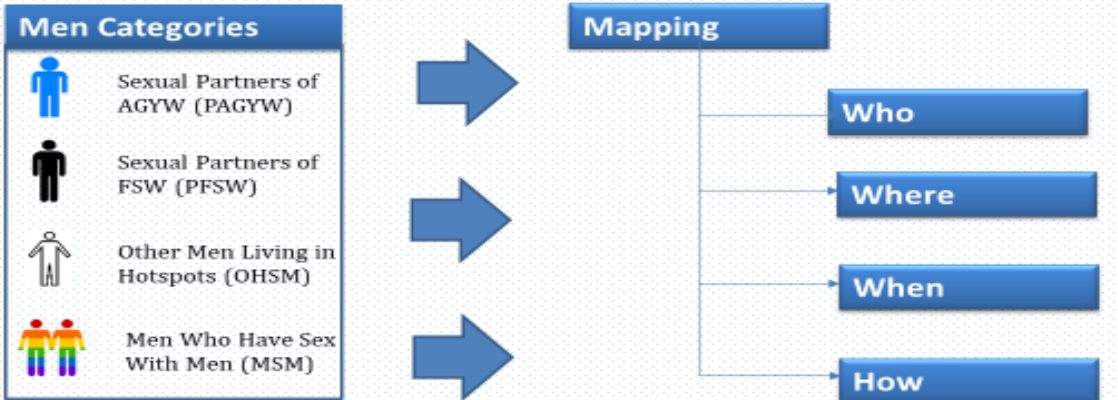
One of the strategies to increase the uptake of HTS is to extend HIV testing beyond health facilities and community-based initiatives. The program will strengthen linkage mechanisms for MVC/OVC services to enhance identification, enrolment and retention of OVCs into care and treatment services.

4.4.4 Men

HSHSP IV has noted low focus on comprehensive, age-appropriate, gender-sensitive sexual education that addresses prevention of HIV and GBV. There is a need to strengthen demand creation and promotion of comprehensive services for HIV and AIDS prevention, treatment, care and support especially HTS, ART (treat all), VMMC and Condoms at all levels. These will synergize with promotion of evidence based and targeted SBCC interventions, through strengthening coordination of partners and sharing of best practices among implementers of SBCC Suggested Key intervention areas in the HSHSP IV, to facilitate male participation in HTS include;

- *Establish a routine combined HTS HIV prevention campaign in workplaces including the informal sector and hard-to-reach communities such as mining areas, fishing camps, and plantation workers*
- *Expand workplace programs that sensitize men to participate in sexual, reproductive, maternal and child health for better health outcomes of their families*
- *Introduce services for men, such as screening for prostatic cancer or non-communicable diseases (NCDs) in reproductive and child health services, especially for spouses of PMTCT clients*
- *Engage male community leaders to address the needs and role of men in sexual, reproductive, maternal and child health services both as peer motivators and influencers*
- *Joint clinics that will cater for both men's and women's needs. For example, partners/spouses of women receiving PMTCT services to receive their ARVs at the PMTCT site until their partner/spouse graduates then they will continue at the CTC together. This will enhance compliance.*

Example of approaches that have been used to engage and reach the men is done at community.



Sauti Approach for engaging and reaching men

Chapter 5: Efficient HTS modalities

5.1 Provider Initiated Testing and Counselling

Modification in testing approach from the usual testing of the general population to a more prioritized, targeted testing was suggested within geographical areas with high burden of HIV and low coverage of individuals who have tested for HIV and know their sero-status and more focused testing in health facilities. Scale up implementation of focused PITC in all health facilities attending children (RCH clinics, OPD, hospital pediatric wards) has also been advocated including all other population groups.

PITC based strategies to health facilities with high HIV positive numbers and high yield, and introduction of “screening” measures in facilities/areas with low yields of HIV positive while focusing on clients with high-risk symptoms is recommended. It is also advocated for community-based testing in high-burden areas including key and vulnerable populations specially to target high-yield for HIV positives for men.

For PITC, the country advocates scale-up the Combination Prevention approach for PITC to facilities with both high numbers of HIV-positive test results and high yield to ensure that it maximizes the value from this investment. The result of this effort will be to increase yield for PITC.

Key Interventions that will be used for PITC include the following;

- Scale-up of differentiated HTS models such as PITC and CIRC and facilitate referral and linkage to ART
- Integration of HIV testing within other services at the health facilities
- Quality provision of services by reducing re-testing and double-testing
- An effective, linked M&E system for monitoring outcomes and assisting in reporting to DHIS 2
- Strengthen and improve integration of TB, HIV and other sectors such as Reproductive and Child Health at all levels to reduce the burden of HIV among TB patients and TB among PLHIV
- Strengthen effective linkages and referrals between community and clinic-based services.

5.2 Differentiated HTS Models to facilitate referral and linkage to ART

HTS Guidance for PITC, CIRC and Index-testing

- Any client voluntarily attending the health facility for HIV testing should be provided with the service directly.
- All clients presenting to any service with signs or symptoms of HIV should be offered HTS.
- For clients attending for another health reason, PITC should be prioritized/Integrated in the following entry point for both adults and children, regardless of whether there are signs or symptoms suggestive of HIV: TB Clinics, STI Clinics, In-patient departments, ANC/PNC

- For all other clients attending OPD, specialist clinics and the laboratory, HTS should be promoted by explaining the benefits of HIV testing and directing clients who choose to be tested to the appropriate HCW, who is trained to perform HTS, or to the laboratory. Use of a screening form is recommended at these testing points.
- Community-based HIV testing services that is generalized campaigns are low yield and hence may not be cost effective in a lower-prevalence setting. In order to practically use them there is a need for screening of clients in such campaigns so that clients who are not at defined risk or have already tested are not re-tested. Community-based testing activities should be targeted at;
 - *Men*
 - *Key populations (female sex workers, MSM, PWID)*
 - *Testing partners and children of an identified index client.*
- Self-testing may have a role in the testing and re-testing of high-risk key populations and in performing index client testing. Self-testing could be one of the modalities to use for young people, although as a strategy it is still being discussed in Tanzania. Once the client is HIV positive, they will still need to be confirmed at the health facility level. As a country the use of media for country-wide sensitization is key so that the population groups that will use self-testing are already informed and know what to do. HIV self-testing may be implemented using a range of strategies:
 - Distribution: from the facility or in the community
 - Testing: supervised, semi-supervised or unsupervised.
- In community-based testing (including community-based index client testing), an integrated approach to HTS should be taken. During community testing, the following health screening activities may be offered - Screening for malnutrition, BP check, Glucose check, TB screening, STI screening and HIV testing.

5.3 HIV Index Testing

The suggested key interventions have been index-testing to improve finding of men in care. For COP 2018, major shifts that PEPFAR/T will implement to address the broad gaps in coverage include three key aspects of HIV case finding: index testing, provider-initiated testing and counseling (PITC), and community-based testing.

The proportion of positive results coming from index testing increased from 1% in FY2017 Q1 to 17% in FY2017 Q4. PEPFAR/T advocates increasing the *scale-up of testing with a focus on sexual and needle-sharing partners to ensure high fidelity*. Through this PEPFAR/T estimates that 30% of all HIV-positive people are identified through index testing. Index testing will accelerate progress broadly but will especially help to close the gap in men, since most HIV-positive clients are currently women.

Modalities of conducting index-testing are elaborated below;

- Passive notification is when HIV-positive clients are encouraged by a trained healthcare worker to disclose their status to their sexual or drug injecting partners by themselves and to suggest HTS to the partner.

- Assisted partner notification is when a consenting HIV-positive client is assisted by a trained healthcare worker to disclose their status or to anonymously notify their sexual partners. The provider then offers HTS to these partners. Assisted partner notification is done using contract referral, provider referral or dual referral.
 - Contract referral: The client makes a contract with a trained healthcare worker and agrees to disclose their status by themselves and to refer their partner to HTS within a specific time. If the partner does not access HTS, the healthcare worker will contact the partner directly to offer HTS.
 - Provider referral is when, with the consent of the HIV-positive client, a trained healthcare worker confidentially contacts the person's partner directly and offers the partner voluntary HTS.
 - Dual referral is when a trained healthcare worker accompanies and provides support to the HIV-positive client when they disclose their status and may then provide HTS to the partner. Capacity building to support HCWs to perform index client testing and partner notification is key.
- Index testing is suggested to be used in combination with other methods to increase yield for example, outreach to fishermen hot-spots is then combined with index-testing to track the sexual contacts.

5.4 Prevention of Mother to Child Transmission

PMTCT program supports elimination of HIV to HIV exposed babies through provision of a package of service that addresses HTS services to pregnant and lactating women. This initiative when integrated with other services at the reproductive and Child Clinics aim to eliminate HIV by 2023.

Key Interventions for PMTCT to be undertaken during implementation of HSHSP IV include;

- Strengthen follow up of HIV infected mothers and infants at facility and community
- Implement the community interventions service package for eMTCT, MNCH, Pediatric HIV care and treatment by using CHWs.
- Improve community knowledge, awareness, attitudes, perceptions, behaviors and practice in eMTCT and Pediatric HIV care and treatment through communication interventions
- Increase male involvement in eMTCT services through improved awareness, reduction in stigma, and community engagement

5.5 Community Initiated Testing and Counselling

As outlined in the National HTS guidelines, community initiated testing will be implemented across all regions of Tanzania. It will help not only with closing broad case finding gaps, but also specifically with case-finding in men, since index testing and community interventions are both high yield for men.

5.6 Strengthening monitoring and evaluation systems for HTS

There are reported existence of multiple vertical recording and reporting systems, this strategy advocates on the use of innovative approaches for data recording and reporting in integrated

service delivery. Furthermore, appropriate and agreed national tools should be used in all routine settings and data review meetings are encouraged to ensure quality improvements for different population groups.

5.7 Strengthen coordination, monitoring and management of supply chain

Key strategies include;

- Strengthen the resource mobilization mechanism to ensure timely and sufficient financial resources for the procurement of HIV and related commodities.
- Improve national forecasting, quantification, procurement and delivery of HIV commodities
- Strengthen collaboration between government and implementing partners to avoid parallel systems
- Improve MSD capacity in terms of infrastructure and transportation to ensure the timely delivery of HIV and related commodities.
- Expand the scope and mandate of Health facility therapeutic committees to include oversight for HIV and AIDS related commodities

Annex: Accelerated Plan Indicator matrix

Goal: To design a two-year, targeted and prioritized, Accelerated Action Plan for HIV Testing Services to reach 90% of PLHIV who know their status by 2020 in Tanzania

Program Aim	<i>To integrate existing and new guidance for HTS for all populations settings using explicit modalities to improve HTS</i>			
Broad Objective	<i>To extend identification, linkage and retention of HIV positive clients synchronized to an efficient record-keeping system</i>			
Indicator Target	<i>Ninety percent (90%) of HIV positive population seen at health facilities and communities know their HIV status and are linked to ART</i>			
Purpose	<i>Instituted targeted, prioritized and cost-effective HTS program linked to ART</i>			
Output 1:	<i>Comprehensive, targeted HIV testing to all prioritized population groups in high HIV prevalent regions and councils</i>			
Output 2:	<i>Efficient, data and recording system for HIV Testing in place for both health facilities and communities</i>			
Output 3:	<i>Effective and targeted demand-creation for HTS such as through use of IEC/BCC as per population need</i>			
Specific Objectives	<i>To revise HIV testing targets and institute a program that consider age, gender, key and vulnerable populations)</i>	<i>To establish efficient practice of HTC approaches (PITC, VCT, CITC, Index Testing, PMTCT, VMMC and Community outreach)</i>	<i>To monitor quality of HIV Testing and take it to scale, (repeat testing and differentiated service delivery models) oriented to HTS human resource</i>	<i>To enable consistent supply for HIV testing kits and health system support structures in an efficient manner as per targets</i>
Outputs I	Low uptake of HTS by men, pediatrics and adolescents addressed.	Guidance on HTS approaches to HTS workers (PITC, VCT, CITC, Index Testing, PMTCT,	Quality-centered (IQC and EQA), compliance to the HIV testing	Consistent supply of HIV testing kits to all testing sites, provided

		VMMC, Community outreach) provided	algorithm for HTS program instituted in all testing sites	
Outputs II	Supported hot-spots for high HIV positives yield - fishermen camps, long-truck drivers' stopovers, mining areas and prisons	Clear pre-determined targets at National, Sub-National and Community levels for testing modalities	Differentiated service delivery models of care used to provide HTS services	System support structures for HTS managed
Outputs III	Prioritized key and vulnerable population for HTS - AGYW, OVC, MSM, IDU, Prisoners and Female Sex Workers	A clear system for supportive supervision integrated within HTS	Validation mechanisms in place for true HIV Positives (sensitivity) and HIV negatives (specificity)	Integrated screening of HIV Testing clients for low yield areas such as OPD and low prevalence regions for HIV

Goal: To design a two-year, targeted and prioritized, Accelerated Action Plan for HIV Testing Services to reach 90% of PLHIV who know their status by 2020

Program Objective: To integrate existing and new guidance for HTS for all populations settings using explicit modalities to improve HTS in Tanzania

<i>Strategies</i>					<i>Performance Indicators' and set target</i>			
<i>Broad Objective</i>	<i>Time-period</i>	<i>Specific Settings</i>	<i>Responsible Entity</i>	<i>Cost resources</i>	<i>Indicator Performance</i>	<i>Current status</i>	<i>Target</i>	<i>Source</i>
<i>Specific Objective 1</i>								
<i>1. To revise HIV testing targets and institute a program that consider age, gender, key and vulnerable populations)</i>	<i>2019 - 2020</i>	<i>Health facilities and communities</i>	<i>NACP</i>	<i>TBD</i>	<i>The proportion of identified HIV positive clients at health facilities and communities who know their HIV status</i>	<i>61%</i>	<i>90% of HIV positive</i>	
<i>Output 1</i>								
<i>1.1 Low uptake of HTS by men, pediatrics and adolescents addressed.</i>	<i>2019 - 2020</i>	<i>Health facilities and communities</i>	<i>NACP/T ACAIDS</i>	<i>TBD</i>	<i>Sex-disaggregated data for all HTS sites</i>			
<i>Activities for output 1</i>								

1.1.1	Institute adolescent friendly services	2019 - 2020	Health facilities and communities	NACP	TBD	Age-disaggregated data for all HTS sites	
1.1.2	Establish men' corners or special men's clinic beyond the working hours and men-friendly clinics	2019 - 2020	Regions with a HIV prevalence of more than 4.7%	NACP	TBD	Number of facilities in regions, that have started men prioritization in HTS	100%
1.1.3	Continue supporting pediatric Saturday clinics in hospitals and health centers and improve index testing to HIV positive women targeting pediatric clients	2019 - 2020	Regions with a HIV prevalence of more than 4.7%	NACP	TBD	Number of councils supporting pediatric clinics	100%
1.1.4	Establish targeted community outreach for IEC/BCC and HTS for men	2019	Communities with HIV burden of disease > 10,000 people	NACP/T ACAIDS	TBD	Number of regions that have initiated targeted outreach for men	100%
1.1.5	Integrate services for men, screening for prostatic cancer and non-communicable diseases (NCDs) in reproductive and child health services, for male partners	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP	TBD	Percentage of male partners attending RCH services	95%
1.1.6	Harmonize Early Infant Diagnosis (EID) with electronic results system to sites to reduce TAT	2019	Central labs	NACP	TBD	Proportion of sites supported with electronic results' system for EID	
1.1.7	Integrate EID DBS, HTS into outreach health services – EPI, TB, NCD and FP services	2019 - 2020	Regions with a HIV prevalence of more than 4.7%	NACP	TBD	Proportion of pediatric clients, who are exposed/positive for HIV	

1.1.8	Provide targeted HIV testing to all at risk clients within the health system (TB, STI, Malnutrition wards, RCH)	2019 - 2020	Regions with a HIV prevalence of more than 4.7%	NACP	TBD	Number of councils that have instituted integrated HTS services	
1.1.9	Introduce targeted self-testing initiatives in work-places followed by a confirmation facility-based HIV test (Once there is policy integration)	2019	All regions	NACP	TBD	Councils with work-place initiatives using self-testing (Once there is policy integration)	
1.1.10	Improve coordination among stakeholders working on adolescents and youth HIV and SRH services	2019 - 2020	All regions	NACP	TBD	Coordinating events for AGYW	
<i>Output 2</i>							
1.2	Supported hot-spots for high HIV positives yield - fishermen camps, long-truck drivers' stopovers, mining areas and prisons	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Percentage of HIV positive identified from "hot-spots" and linked to ART	
<i>Activities for Output 2</i>							
1.2.1	Mapping of fishermen camps, long-truck drivers' stop-overs, mining areas and prisons	2019	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Councils that have mapped and developed targeted intervention for HTS in "hot-spots" - quarterly basis	50% of hot-spots

1.2.2	Provision of targeted IEC/BCC to the mapped hot-spots	2019	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Number of IEC/BCC activities/events successfully conducted	
1.2.3	Targeted invitations to men for miners, fishermen and truck stop-over points to nearby health facilities for HTS by men providers in men friendly clinics and out-reach clinics	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Mapped hotspots with established male targeted interventions	90%
1.2.4	Provision of linked activities to ART services and retention to care for all identified HIV positive clients from the hotspots (linkage case management, escorted referrals, use of CHW)	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Percentage of clients linked to ART	90%
<i>Output 3</i>							
1.3	Prioritized key and vulnerable population for HTS - AGYW, OVC, MSM, IDU, Prisoners and Female Sex Workers	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/C ommunity stakeholders	TBD	Percentage of key and vulnerable population provided with HTS disaggregated by group	
<i>Activities for Output 3</i>							
1.3.1	Provision of HTS and linked ART support to OVC clients	2019 - 2020	All regions	NACP	TBD	Number of councils providing HIV services and support to OVC	

1.3.2	<i>Provision of community-based testing to adolescent girls and young women integrated to adolescent friendly services</i>	2019 - 2020	All regions	NACP/T ACAIDS	TBD	<i>Number of regions with integrated adolescent friendly programs linked to AGYW community programs</i>	
1.3.3	<i>Strengthen linkage mechanisms for facility and community-based services to increase retention in care and treatment services for adolescents and youth</i>	2019 - 2020	All regions	NACP	TBD	<i>Percentage of adolescents and youth HIV positive, linked to ART</i>	95%
1.3.4	<i>Expand access at health facilities to utilization of integrated quality HIV and AIDS services by adolescents and youth (FP, STI Screening and treatment, GVB Services, PEP)</i>	2019 - 2020	All regions	NACP	TBD	<i>Percentage of adolescents and youth linked to RCH services</i>	100%
1.3.5	<i>Promote evidence based and targeted SBCC interventions for youth and KVP</i>	2019 - 2020	All regions	NACP/T ACAIDS	TBD	<i>Number of councils with SBCC interventions for youth and KVP</i>	
1.3.6	<i>Mapping of KVP in regions to identify community hotspots</i>		All regions	NACP/T ACAIDS	TBD	<i>Number of mapped hotspot at a regional level</i>	
1.3.7	<i>Integration of HTS within programs supporting MSM, IDU and female sex workers</i>	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/T ACAIDS	TBD	<i>Number of regions supporting integrated HTS within programs for MSM, IDU and female sex workers</i>	
1.3.8	<i>Provision of moonlight services for HIV testing at targeted hotspots</i>	2019 - 2020	Communities with HIV burden of	NACP	TBD	<i>Number of hotspots provided with moonlight services in a council</i>	

			disease > 10,000 people				
1.3.9	Targeted community testing provided with escorted referrals and use of CHW	2019 - 2020	Communities with HIV burden of disease > 10,000 people	NACP/T ACAIDS	TBD	Percentage of clients linked to ART	
1.3.10	Linkage for pediatric and HTS activities through the school health program	2019 - 2020	All regions	NACP	TBD	Number of supported school health programs supporting HTS for pediatric/adolescents	
1.3.11	Targeted HTS services and linkage to ART for clients in prisons	2019 - 2020	All regions	NACP	TBD	Number of regions supporting HTS in prisons	
1.3.12	Linkage initiatives to ART for key and vulnerable population groups while tracking retention rates through detailed data system follow-ups and review	2019 - 2020	All regions	NACP	TBD	Proportion of Key and vulnerable population tested for HIV and linked to care	90%

Specific Objective 2

2.	To establish efficient practice for HTC approaches (PITC, VCT, CITC, Index Testing, PMTCT, VMMC and Community outreach	2019 - 2020	All regions	NACP	TBD	Targeted use for different population group and HTC sites determined	
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Output 1

2.1	Guidance on HTS approaches to HTS workers (PITC, VCT, CITC, Index	2019	All regions	NACP	TBD	Proportion of HTS providers oriented to HTS testing	
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	<i>Testing, PMTCT, VMMC, Community outreach) provided</i>					<i>modalities within the last quarter/6 months</i>	
<i>Activities for Output 1</i>							
<i>2.1.1</i>	<i>Provision of PITC, VCT and PMTCT for all facility-based testing and tracking of resulting data</i>	<i>2019 - 2020</i>	<i>All regions</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of clients provided by HTS disaggregated by each testing modality</i>	
<i>2.1.2</i>	<i>Provision of CITC and VMMC to targeted community "hot-spots" and key and vulnerable populations as outreach sites</i>	<i>2019 - 2020</i>	<i>Regions that have not reached the 80% target</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of clients provided by HTS through VMMC at the community level</i>	
<i>2.1.3</i>	<i>Integration of VMMC and EIMC services at HTS in health facilities within high-HIVburden regions</i>	<i>2019 - 2020</i>	<i>Communities in Regions with HIV prevalence > 4%</i>	<i>NACP</i>	<i>TBD</i>	<i>Percentage of identified HIV positives from VMMC and EIMC services</i>	<i>80%</i>
<i>2.1.4</i>	<i>Orientation of HTS providers on use of HIV index testing and filling of specific registers</i>	<i>2019</i>	<i>All regions</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of councils that have provided orientation to HTS providers for index clients</i>	
<i>2.1.5</i>	<i>Institute index-testing through orientation to HTC human resource for in-depth counselling skills (using 5C approach) to enable clients' disclosure of sexual partners (anonymous index using cards, AGYW linking to index male</i>	<i>2019</i>	<i>All regions</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of orientation sessions to HTS staff conducted in a region</i>	

2.1.5	Provision of National registers for index testing to all HTS sites	2019 - 2020	All regions	NACP	TBD	Number of councils that document identification (of sexual partners and biological children < 15 years)	
<i>Output 2</i>							
2.2	Clear pre-determined targets at National, Sub-National and Community levels for HTS testing modalities	2019	All regions	NACP	TBD	Number of regions with clear HTS targets	
<i>Activities for Output 2</i>							
2.2.1	Clear review of targets and the resulting data to clear out duplications of HTS numbers by DHIS 2	2019 - 2020	All regions	NACP	TBD	Percentage of clients tested for HIV as per set regional baseline at health facilities and community testing points	90%
2.2.2	Link all HTS points at hospitals and health centers' levels to an efficient electronic system	2019 - 2020	Regions with a HIV prevalence of more than 4%	NACP	TBD	Number of HTS reports received at each council	
2.2.3	Enhanced pre and post-testing sessions to clients provided by HTS providers, to reduce clients' need for retesting for HIV once determined HIV positive (part of supportive supervision)	2019 - 2020	Regions with a HIV prevalence of more than 4%	NACP	TBD	Number of councils that have conducted supportive supervision for HTS	100%

2.2.4	Determine planned efficiency of use of test kits against number tested	2019 - 2020	All regions	NACP	TBD	Review number of test-kits used in a testing point versus the number of clients tested at regional level	>80%
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Output 3

2.3	A clear system for supportive supervision integrated within HTS	2019 - 2020	All regions	NACP	TBD	Number of supportive supervision visits conducted	
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Activities for Output 3

2.3.1	Institute quarterly supportive supervision for HTS in all regions	2019	Regions with a HIV prevalence of more than 4%	NACP	TBD	Number of supportive supervision visits conducted	
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Specific Objective 3

3.	To monitor quality of HIV Testing and take it to scale, (repeat testing and differentiated service delivery models) oriented to HTS human resource	2019 - 2020	All regions	NACP	TBD	Number of councils with internal quality assurance as per National HIV guideline for reliable results and documentation for all laboratories	
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Outputs 1

3.1	<i>Quality-centered (IQC and EQA), compliance to the HIV testing algorithm for HTS program instituted in all testing sites</i>	2019 - 2020	All regions	NACP	TBD	<i>Number of testing sites with internal Quality Control mechanisms for HIV testing in a council</i>	
<i>Activities for Output 1</i>							
3.1.1	<i>Provide specific registers for HTC to all community testing points and outreach sites</i>	2019	All regions	NACP	TBD	<i>Number of HTS community sites reporting data</i>	
3.1.2	<i>Support data clerks' orientation for documenting and reporting HTS data to council levels</i>	2019	All regions	NACP	TBD	<i>Number of orientation sessions supported</i>	
3.1.3	<i>Mentoring of HIV testers for certification and site enrollment to PT programs</i>	2019 - 2020	All regions	NACP	TBD	<i>Proportion of PT sites that have a PT performance of >90% in a particular quarter in a region</i>	> 80%
3.1.4	<i>Verification of HTC registers and HIV logbook for consistent results, reported up to the level of the district and to the National reporting system</i>	2019 - 2020	All regions	NACP	TBD	<i>The percentage of testers complying with National Rapid testing procedures in a council</i>	100%
3.1.5	<i>Mentoring on quality of HIV testing focusing on IQC/PT/EQA competence of testers, safety, testing materials availability and monitoring the testing points</i>	2019 - 2020	All regions	NACP	TBD	<i>Number of councils documenting improvement in timeliness and accuracy of site-level HIV Testing information at the site</i>	100%
3.1.6	<i>Mentorship on improving documentation of:</i> <i>- HTC Registers</i>	2019 - 2020	All regions	NACP	TBD	<i>Number of councils with mentorship plans for HTS services</i>	

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- *HIV logbooks*
 - *Referral forms*
 - *ANC Registers*
 - *PEP Register*
 - *OPD Registers*
 - *GBV Register*
 - *TB Suspect Registers*
 - *Mother-Child Cohort Register*
 - *VMMC Registers*
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Output 2

3.2	<i>Differentiated service delivery models of care used to provide HTS services</i>	2019 - 2020	<i>All regions</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of regions that have instituted service delivery models for HTS</i>
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Activities for output 2

3.2.1	<i>Provision of HTS in all health facilities at all times during opening hours</i>	2019 - 2020	<i>All Regions</i>	<i>NACP</i>	<i>TBD</i>	<i>Number of councils providing HTS</i>
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3.2.2	All entry points of health facilities (IPD, OPD, CTC, TB, STI, RCH and Specialized clinics) providing PITC	2019 - 2020	All Regions	NACP	TBD	Number of councils providing HTS	
3.2.3	Targeted testing as community-based outreach HTS provided from all health facilities (pediatrics, adolescents, KVP, Men)	2019 - 2020	All Regions	NACP	TBD	Incidence of HIV from all population groups	81,000 Annually
3.2.4	Re-testing of HIV negative pregnant and breast-feeding women integrated in facility and outreach EPI activities	2019 - 2020	All Regions	NACP	TBD	Percentage of re-testing rates at council levels	
3.2.5	Linkage to ART for all consenting HIV positive clients, follow-up adherence, viral load monitoring and link to community-based providers	2019 - 2020	All Regions	NACP	TBD	Percentage of clients retained on ART	95%
3.2.6	Re-testing before ART initiation for referred, un-verified HIV positive clients (indeterminate), exposed clients (SW, IDU, MSM, STI, partner with unknown status, clinical indication and victims of sexual violence, rape or occupational exposure) as per National guideline	2019 - 2020	All Regions	NACP	TBD	Percentage of re-testing rates at health facility levels	

Output 3

3.3	<i>Validation mechanisms in place for true HIV Positives (sensitivity) and HIV negatives (specificity)</i>	2019 - 2020	All Regions	NACP	TBD	National level validation mechanisms in place	
<i>Activities for Output 3</i>							
3.3.1	<i>Define the positivity rate for different population groups (yield) at regional level (age and sex-disaggregation)</i>	2019 - 2020	All regions	NACP	TBD	Percentage of clients who are HIV positive (prevalence and incidence) in a particular region	
3.3.2	<i>Define the positivity rate for HIV testing modality (yield) at regional level (age and sex disaggregation)</i>	2019 - 2020	All regions	NACP	TBD	Percentage of clients who are HIV positive (prevalence and incidence) in a particular region	
3.3.3	<i>Determine the regional rates of successful referrals to ART for all identified HIV positive clients</i>	2019 - 2020	All regions	NACP	TBD	Percentage of HIV positives, newly identified and linked to ART	
3.3.4	<i>Determine regional projected target for HIV testing at quarterly basis</i>	2019 - 2020	All regions	NACP	TBD	Number of clients estimated for HTS at a quarterly basis for the regional target (yield)	
<i>Specific Objective 4</i>							
4.	<i>To enable consistent supply for HIV testing kits and health system support structures in an efficient manner as per targets</i>	2019 - 2020	All Regions	NACP/M SD	TBD	Number of regions with consistent HTS supplies	100%
<i>Output 1</i>							

4.1	<i>Consistent quantification and supply of HIV testing kits to all testing sites, targeted by testing modality and population sub-groups</i>	2019 - 2020	All regions	NACP/M SD	TBD	<i>Proportion of consumables for HIV Testing available (HIV Testing Kits) for health facility and community HTS</i>	100%
<i>Activities for Output 1</i>							
4.1.1	<i>To determine/plan the total annual regional targets and institutionalize accountability system used for kits (ordered/procured/used/expired)</i>	2019 - 2020	All regions	NACP/M SD	TBD	<i>Determine the proportion of kits used for testing compared to kits procured in a quarter for a specific region</i>	
4.1.2	<i>To review record-keeping mechanisms to monitor HTS activities</i>	2019 - 2020	All regions	NACP/M SD	TBD	<i>Number of regions providing timely reports on HIV testing kits and consumables used</i>	
4.1.3	<i>Improve National forecasting, quantification, procurement and delivery of HIV commodities</i>	2019 - 2020	All Regions	NACP/M SD	TBD	<i>Number of regions with consistent HTS support for kits and other supplies</i>	
<i>Output 2</i>							
4.2	<i>System support structures for HTS managed</i>	2019 - 2020	All Regions	NACP/M SD	TBD	<i>Efficient systems in place to support HTS</i>	
<i>Activities for output 2</i>							

4.2.1	Mobilize resources and procure of enough test kits to support HTS services and establish monitoring system for test kits from MSD to user and back	2019 - 2020	All regions	NACP/M SD	TBD	Number of kits procured and delivered to HTS testing points
<i>Output 3</i>						
4.3	Integrated screening of HIV Testing clients for low yield areas such as OPD and low prevalence regions for HIV	2019 - 2020	Communities with low burden of HIV < 10,000 HIV clients	NACP	TBD	Number of testing sites using HTS screening tool
<i>Activities for output 3</i>						
4.3.1	Preparation and adaptation of HIV Testing screening tool and its distribution to testing sites	2019 - 2020	Communities with low burden of HIV < 10,000 HIV clients	NACP	TBD	Screening tool in place and used
4.3.2	Coordinated HTS partners' meetings for quarterly reviews of HIV Test kits at regional levels	2019 - 2020	All regions	NACP	TBD	Number of coordination meetings conducted
4.3.3	Provide orientation sessions to the use of HIV test kits and screening tools for use	2019 - 2020	Communities with low burden of HIV < 10,000 HIV clients	NACP	TBD	Number of orientation sessions conducted

References

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<http://apps.who.int/iris/bitstream/handle/10665/246178/WHO-HIV-2016.05-eng.pdf;jsessionid=C0AC86F0377BB0BA08E53942723F1E29?sequence=1>
- ⁱⁱ HIV Prevention 2020 Road Map Accelerating HIV prevention to reduce new infections by 75%
- ⁱⁱⁱ Tanzania Country Operational Plan COP 2018 Strategic Direction Summary April 17, 2018
- ^{iv} THE GLOBAL FUND STRATEGY 2017-2022: INVESTING TO END EPIDEMICS -
https://www.theglobalfund.org/media/1176/bm35_02-theglobalfundstrategy2017-2022investingtoendepidemics_report_en.pdf
- ^v HEALTH SECTOR HIV AND AIDS STRATEGIC PLAN (HSHSP IV) 2017–2022
- ^{vi} Tanzania National Multisectoral Strategic Framework for HIV and AIDS 2018/19 to 2022/23
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- ^{viii} NATIONAL GUIDELINE FOR COMPREHENSIVE PACKAGE OF HIV INTERVENTIONS FOR KEY POPULATIONS
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