Sustainability Index and Dashboard Summary: Tanzania

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed periodically by PEPFAR teams and partner stakeholders to sharpen the understanding of each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to 90 questions, the SID assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. As the SID is completed over time, it will allow stakeholders to track progress and gaps across these key components of sustainability.

Dark Green Score (8.50-10 points) **(sustainable and requires no additional investment at this time)**
Light Green Score (7.00-8.49 points) **(approaching sustainability and requires little or no investment)**
Yellow Score (3.50-6.99 points) **(emerging sustainability and needs some investment)**
Red Score (<3.50 points) **(unsustainable and requires significant investment)**

Country Overview: Tanzania's overall performance in the area of sustainability demonstrates that ongoing investments are required across all domains. Tanzania has received substantial external financing for its national response to HIV and AIDS since the establishment of PEPFAR and the Global Fund. In addition, a number of cross-cutting investments from HIV funding sources have strengthened the health system as a whole. However, insufficient host country investments in HIV and the health sector have prevented Tanzania from reaching its potential for sustaining the national response.

SID Process: The SID 2.0 process began in January 2016 with a desk review of required documents, including those referenced in SID 1.0 for COP 2015. Additional one-on-one consultations were held with staff in the Ministry of Health and Tanzania Commission for AIDS. Responses to the private sector section were received through the Public-Private Partnership Technical Working Group in the Ministry of Health, which met on January 20, 2016. Consultations with development partners were facilitated through the UN Joint Working Group on HIV and AIDS, which met on February 2, 2016 to review the SID and coordinate necessary follow-ups. On January 15, 2016, Civil Society Organizations met to discuss PEPFAR Q4 results (APR) and also discussed relevant questions in the SID. A final opportunity for all external stakeholders to provide feedback on the SID occurred during a meeting on March 16, 2016. Out of 100 representative organizations in attendance, one quarter attended a breakout session on sustainability of the national response, reviewing the details of the SID as well as suggesting interventions for COP 2016. These suggestions were incorporated into the consolidated external stakeholder recommendations to PEPFAR Tanzania.

Sustainability Strengths: Although no sustainability elements scored within the green color range (7-10 points), two elements performed better than the others: **Quality Management (5.19, yellow)** and **Performance Data (5.99, yellow)**. In the area of quality management, positive steps include continuous quality improvement activities and a national level budget that includes HIV/AIDS activities. The Big

Results Now Initiative also includes a Star-Rating System for facilities in order to enhance quality improvement and public accountability. By law, communities have the opportunity to hold facility services accountable through Health Facility Governing Committees. However, there remain many facilities in which these committees are neither effective nor active. In the domain of Performance Data, sustainability has been enhanced after many years of investment in national information systems, including the Health Management Information System (HMIS) which uses the monthly updated District Health Information Software version 2. (DHIS2), the electronic Logistics Information Management System (eLMIS), electronic HIV Care and Treatment Center (CTC) database, and the Human Resources for Health Information System (HRHIS).

Sustainability Vulnerabilities: Among all SID elements, 4 were registered as unsustainable and requiring significant investment:

- **Service Delivery (3.38, red)**: Although HIV services continue to be rapidly scaled up, the financing for service delivery remains externally sourced, primarily by PEPFAR and the Global Fund. In addition, targeting GOT financial resources to match the burden of HIV at the sub-national level has proven challenging. Following a centralized model of equitable service delivery, GOT resources have been evenly spread among districts or regions rather than being guided by disease burden. Although PEPFAR resources are being targeted in this way, this issue remains a challenge with GOT resources.

- **Laboratory (3.33, red)**: Insufficient capacity of qualified laboratory personnel, limited infrastructure for viral load monitoring, and inadequate domestic resources continue to limit the sustainability of the laboratory program.

- **Domestic Resource Mobilization (1.94, red)**: DRM is the most significant sustainability vulnerability in the national response. Health sector budgets have been decreasing as a percentage of the total for the last few years and are well below the Abuja targeted 15%. In the last Public Expenditure Review for HIV and AIDS, external investment accounted for 98.8% of the national response.

- **Technical and Allocative Efficiencies (3.17, red)**: The greatest limitation to improve technical efficiencies for GOT resources is a lack of sufficient data. There is no use of unit costs and program disaggregates to target spending or to reprogram funds. More active engagement at both national and decentralized levels will be necessary to improve budget execution and effectiveness for the national response.

Additional Observations: Although still scoring in the yellow range, Public Access to information has also been improving through open data commitments by government leadership, improved access to information systems with online web portals (DHIS and eLMIS), and performance indicators in the Big Results Now initiative.

Contact: For questions or further information about PEPFAR's efforts to support sustainability of the national response to HIV and AIDS, please contact Joshua Levens at LevensJP@state.gov

Sustainability Analysis for Epidemic Control: Tanzania

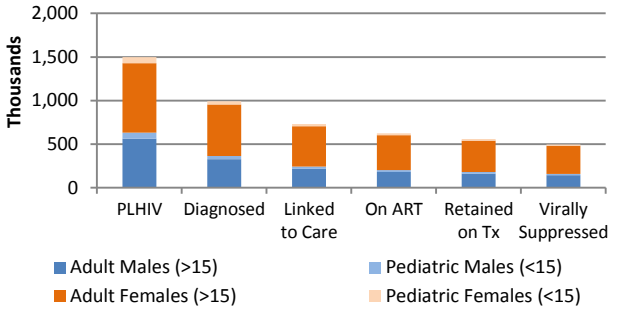
Epidemic Type: Generalized
Income Level: Low-income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 16 Planning Level: $430,000,000

SUSTAINABILITY DOMAINS and ELEMENTS

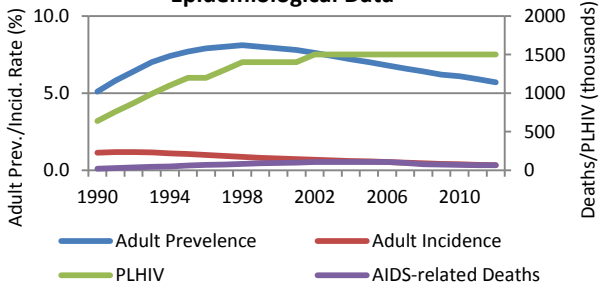
	2016	2017	2018	2019
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43			
2. Policies and Governance	3.85			
3. Civil Society Engagement	4.17			
4. Private Sector Engagement	4.86			
5. Public Access to Information	5.00			
National Health System and Service Delivery				
6. Service Delivery	3.38			
7. Human Resources for Health	5.00			
8. Commodity Security and Supply Chain	4.94			
9. Quality Management	5.19			
10. Laboratory	3.33			
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	1.94			
12. Technical and Allocative Efficiencies	3.17			
Strategic Information				
13. Epidemiological and Health Data	4.70			
14. Financial/Expenditure Data	4.58			
15. Performance Data	5.99			

CONTEXTUAL DATA

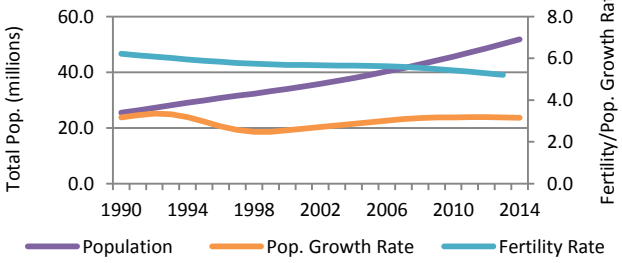
National Clinical Cascade



Epidemiological Data

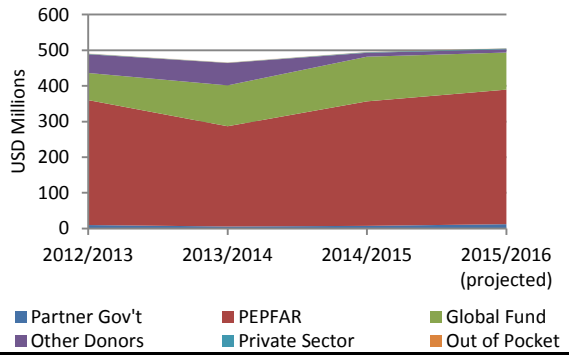


Population and Fertility

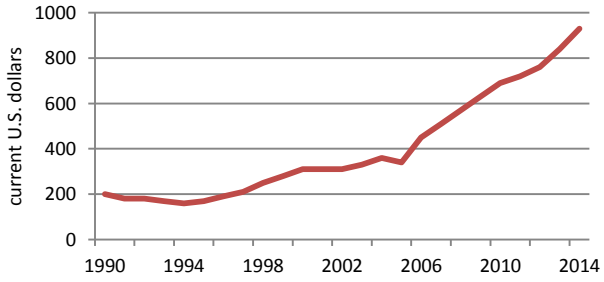


CONTEXTUAL DATA

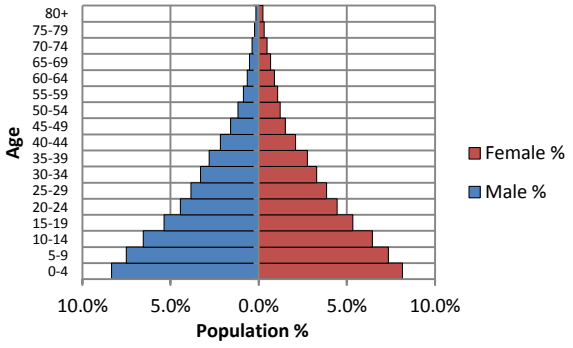
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2015)



Domain A. Governance, Leadership, and Accountability

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS

1. Planning and Coordination: Host country develops, implements, and oversees a costed 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.			**Data Source**	**Notes/Comments**
1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	○ A. There is no national strategy for HIV/AIDS ◉ B. There is a multiyear national strategy. Check all that apply: ☑ It is costed ☑ It is updated at least every five years ☐ Strategy includes all crucial response components for prevention and treatment (HIV testing, treatment and care [including children and adolescents], PMTCT, transition from 'catchup' to sustainable VMMC if country performs VMMCs, scale-up of viral load, EID, and other key metrics) ☐ Strategy includes explicit plans and activities to address the needs of key populations. ☐ Strategy includes all crucial response components to mitigate the impact of HIV on vulnerable children	1.1 Score: 1.60	Tanzania Third National Multi-Sectoral Stragic Framework for HIV and AIDS (2013/14-2017/18) November 2013 www.tacaids.go.tz	Detailed response components are typically spelled out in Operational Plans that follow the high-level strategies. The mainland Tanzania NMSF III does not have an operational plan with the additional details outlined.
1.2 Participation in National Strategy Development: Who actively participates in development of the country's national HIV/AIDS strategy?	○ A. There is no national strategy for HIV/AIDS ◉ B. The national strategy is developed with participation from the following stakeholders (check all that apply): ☑ Its development was led by the host country government ☑ Civil society actively participated in the development of the strategy ☐ Private health sector providers, facilities, and training institutions, actively participated in the development of the strategy ☐ Businesses and the corporate sector actively participated in the development of the strategy including workplace development and corporate social responsibility (CSR) ☑ External agencies (i.e. donors, other multilateral orgs., etc.) supporting HIV services in-country participated in the development of the strategy	1.2 Score: 1.50	For COP 15 and COP 16, PCO organized meetings representatives of CSOs and associations of private health providers who were surveyed to answer these questions.	There is no clear consensus around the notion of "active" engagement. There are differences of opinion regarding the extent to which ideas proposed to the government are genuinely considered and the extent to which local CSOs and private health providers can ever compete with the more heavily resourced international CSOs and private companies.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS implemented activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Check all that apply: ☑ There is an effective mechanism within the host country government for internally coordinating HIV/AIDS activities implemented by various government ministries, institutions, offices, etc. ☑ The host country government routinely tracks and maps HIV/AIDS activities of: ☑ civil society organizations ☐ private sector ☑ donors ☑ The host country government leads a mechanism or process (i.e. committee, working group, etc.) that routinely convenes key internal and external stakeholders and implementers of the national response for planning and coordination purposes. ☐ Joint operational plans are developed that include key activities of implementing organizations. ☐ Duplications and gaps among various government, CSO, private sector, and donor activities are systematically identified and addressed.	1.3 Score: 1.33	Minutes and presentations from the TACAIDS Joint Thematic Working Group June 17, 2015	The Tanzania and Zanzibar AIDS Commissions (TACAIDS and ZAC) are mandated and staffed to coordinate HIV/AIDS activities implemented by internal government ministries, departments and agencies. Proactive engagement with the commerical private sector is minimal, engagement with CSOs is more active but often after GOT position has been fairly well established.
1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for B and C)	◉ A. There is no formal link between the national plan and sub-national service delivery. ○ B. Sub-national units have performance targets that contribute to aggregate national goals or targets. ○ C. The central government is responsible for service delivery at the sub-national level.	1.4 Score: 0.00		While TACAIDS has representation at the LGA level, this does not equate to holding the LGAs accountable to national goals and targets.
		Planning and Coordination Score: 4.43		

2. Policies and Governance: 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.			**Data Source**	**Notes/Comments**
2.1 WHO Guidelines for ART Initiation: Does current national HIV/AIDS technical practice follow current or recent WHO guidelines for initiation of ART?	For each category below, check no more than one box that reflects current national policy for ART initiation: A. Adults (>19 years) ☐ Test and START (current WHO Guideline) ☑ CD4 <500 B. Pregnant and Breastfeeding Mothers ☑ Test and START/Option B+ (current WHO Guideline) ☐ Option B C. Adolescents (10-19 years) ☐ Test and START (current WHO Guideline) ☑ CD4<500 D. Children (<10 years) ☑ Test and START (current WHO Guideline) ☐ CD4<500 or clinical eligibility	2.1 Score: 1.07	National Guidelines for Management of HIV and AIDS, 5th Edition, 2015 Circular issued on Dec. 21, 2015 initiated the CD4 500 guideline implementation	Adolescents up to age 15 are eligible for Test and START while 16-19 year olds are eligible under the CD4<500 guideline.

2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery?	Check all that apply: ☑ A national public health services act that includes the control of HIV ☐ A task-shifting policy that allows trained non-physician clinicians, midwives, and nurses to initiate and dispense ART ☐ A task-shifting policy that allows trained and supervised community health workers to dispense ART between regular clinical visits ☐ Policies that permit patients stable on ART to have reduced clinical visits (i.e. every 6-12 months) ☐ Policies that permit patients stable on ART to have reduced ARV pickups (i.e. every 3-6 months) ☐ Policies that permit streamlined ART initiation, such as same day initiation of ART for those who are ready ☐ Legislation to ensure the well-being and protection of children, including those orphaned and made vulnerable by HIV/AIDS	2.2 Score: 0.20	The National Multi-Sectoral Strategic Framework for HIV and AIDS 2013/14-2017/18	The task shifting policy for nurses to dispense ART has been formulated and is awaiting official approval.
2.3 Non-discrimination Protections: Does the country have non-discrimination laws or policies that specify protections (not specific to HIV) for specific populations? Are these fully implemented? (Full score possible without checking all boxes.)	Check all that apply: Adults living with HIV (women): ☑ Law/policy exists ☐ Law/policy is fully implemented Adults living with HIV (men): ☑ Law/policy exists ☐ Law/policy is fully implemented Children living with HIV: ☑ Law/policy exists ☐ Law/policy is fully implemented Gay men and other men who have sex with men (MSM): ☑ Law/policy exists ☐ Law/policy is fully implemented	2.3 Score: 0.87	The Report on the Legal Environment Assessment in Response to HIV and AIDS within the United Republic of Tanzania, TACAIDS, ZAC, and UNDP (2016)	

	Migrants: ☑ Law/policy exists ☐ Law/policy is fully implemented People who inject drugs (PWID): ☑ Law/policy exists ☐ Law/policy is fully implemented People with disabilities: ☑ Law/policy exists ☐ Law/policy is fully implemented Prisoners: ☑ Law/policy exists ☐ Law/policy is fully implemented Sex workers: ☑ Law/policy exists ☐ Law/policy is fully implemented Transgender people: ☑ Law/policy exists ☐ Law/policy is fully implemented Women and girls: ☑ Law/policy exists ☐ Law/policy is fully implemented			

2.4 Structural Obstacles: Does the country have laws and/or policies that present barriers to delivery of HIV prevention, testing and treatment services or the accessibility of these services? Are these laws/policies enforced? (Enforced means any instances of enforcement even if periodic)	Check all that apply: Criminalization of sexual orientation and gender identity: ☑ Law/policy exists ☐ Law/policy is enforced Criminalization of cross-dressing: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of drug use: ☑ Law/policy exists ☑ Law/policy is enforced Criminalization of sex work: ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on needle and syringe programs for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy for people who inject drugs (PWID): ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on needle and syringe programs in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced Ban or limits on opioid substitution therapy in prison settings: ☐ Law/policy exists ☐ Law/policy is enforced	2.4 Score: 0.99	This question aligns with the revised UNAIDS NCPI (2015). If your country has completed the new NCPI, you may use it as a data source to answer this question.	

	Ban or limits on the distribution of condoms in prison settings: ☑ Law/policy exists ☑ Law/policy is enforced Ban or limits on accessing HIV and SRH services for adolescents and young people: ☐ Law/policy exists ☐ Law/policy is enforced Criminalization of HIV non-disclosure, exposure or transmission: ☑ Law/policy exists ☐ Law/policy is enforced Travel and/or residence restrictions: ☐ Law/policy exists ☐ Law/policy is enforced Restrictions on employment for people living with HIV: ☐ Law/policy exists ☐ Law/policy is enforced			

2.5 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?	There are host country government efforts in place as follows (check all that apply): ☑ To educate PLHIV about their legal rights in terms of access to HIV services ☐ To educate key populations about their legal rights in terms of access to HIV services ☑ 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	2.5 Score: 0.71	The National Multi-Sectoral Strategic Framework for HIV and AIDS 2013/14-2017/18	In 2008, Tanzania enacted the HIV Prevention and Control Act (HAPCA). Part VIII of the Act provides for PLHIV rights and obligations. Section 33(1) (a) and (b) provide for rights to access quality medical services and treatment for opportunistic diseases. According to Section 28-32 of this law, discrimination is a punishable offence. In 2010, regulations for HIV Counselling and Testing, use of ARVs, and disclosure were developed and gazetted. The regulations provide for protection against forced testing and mandatory disclosure. In Zanzibar this is covered under Section 23 of an Act ot Provide for the Prevention and Managmeent of HIV and AIDS in Zanzibar, Act No. 18 of 2014. However, According to Section 154 of the Tanzania Penal code of 1945: "Any person who has carnal knowledge of any person against the order of nature or permits a male person to have carnal knowledge of him or her against the order of nature commits an offence and is liable to imprisonment."
2.6 Audit: Does the host country government conduct a national HIV/AIDS program audit or audit of Ministries that work on HIV/AIDS on a regular basis (excluding audits of donor funding that are through government financial systems)?	◉ A. No audit is conducted of the National HIV/AIDS Program or other relevant ministry. ○ B. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 4 years or more. ○ C. An audit is conducted of the National HIV/AIDS program or other relevant ministries every 3 years or less.	2.6 Score: 0.00		Response following consultation with TACAIDS. There are joint annual reviews but these are no substitute for an audit by independent program and financial auditors.
2.7 Audit Action: To what extent does the host country government respond to the findings of a HIV/AIDS audit or audit of Ministries that work on HIV/AIDS?	◉ A. Host country government does not respond to audit findings, or no audit of the national HIV/AIDS program is conducted. ○ B. The host country government does respond to audit findings by implementing changes as a result of the audit. ○ C. The host country government does respond to audit findings by implementing changes which can be tracked by legislature or other bodies that hold government accountable.	2.7 Score: 0.00		There is no evidence of Ministries being audited for their work on HIV/AIDS.
	Policies and Governance Score:	**3.85**		

3. Civil Society Engagement: Local civil Society is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, and as a key stakeholder to inform the national HIV/AIDS response. There are mechanisms for civil society to review and provide feedback regarding public programs, services and fiscal management and civil society is able to hold government institutions accountable for the use of HIV/AIDS funds and for the results of their actions.			**Data Source**	**Notes/Comments**
3.1 Civil Society and Accountability for HIV/AIDS: Are there any laws or policies that restrict civil society from playing an oversight role in the HIV/AIDS response?	○ A. There exists a law or laws that restrict civil society from playing an oversight role in the HIV/AIDS response. ◉ B. There are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it does not happen. ○ C. There are no laws or policies that prevent civil society from providing an oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight.	3.1 Score: 0.83	The State of Civil Society Annual Report 2009 and The State of CSOs in Tanzania Annual Report 2010, both by The Foundation of Civil Society, Dar es Salaam.	Civil society is represented on the Tanzania National Coordinating Mechanism (TNCM). However, CSOs often implement activities as specified by funders. This is a condition that characterizes the CSO community in general; CSO involved in HIV/AIDS are not immune to this being subject to oversight as opposed to providing oversight.
3.2 Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including Global Fund CCM civil society engagement requirements)?	Check A, B, or C; if C checked, select appropriate disaggregates: ○ A. There are no formal channels or opportunities. ◉ B. There are formal channels or opportunities, but civil society is called upon in an ad hoc manner to provide inputs and feedback. ○ C. There are functional 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 government HIV/AIDS program evaluation teams ☐ Involvement in surveys/studies ☐ Collecting and reporting on client feedback	3.2 Score: 1.67	Meeting minutes and presentations from the Joint Thematic Working Group for HIV and AIDS, June 17, 2015	At meetings convened to solicit input from CSOs in 2015, the general opinion is that CSOs are consulted in an infrequent and sometimes ad hoc manner.

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy and budget decisions (check all that apply): ☑ In advocacy ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 0.33		At PEPFAR-Civil Society Engagement meetings convened to solicit input from CSOs in 2015 and 2016, the general opinion is that policies are externally driven. However, at a joint development partners-civil society meeting on domestic resource mobilization in Jan 2016, various CSOs presented their advocacy plans which include direct advocacy to parliament, including work related to HIV and AIDS.
3.4 Domestic Funding of Civil Society: To what extent are HIV/AIDS related Civil Society Organizations funded domestically (either from government, private sector, or self generated funds)? (if exact or approximate overall percentage known, or the percentages from the various domestic sources, please note in Comments column)	◉ A. No funding (0%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ B. Minimal funding (approx. 1-9%) for HIV/AIDS related civil society organizations comes from domestic sources. ○ C. Some funding (approx. 10-49%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ D. Most funding (approx. 50-89%) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants through government Principal Recipients). ○ E. All or almost all funding (approx. 90%+) for HIV/AIDS related civil society organizations comes from domestic sources (not including Global Fund grants).	3.4 Score: 0.00	The State of Civil Society Annual Report 2009 and The State of CSOs in Tanzania Annual Report 2010, both by The Foundation of Civil Society, Dar es Salaam.	Out of 169 CSOs involved in HIV/AIDS, 149 were found to be highly dependant on grants from non-domestic donors (2009). Funding of CSOs by the government is relatively insignificant (2010). Because many CSOs have capacity challenges, private companies tend to manage their CSR programs using their own staff (2010)
3.5 Civil Society Enabling Environment: Is the legislative and regulatory framework conducive to Civil Society Organizations (CSOs) or not-for-profit organizations to engage in HIV service provision or health advocacy?	○ A. The legislative and regulatory framework is not conducive for engagement in HIV service provision or health advocacy ◉ B. The legislative and regulatory framework is conducive for engagement in HIV service delivery and health advocacy as follows (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 ☑ There is a national public private partnership (PPP) technical working group or desk officer within the government (ministry of health, finance, or president's office) in which CSOs or non-profit organizations participate/engage.	3.5 Score: 1.33	Income Tax Act of 2004, Value Added Tax Act, 1997	
		Civil Society Engagement Score:	**4.17**	

4. Private Sector Engagement: Global as well as local private sector (both private health care providers and private business) is an active partner in the HIV/AIDS response through service delivery provision when appropriate, advocacy efforts as needed, innovation, and as a key stakeholder to inform the national HIV/AIDS response. There are supportive policies and mechanisms for the private sector to engage and to review and provide feedback regarding public programs, services and fiscal management of the national HIV/AIDS response. The public uses the private sector for HIV service delivery at a similar level as other health care needs.			**Data Source**	**Notes/Comments**
4.1 Government Channels and Opportunities for Private Sector Engagement: Does host country government have formal channels and opportunities for diverse private sector entities to engage and provide feedback on its HIV/AIDS policies, programs, and services?	○ A. There are no formal channels or opportunities ○ B. There are formal channels or opportunities, but private sector is called upon in an ad hoc manner to provide inputs and feedback ◉ C. There are functional formal channels and opportunities for private sector engagement and feedback. Check all that apply: ☑ Corporate contributions, private philanthropy and giving ☑ Joint (i.e. public-private) supervision and quality oversight of private facilities ☐ Collection of service delivery and client satisfaction data from private providers ☐ Tracking of private training institution HRH graduates and placements ☑ Contributing to develop innovative solutions, both technology and systems innovation ☑ For technical advisory on best practices and delivery solutions	4.1 Score: 1.11	PPP TWG review on January 20, 2016 provided responses to this section. ILO was also consulted. National Response Report, TACAIDS (2014) Indicator #23: Percentage of implementers of HIV and AIDS interventions that have submitted TOMSHA forms on time in the last 12 months (TOMSHA). The reporting compliance rate of HIV and AIDS implementers submitted TOMSHA forms on time for the last 12 months stood at 30% (669/2200). This reporting rate attained rate is below the set target which is 80% within 12 months.	The National Response Report details that inadequate data are collected from the private sector.

4.2 Private Sector Partnership: Do private sector partnerships with government result in stronger policy and budget decisions for HIV/AIDS programs?	○ A. Private sector does not actively engage, or private sector engagement does not influence policy and budget decisions in HIV/AIDS. ◉ B. Private sector engagement influences HIV/AIDS policy and budget decisions in the following areas (check all that apply): ☐ In patient advocacy and human rights ☐ In programmatic decision making ☐ In technical decision making ☐ In service delivery for both public and private providers ☐ In HIV/AIDS basket or national health financing decisions ☐ In advancing innovative sustainable financing models ☐ In HRH development, placement, and retention strategies ☐ In building capacity of private training institutions ☐ In supply chain management of essential supplies and drugs	4.2 Score: 0.00	PPP TWG review on January 20, 2016	Private sector engagement may influence policy formula but has no influence on budget decisions. Furthermore, policies may be formulated but not implemented.

4.3 Legal Framework for Private Health Sector: Does the legislative and regulatory framework make provisions for the needs of the private health sector (including hospitals, networks, and insurers)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☑ Systems are in place for service provision and/or research reporting by private sector facilities to the government. ☑ Mechanisms exist to ensure that private providers receive, understand and adhere to national guidelines/protocols for ART. ☐ Tax deductions for private health providers. ☑ Tax deductions for private training institutions training health workers. ☐ Open competition for private health providers to compete for government services. ☑ General or HIV/AIDS-specific service agreement frameworks exist between local government authorities/municipalities and private providers at the sub-national unit (e.g. district) levels. ☑ Freedom of private providers to advocate for policy, legal, and regulatory frameworks. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between public and private providers.	4.3 Score: 1.25	PPP TWG review on January 20, 2016	
4.4 Legal Framework for Private Businesses: Does the legislative and regulatory framework make provisions for the needs of private businesses (local or multinational corporations)?	The legislative and regulatory framework makes the following provisions (check all that apply): ☐ Tax deductions for health-related private businesses (i.e. pharmacists, supply chain, etc.). ☐ Systematic and timely process for private company registration and/or testing of new health products; drugs, diagnostics kits, medical devices. ☑ Standardized processes for developing public-private partnerships (PPP) and memorandums of understanding (MOUs) between local government and private business. ☐ Corporate Social Responsibility (CSR) tax policies (compulsory or optional) contributing private corporate resources to the HIV/AIDS response. ☑ Workplace policies support HIV-related services and/or benefits for employees. ☑ Existing forums between business community and government to engage in dialogue to support HIV/AIDS and public health programs.	4.4 Score: 0.83	PPP TWG review on January 20, 2016 • NMSF III. (2013/14 – 2017/18) • National Response Report 2014. • HIV and AIDS work place Code of Conduct for Tanzania Mainland (Pending adoption by LESCO) • ToR tripartite Plus Forum • Recommendation concerning HIV and AIDS and the World of Work, 2010 (No. 200), and • The ILO Code of Practice on HIV/AIDS and the World of Work both of which were adopted by member states Tanzania included. http://www.ilo.org/aids/WCMS_142706/lang--en/index.htm	The formal private sector is coordinated through the Association of Tanzania Employees (ATE) in collaboration with Tanzania Private sector Foundation (TPSF). The Trade Union Congress of Tanzania (TUCTA) together with Ministry of Labour has also formed an umbrella organization supporting public-private partnerships since 2009. This forum is commonly known as the Tripartite plus Forum on HIV and AIDS respons. It aims to stimulate dialogue among partners to advocate and influence workplace HIV policies and to share best practices. This Forum has been instrumental in effecting the VCT@Work initiative and other interventions through work place settings. Likewise the informal private is coordinated through the Tanzania Informal Economy Networks on AIDS Initiative (TIENAI) and has collaborated with tripartite to affect interventions in the informal working settings.

4.5 Private Health Sector Supply: Does the host country government enable private health service provision for lower and middle-income HIV patients?	○ A. There are no enablers for private health service provision for lower and middle-income HIV patients. ◉ B. The host country government enables private health service provision for lower and middle-income patients in the following ways (check all that apply): ☑ Private for-profit providers are eligible to procure HIV and/or ART commodities via public sector procurement channels and/or vertical programs. ☑ The private sector scope of practice for physicians, nurses and midwives serving low and middle-income patients currently includes HIV and/or ART service provision.	4.5 Score: 1.67	PPP TWG review on January 20, 2016	
4.6 Private Health Sector Demand: Is the percentage of people accessing HIV treatment services through the private sector similar to (or approaching) the percentage of those seeking other curative services through the private sector?	◉ A. The percentage of people accessing HIV treatment services through the private sector is significantly lower than the percentage seeking other curative services through the private sector. ○ B. The percentage of people accessing HIV treatment services through the private sector is similar to (or approaching) the percentage seeking other curative services through the private sector due to the following factors (check all that apply): ☐ HIV-related services/products are covered by national health insurance. ☐ HIV-related services/products are covered by private or other health insurance. ☐ Adequate risk pooling exists for HIV services. ☐ Models currently exist for cost-recovery for ART. ☐ HIV drugs are not subject to higher pharmaceutical mark-ups than other drugs in the market.	4.6 Score: 0.00	PPP TWG review on January 20, 2016	The percentage depends upon the HIV burden in the area where the private facility is operating
		Private Sector Engagement Score: 4.86		

5. 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. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.			**Source of Data**	**Notes/Comments**
5.1 Surveillance and Survey Transparency: Does the host country government ensure that HIV/AIDS surveillance and survey data, or at least a summary report of data, and analyses are made available to stakeholders and general public in a timely way?	○ A. The host country government does not make HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public, or they are made available 3 or more years after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within 1-3 years. ○ C. The host country government makes HIV/AIDS surveillance and survey summary reports available to stakeholders and the general public within the same year.	5.1 Score: 1.00	http://www.nbs.go.tz/tnada/index.php/catalog/23 http://www.nacp.go.tz/site/publications/epidemiology-and-research-coordination	THMIS 2011-12 was published Aug 20 2013 by NBS. Last NACP surveillance report: HIV/AIDS/STI Surveillance Report, Report Number 23, November 2013
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data, or at a minimum at least a summary of it, available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS expenditure summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of expenditures. ◉ B. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public or website within 1-3 years after date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure summary reports available to stakeholders and the general public within 1 year after expenditures.	5.2 Score: 1.00	http://www.tacaids.go.tz/index.php?option=com_docman&task=doc_details&gid=99&Itemid=142 http://www.nacp.go.tz/site/download/bookreport3.pdf	Verifiied by Y. Abbas, Dir of Finance and Administration, TACAIDS
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data (or at a minimum of summary of it) available to stakeholders and the public in a timely way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public or they are made available 3 or more years after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1-3 years after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery summary reports available to stakeholders and the general public within 1 year after date of programming .	5.3 Score: 1.00	http://www.tacaids.go.tz/index.php?option=com_docman&task=doc_details&gid=99&Itemid=142 http://www.nacp.go.tz/site/download/bookreport3.pdf	NATIONAL HIV AND AIDS RESPONSE REPORT 2013 was published August 2014 by TACAIDS. Last report from NACP is Implementation of HIV/AIDS Care and Treatment Services in Tanzania, Report 3, May 2013

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. Host country government does not make any HIV/AIDS procurements. ◉ B. Host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. Host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ○ D. Host Country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 0.00		The host country does not routinely make HIV/AIDS procurement awards public. The last publication of awarded contracts was for financial year 2012/2013. There have been two subsequent solitications for awards but no published report on contracts awarded. In addition, as detailed in the Global Fund Management Letter "GMD/HIA2/LM-TP/TNZ Rd 8 HIV/Cash Reansfer Lab," restrictive tendering practices for HIV Lab reagents has led to effectively single-sourcing certain commodities.
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for educating the public about HIV?	○ A. There is no government institution that is responsible for this function and no other groups provide education. ○ B. There is no government institution that is responsible for this function but at least one of the following provides education: ☐ Civil society ☐ Media ☐ Private sector ◉ C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.	5.5 Score: 2.00	http://www.tacaids.go.tz/index.php?option=com_content&view=article&id=174:goals-objectives-functions&catid=24:what-we-do&Itemid=126	Function of TACAIDS is "7. To promote high level advocacy and education of HIV/AIDS"
	Public Access to Information Score:	**5.00**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System 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 prevention, treatment, and care services and interventions. There is a high demand for HIV/AIDS services, which are 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.

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☐ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.74	The Tanzania SPA 2014-15 was a sample survey of all formal-sector health facilities, conducted from October 2014 to March 2015. A total of 1,188 facilities across all sectors were surveyed, including 256 hospitals, 379 health centers, 493 dispensaries, and 60 clinics.	Demand generation of HIV services has been observed in back to treatment campaigns and is being further developed and improved. The ability of public faclilities ro modify or add working hours has been in place for some time, although its effective use will need to continue to grow. The use of mobile clinics/outreach services exists for HTS and patient follow-up. However, community ART is only now being piloted by two partners and is not yet scaled up nationally. From the TSPA: About 81% of all facilities had HIV testing system (only 42% of clinics). • Only 28% of all facilities (only 4% of clinics) offer antiretrovirals (ARTs). 87% of ART facilities had first-line ART available on the day of survey.
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services?	The host country has standardized the following design and implementation components of community-based HIV services through (check all that apply): ☑ Formalized mechanisms of participation by communities, high-burden populations and/or civil society engagement in delivery or oversight of services ☑ National guidelines detailing how to operationalize HIV services in communities ☑ Providing official recognition to skilled human resources (e.g. community health ☐ Providing financial support for community-based services ☐ Providing supply chain support for community-based services ☑ Supporting linkages between facility- and community-based services through formalized bidirectional referral services (e.g., use of national reporting systems to refer and monitor referrals for completeness)	6.2 Score: 0.74	Health Sector Strategic Plan (HSSP) IV (2015), Draft HBC kits for CHWs	HSSP IV The cadre of CHWs is being formalised, their role in providing health promotion, preventive and curative services is being defined, a training curriculum is being finalized, and a standard remuneration scheme is being established.

6.3 Domestic Financing of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services in high burden areas (i.e. excluding any external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	○ A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services in high burden areas ◉ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services in high burden areas ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services in high burden areas ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services in high burden areas ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services in high burden areas	6.3 Score: 0.42	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	
6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services in high burden areas are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services in high burden areas but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services in high burden areas with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services in high burden areas with minimal or no external technical assistance.	6.4 Score: 0.37	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	
6.5 Domestic Financing of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) finance the delivery of HIV/AIDS services to key populations in high burden areas (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations in high burden areas. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations in high burden areas.	6.5 Score: 0.00	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	There is no specific disaggregation of GOT funds for HIV and AIDS. However, the funding for KAP represented in the PER is supported by PEPFAR and the Global Fund.
6.6 Domestic Provision of Service Delivery for Key Populations: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services to key populations in high burden areas without external technical assistance from donors?	○ A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.	6.6 Score: 0.37	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	

6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services in high HIV burden areas?	The national MOH (check all that apply): ☑ Translates national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☑ Uses epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☐ Assesses current and future staffing needs based on HIV/AIDS program goals and ☐ Develops sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engages with civil society in program planning and evaluation of services . ☐ Designs a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.7 Score: 0.37	Hoffman, Barak D. and Clark C. Gibson. 2005. Fiscal Governance and Public Services: Evidence from Tanzania and Zambia. San Diego: University of California, San Diego. http://ostromworkshop.indiana.edu/colloquia/materials/papers/gibson_paper.pdf	About 90% of local government budgets in Tanzania come from the central government and donors. Whereas the central government uses a transparent process for transfers to local governments, donors appear to follow no such logic. In Tanzania, local governments record two types of donor flows. The first are Direct Donor Transfers for local projects. The second, Total Donor Transfers, includes direct transfers plus programs that are financed by donors but are distributed through independent government agencies that neither parliament nor the central government controls. There were mixed responses about whether the MoH effectively engages with civil society in program planning and evaluation of services.
6.8 Sub-national Service Delivery Capacity: Do sub-national health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Sub-national health authorities (check all that apply): ☑ Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. ☐ Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. ☑ Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations. ☐ Develop sub-national level budgets that allocate resources to high burden service delivery locations. ☐ Effectively engage with civil society in program planning and evaluation of services. ☐ Design a staff performance management plan to assure that staff working at high burden sites maintain good clinical and technical skills, such as through training and/or mentorship.	6.8 Score: 0.37	see immediately above	see immediately above
	Service Delivery Score	**3.38**		

7. 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.			**Data Source**	**Notes/Comments**
7.1 HRH Supply: To what extent is the health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or comm site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of health care providers ☐ The country's health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address health worker vacancy or attrition in high HIV burden areas ☐ The country's pre-service education institutions are producing an adequate supply and appropriate skills mix of social service workers to deliver social services to vulnerable children	7.1 Score: 0.00	Human Resource for Health Strategic Plan 2008 – 2013, Dar es Salaam: MoHSW.	There were mixed responses about whether the country's pre-service education institutions are producing an adequate supply and skills mix of health care providers.
7.2 HRH transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?	○ A. There is no inventory or plan for transition of donor-supported health workers ◉ B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support ○ C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented ○ 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	7.2 Score: 0.33		PEPFAR/T conducted the first healthcare workers inventory in November, 2014; an inventory update for 2015 is underway. PEPFAR/T expects preliminary results from the second round by January, 2016
7.3 Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are supported with domestic public or private resources (i.e. excluding donor resources)?	○ A. Host country institutions provide no (0%) health worker salaries ○ B. Host country institutions provide minimal (approx. 1-9%) health worker salaries ○ C. Host country institutions provide some (approx. 10-49%) health worker salaries ◉ D. Host country institutions provide most (approx. 50-89%) health worker salaries ○ E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries	7.3 Score: 2.50	Human Resource for Health Strategic Plan 2008 – 2013, Dar es Salaam: MoHSW.	There are insufficient data to state the proportion of healthcare worker salaries supported by Tanzania. The selection is based on preliminary consultations with the Ministry of Health and include the caveat that base salaries are considered rather than additional allowances. However, PEPFAR pays for over 40,000 CHWs and paid over $8 million in clinical worker salaries in FY 2015.

7.4 Pre-service: Do current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?	○ A. Pre-service education institutions do not have HIV content, or HIV content used by pre-service education institutions is out of date (not updated within 3 years) ◉ B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply): ☑ Updated content reflects national standards of practice for cadres offering HIV/AIDS-related services ☑ Institutions maintain process for continuously updating content, including HIV/AIDS content ☐ Updated curricula contain training related to stigma & discrimination of PLWHA ☐ Institutions track student employment after graduation to inform planning	7.4 Score:	1.00	Human Resource for Health Strategic Plan 2008 – 2013, Dar es Salaam: MoHSW.	Health Training Institutions do not systematically track student employment after graduating. The larger GOT system does link with HTI to merge employment and graduation information.
7.5 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control? (if exact or approximate percentage known, please note in Comments column)	Check all that apply among A, B, C, D: ☑ A. The host country government provides the following support for in-service training in the country (check ONE): ☐ Host country government implements no (0%) HIV/AIDS related in-service training ☐ Host country government implements minimal (approx. 1-9%) HIV/AIDS related in-service training ☑ Host country government implements some (approx. 10-49%) HIV/AIDS in-service training ☐ Host country government implements most (approx. 50-89%) HIV/AIDS in-service training ☐ Host country government implements all or almost all (approx. 90%+) HIV/AIDS in-service training ☐ B. The host country government has a national plan for institutionalizing (establishing capacity within local institutions to deliver) donor-supported in-service training in HIV/AIDS ☐ C. The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians ☐ D. The host country government maintains a database to track training for HIV/AIDS, and allocates training based on need (e.g. focusing on high burden areas)	7.5 Score:	0.17	RE C: from HSSP IV "Continuing Professional Development (CPD) has limited continuity; the impact on the health system as a whole is insufficient, as the approach is fragmented and ad-hoc. There is no system of accreditation and re-registration of professionals based on attending CPD. There is no system of quality assurance of competencies of health professionals."	About 40% of in-service training is implemented by the government of Tanzania.

7.6 HR Data Collection and Use: Does the country systematically collect health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	○ A. There is no HRIS in country and data on the health workforce is not collected systematically for planning and management ○ B. There is no HRIS in country, but some data is collected for planning and management ☐ Registration and re-licensure data for key professionals is collected and used for planning and management ☐ MOH health worker employee data (number, cadre, and location of employment) is collected and used ☐ Routine assessments are conducted regarding health worker staffing at health facility and/or community sites ◉ C. There is an HRIS (an interoperable system that captures at least regulatory and deployment data on health workers) in country: ☑ The HRIS is primarily financed and managed by host country institutions ☐ There is a national strategy or approach to interoperability for HRIS ☑ The government produces HR data from the system at least annually ☐ Host country institutions use HR data from the system for planning and management (e.g. health worker deployment)	7.6 Score: 1.00		
	Human Resources for Health Score	**5.00**		
8. 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, diagnosis 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.			**Data Source**	**Notes/Comments**
8.1 ARV Domestic Financing: What is the estimated percentage of ARV procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known. ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50 – 89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.1 Score: 0.00	Global Fund Procurement Plan submitted 2015	
8.2 Test Kit Domestic Financing: What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources? (Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds) (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ◉ B. No (0%) funding from domestic sources ○ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.2 Score: 0.00	Global Fund Procurement Plan submitted 2015	

8.3 Condom Domestic Financing: What is the estimated percentage of condom procurement funded by domestic (not donor) sources? *Note:* The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs. (if exact or approximate percentage known, please note in Comments column)	○ A. This information is not known ○ B. No (0%) funding from domestic sources ◉ C. Minimal (approx. 1-9%) funding from domestic sources ○ D. Some (approx. 10-49%) funded from domestic sources ○ E. Most (approx. 50-89%) funded from domestic sources ○ F. All or almost all (approx. 90%+) funded from domestic sources	8.3 Score: 0.21	MOHSW Budget, Medium Term Expenditure Framework (MTEF) 2015/16	
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	○ A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). ◉ B. There is a plan/SOP that includes the following components (check all that apply): ☑ Human resources ☐ Training ☑ Warehousing ☑ Distribution ☑ Reverse Logistics ☑ Waste management ☑ Information system ☑ Procurement ☑ Forecasting ☑ Supply planning and supervision ☑ Site supervision	8.4 Score: 2.02	Tanzania: Strategic Review of the National Supply Chain for Health Commodities, MOHSW, April 2102; Medium Term Strategic Plan II 2014 – 2020, Medical Stores Department	

8.5 Supply Chain Plan Financing: What is the estimated percentage of financing for the supply chain plan that is provided by domestic sources (i.e. excluding donor funds)? (if exact or approximate percentage known, please note in Comments column)	◉ A. This information is not available. ○ B. No (0%) funding from domestic sources. ○ C. Minimal (approx. 1-9%) funding from domestic sources. ○ D. Some (approx. 10-49%) funding from domestic sources. ○ E. Most (approx. 50-89%) funding from domestic sources. ○ F. All or almost all (approx. 90%+) funding from domestic sources.	8.5 Score:	0.00	Tanzania: Strategic Review of the National Supply Chain for Health Commodities, MOHSW, April 2102	There was a conspicuous absence of any agreed upon national projections for the quantity and costs of essential medicines and commodities needed in the public sector. The GOT contribution to the national medicines and health commodity requirements has not increased significantly in tandem with population growth, inflation and other factors over the last six years. Contributions from the Global Fund for AIDS, TB and Malaria have increased significantly over the years and have remained the top source of funds for medicines and supplies in the public health supply chain.
8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock levels?	Check all that apply: ☐ The group making re-supply decisions for ARVs, have timely visibility into the ARV stock on hand at facilities ☐ Facilities are stocked with ARVs according to plan (above the minimum and below the maximum stock level) 90% of the time ☑ MOH or other host government personnel make re-supply decisions with minimal external assistance: ☑ Decision makers are not seconded or implementing partner staff ☑ Supply chain data are maintained within the Ministry of Health and not solely stored by donor-funded projects ☐ Team that conducts analysis of facility data is at least 50% host government	8.6 Score:	0.49	Electronic Logistics Management Information System (eLMIS) http://elmis.co.tz/public/pages/login.html	
8.7 Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment or top quartile for an equivalent assessment conducted within the last three years? (if exact or approximate percentage known, please note in Comments column)	○ A. A comprehensive assessment has not been done ○ B. A comprehensive assessment has been done but the score was lower than 80% (for NSCA) or in the bottom three quartiles for the global average of other equivalent assessments ◉ C. A comprehensive assessment has been done and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score:	2.22		
	Commodity Security and Supply Chain Score:		**4.94**		

9. Quality Management: Host country has institutionalized quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services			**Data Source**	**Notes/Comments**
9.1 Existence of a Quality Management (QM) System: Does the host country government support appropriate QM structures to support continuous quality improvement (QI) at national, sub-national and site levels?	○ A. The host country government does not have structures or resources to support site-level continuous quality improvement ◉ B. The host country government: ☑ Has structures with dedicated focal points or leaders (e.g., committee, focal person, working groups, teams) at the national level, sub-national level and in a majority of sites where HIV/AIDS care and services are offered that are supporting site-level continuous quality improvement ☑ Has a budget line item for the QM program ☑ Supports a knowledge management platform (e.g., web site) and/or peer learning opportunities available to site QI participants to gain insights from other sites and interventions	9.1 Score: 2.00	MOHSW budget, MTEF 2015/16	The budget is at the national level; it does not trickle to districts or site level.
9.2 Quality Management/Quality Improvement (QM/QI) Plan: Is there a current (updated within the last 2 years) QM/QI plan? (The plan may be HIV program-specific or include HIV program-specific elements in a national health sector QM/QI plan.)	○ A. There is no HIV/AIDS-related QM/QI strategy ○ B. There is a QM/QI strategy that includes HIV/AIDS, but it is not current (updated within the last 2 years) ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements ○ D. There is a current HIV/AIDS program specific QM/QI strategy	9.2 Score: 1.33	National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018; National Guidelines of Quality Improvement of HIV/AIDS, Comprehensive Supportive Supervision and Mentorship Participant Manual	
9.3 Performance Data Collection and Use for Improvement: Are HIV program performance measurement data systematically collected and analyzed to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting?	○ A. HIV program performance measurement data are not used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting. ◉ B. HIV program performance measurement data are used to identify areas of patient care and services that can be improved through national decision making, policy, or priority setting (check all that apply): ☐ The national quality structure has a clinical data collection system from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement ☐ There is a system for sharing data at the national, SNU, and local level, with evidence that data is used to identify quality gaps and initiate QI activities ☐ There is documentation of results of QI activities and demonstration of national HIV program improvement	9.3 Score: 0.00	National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018; National Guidelines of Quality Improvement of HIV/AIDS, Comprehensive Supportive Supervision and Mentorship Participant Manual	

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 1.00	National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018; National Guidelines of Quality Improvement of HIV/AIDS, Comprehensive Supportive Supervision and Mentorship Participant Manual	
9.5 Existence of QI Implementation: Does the host country government QM system use proven systematic approaches for QI?	The national-level QM structure: ☑ Provides oversight to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convenes meetings that includes health services consumers ☐ Routinely reviews national, sub-national and clinical outcome data to identify and prioritize areas for improvement Sub-national QM structures: ☑ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services ☐ Regularly convene meetings that includes health services consumers ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement Site-level QM structures: ☑ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement	9.5 Score: 0.86	National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018; National Guidelines of Quality Improvement of HIV/AIDS, Comprehensive Supportive Supervision and Mentorship Participant Manual	
	Quality Management Score:	**5.19**		

10. Laboratory: The host country ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV.			**Data Source**	**Notes/Comments**
10.1 Strategic Plan: Does the host country have a national laboratory strategic plan?	○ A. There is no national laboratory strategic plan ○ B. National laboratory strategic plan is under development ○ C. National laboratory strategic plan has been developed, but not approved ◉ D. National laboratory strategic plan has been developed and approved ○ E. National laboratory plan has been developed, approved, and costed	10.1 Score: 1.25	Tanzania Laboratory Strategic Plan 2009 - 2015	New plan is under development and will be costed although the previous one was not.
10.2 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	○ A. Regulations do not exist to monitor minimum quality of laboratories in the country. ○ B. Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). ○ C. Regulations exist, but are minimally implemented (approx.. 1-9% of laboratories and POCT sites regulated). ○ D. Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). ◉ E. Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). ○ F. Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).	10.2 Score: 1.25	The Health Laboratory Practitioners Act, 2007 and The HIV and AIDS (Prevention and Control) Act,2008	
10.3 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression?	◉ A. There are not adequate qualified laboratory personnel to achieve sustained epidemic control ○ B. There are adequate qualified laboratory personnel to perform the following key functions: ☐ HIV diagnosis in laboratories and point-of-care settings ☐ TB diagnosis in laboratories and point-of-care settings ☐ CD4 testing in laboratories and point-of-care settings ☐ Viral load testing in laboratories and point-of-care settings ☐ Early Infant Diagnosis in laboratories ☐ Malaria infections in laboratories and point-of-care settings ☐ Microbiology in laboratories and point-of-care settings ☐ Blood banking in laboratories and point-of-care settings ☐ Opportunistic infections including Cryptococcal antigen in laboratories and point-of-care settings	10.3 Score: 0.00	Tanzania Laboratory Strategic Plan 2009 - 2015	from the HSHSP- III "Currently, the guideline for the clinical management of HIV and AIDS does not clearly stipulate the use of Viral Load testing for routine ART monitoring."

10.4 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	◉ A. There is not sufficient infrastructure to test for viral load. ○ B. There is sufficient infrastructure to test for viral load, including: ☐ Sufficient viral load instruments and reagents ☐ Appropriate maintenance agreements for instruments ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.00	Tanzania Laboratory Strategic Plan 2009 - 2015	from the HSHSP- III "for health care services in general most of the tests are done using the laboratory equipment provided (with the exception of CD4 counts) which are not specific to HIV and AIDS."
10.5 Domestic Funds for Laboratories: To what extent are laboratory services financed by domestic public or private resources (i.e. excluding external donor funding)? (if exact or approximate percentage known, please note in Comments column)	○ A. No (0%) laboratory services are financed by domestic resources. ◉ B. Minimal (approx. 1-9%) laboratory services are financed by domestic resources. ○ C. Some (approx. 10-49%) laboratory services are financed by domestic resources. ○ D. Most (approx. 50-89%) laboratory services are financed by domestic resources. ○ E. All or almost all (approx. 90%+) laboratory services are financed by domestic resources.	10.5 Score: 0.83	Tanzania Laboratory Strategic Plan 2009 - 2015	
	Laboratory Score:	**3.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Investments, Efficiency, and Sustainable Financing

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.

11. Domestic Resource Mobilization: The partner country budgets for its HIV/AIDS response and makes adequate resource commitments and expenditures to achieve national HIV/AIDS goals for epidemic control in line with its financial ability.			**Data Source**	**Notes/Comments**
11.1 Domestic Budget: To what extent does the national budget explicitly account for the national HIV/AIDS response?	○ A. There is no explicit funding for HIV/AIDS in the national budget. ◉ B. There is explicit HIV/AIDS funding within the national budget. ☐ The HIV/AIDS budget is program-based across ministries ☐ The budget includes or references indicators of progress toward national HIV/AIDS strategy goals ☐ The budget includes specific HIV/AIDS service delivery targets ☐ National budget reflects all sources of funding for HIV, including from external donors	11.1 Score: 1.11	THE UNITED REPUBLIC OF TANZANIA MINISTRY OF FINANCE GOVERNMENT BUDGET FOR FINANCIAL YEAR 2015/16 CITIZENS' BUDGET EDITION http://www.mof.go.tz/mofdocs/budget/Citizens%20Budget/CITIZENS%20BUDGET%202015_2016%20_ENGLISH.pdf	In the 2015/16 budget "Shs 235.43 billion has been set aside for prevention of HIV infections, increase access to HIV and AIDS care services, and reaching people who are at high risk of HIV infection country wide."
11.2 Annual Targets: Did the most recent budget as executed achieve stated annual HIV/AIDS goals? (if exact or approximate percentage known, please note in Comments column)	◉ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but none (0%) were attained. ○ C. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, but very few (approx. 1-9%) were attained. ○ D. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and some (approx. 10-49%) were reached. ○ E. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and most (approx. 50-89%) were reached. ○ F. There are annual HIV/AIDS goals/targets articulated in the most recent national budget, and all or almost all (approx. 90%+) were reached.	11.2 Score: 0.00	HSSP IV: There is a projected budget but there are no targets; NMSF III: There are targets but there is no budget	HSSP IV: There is a projected budget but there are no targets; NMSF III: There are targets but there is no budget

11.3 Budget Execution: For the previous three years, what was the average execution rate for budgeted domestic HIV/AIDS resources (i.e. excluding any donor funds) at both the national and subnational level? (If subnational data does not exist or is not available, answer the question for the national level. Note level covered in the comments column)	◉ A. Information is not available ◯ B. There is no national HIV/AIDS budget, or the execution rate was 0%. ◯ C. 1-9% ◯ D. 10-49% ◯ E. 50-89% ◯ F. 90% or greater	11.3 Score: 0.00	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	Data on budget execution are not available for domestic resources exclusively.
11.4 PLACEHOLDER for future indicator measuring country's financial ability to pay for its HIV response (will not be included in SID for COP 16)				
11.5 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding (excluding out-of-pocket and donor resources)? (if exact or approximate percentage known, please note in Comments column)	◯ A. None (0%) is financed with domestic funding. ◉ B. Very little (approx. 1-9%) is financed with domestic funding. ◯ C. Some (approx. 10-49%) is financed with domestic funding. ◯ D. Most (approx. 50-89%) is financed with domestic funding. ◯ E. All or almost all (approx. 90%+) is financed with domestic funding.	11.6 Score: 0.83	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	98.8% of HIV and AIDS expenditures are externally funded by development partners, predominantly PEPFAR and the Global Fund.
	Domestic Resource Mobilization Score:	**1.94**		

12. Technical and Allocative Efficiencies: 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). Unit costs are tracked and steps are taken to improve HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources).			**Data Source**	**Notes/Comments**
12.1 Resource Allocation Process: Does the partner country government utilize a recognized data-driven model to inform the allocation of domestic (i.e. non-donor) public HIV resources? (note: full score achieved by selecting one checkbox)	○ A. The host country government does not use one of the mechanisms listed below to inform the allocation of their resources. ◉ B. The host country government does use the following mechanisms to inform the allocation of their resources (check all that apply): ☐ Optima ☑ Spectrum (including EPP and Goals) ☐ AIDS Epidemic Model (AEM) ☑ Modes of Transmission (MOT) Model ☐ Other recognized process or model (specify in notes column)	12.1 Score: 1.43	Tanzania Investment Case, Draft Final Report, September 18, 2015	Avenir Health has produced this draft report, which uses SPECTRUM and which awaits GOT endorsement and publication.
12.2 High Impact Interventions: What percentage of site-level point of service HIV domestic public sector resources (excluding any donor funds) are being allocated to the following set of interventions: provision of ART, VMMC, PMTCT, HTC, condoms, and targeted prevention for key and priority populations? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available ○ B. No (0%) site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ C. Minimal (approx. 1-9%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ D. Some (approx. 10-49%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ E. Most (approx. 50-89%) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions. ○ F. All or almost all (approx. 90%+) of site-level, point-of-service domestic HIV resources are allocated to the listed set of interventions.	12.2 Score: 0.00	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	Programmatic disaggregates are not available for domestic resources only.

12.3 Geographic Allocation: Of central government HIV-specific resources (excluding any donor funds) allocated to geographic subunits in the most recent year available, what percentage is being allocated in the highest burden geographic areas (i.e. districts that cumulatively account for 80% of PLHIV)? (if exact or approximate percentage known, please note in Comments column)	◉ A. Information not available. ○ B. No resources (0%) are targeting the highest burden geographic areas. ○ C. Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas. ○ D. Some resources (approx. 10-49%) are targeting the highest burden geographic areas. ○ E. Most resources (approx. 50-89%) are targeting the highest burden geographic areas. ○ F. All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.	12.3 Score: 0.00	HSSP IV and Big Results Now Healthcare Lab 4 December 2014.	HSSP IV gives a general endorsement of HIV/AIDS geographic focus "A special focus will be on geographical areas characterised by higher than national average HIV prevalence, high burden in terms of number of People Living with HIV, increasing prevalence over several years, and relatively lower performance on key HIV and TB indicators." (The HSSP IV is silent about whether domestic resources will shift to these geographic areas). HSSP IV "The health and social welfare sector will take the BRN approach further, to all regions in the country and beyond 2018 (when the BRN programme ends)." BRN prioritized geographic areas based on RMNCH indicators, health facility density/quality, HRH supply and equitable distribution, and commodity supply but NOT HIV/AIDS.
12.4 Data-Driven Reprogramming: Do host country government policies/systems allow for reprograming domestic investments based on new or updated program data during the government funding cycle?	◉ A. There is no system for funding cycle reprogramming ○ B. There is a policy/system that allows for funding cycle reprogramming, but it is seldom used. ○ C. There is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data ○ D. 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: 0.00	Rapid Budget Analysis 2014	

12.5 Unit Costs: Does the host country government use recent expenditure data or cost analysis (i.e. data from within the last three years) to estimate unit costs of HIV/AIDS services for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country government does not use recent expenditure data or cost analysis to estimate unit costs ◉ B. The host country government uses recent expenditure data or cost analysis to estimate unit costs for (check all that apply): ☑ HIV Testing ☑ Care and Support ☑ ART ☑ PMTCT ☑ VMMC ☑ OVC Service Package ☑ Key population Interventions	12.5 Score: 1.43	Tanzania Commission for AIDS. August 2015. Public Expenditure Review, 2013/14 HIV/AIDS Tanzania Mainland.	The PER uses expenditure data (principally PEPFAR and GF expenditure data) to estimate unit costs. However, there is no evidence that these unit costs have been used by the GOT for budgeting or planning with domestic sources.
12.6 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?	Check all that apply: ☐ Improved operations or interventions based on the findings of cost-effectiveness or efficiency studies ☐ Reduced overhead costs by streamlining management ☐ Lowered unit costs by reducing fragmentation, i.e. pooled procurement, resource pooling, etc. ☐ Improved procurement competition ☐ Integrated HIV/AIDS into national or subnational insurance schemes (private or public -- need not be within last three years) ☐ Integrated HIV into primary care services with linkages to specialist care (need not be within last three years) ☑ Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years) ☑ Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years) ☐ Developed and implemented other new and more efficient models of HIV service delivery (specify in comments)	12.6 Score: 0.32	From UNAIDS/Tanzania NCPI: "While the country is doing a lot on strategic planning the government need to focus on quality implementation of priority services to scale, including strengthening responsibilities for coordination and meaningful supportive supervision, ever-focusing on quality improvement and efficient use of resources ie using human resources wisely through expanding, formalizing and adopting task shifting."	JSI Cost Efficiency Study conducted in May 2015 in draft, not yet approved, and not yet applied

12.7 ARV Benchmark prices: How do the costs of ARVs (most common first line regimen) purchased in the previous year by the partner government using domestic resources compare to international benchmark prices for that year? (Use the "factory cost" of purchased commodities, excluding transport costs, distribution costs, etc.)	◉ A. Partner government did not pay for any ARVs using domestic resources in the previous year. ○ B. Average price paid for ARVs by the partner government in the previous year was more than 50% greater than the international benchmark price for that regimen. ○ C. Average price paid for ARVs by the partner government in the previous year was 10-50% greater than the international benchmark price for that regimen. ○ D. Average price paid for ARVs by the partner government in the previous year was 1-10% greater than the international benchmark price for that regimen. ○ E. Average price paid for ARVs by the partner government in the previous year was below or equal to the international benchmark price for that regimen.	12.7 Score:	0.00	NACP Procurement Plan, Global Fund Budget Submission 2015	
	Technical and Allocative Efficiencies Score:		**3.17**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN C

Domain D: Strategic Information

What Success Looks Like: Using local and national systems, the host country government collects, analyzes 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.

13.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, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.			**Data Source**	**Notes/Comments**
13.1 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (population-based household surveys, case reporting/clinical surveillance, drug resistance surveillance, etc.)?	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with minimal or no technical assistance from external agencies	13.1 Score: 0.48	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017, p.2; http://www.tacaids.go.tz/index.php?option=com_content&view=article&id=174:goals-objectives-functions&catid=24:what-we-do&Itemid=126 http://www.nacp.go.tz/site/about/national-aids-control-program-profile http://www.nbs.go.tz/nbs/index.php?option=com_content&view=category&id=55&Itemid=145	The Tanzania AIDS Commission (TACAIDS) has the role of coordination, overseeing and guiding the multi-sectoral response; National Bureau of Statistics conducts the Tanzania HIV/AIDS and Malaria Indicator Survey on belhalf of TACAIDS; National AIDS Control Program (NACP) in the Ministry has the responsibility of leading the health sector responses of the National Multi-sectoral Strategic Framework (NMSF).
13.2 Who Leads Key Population Surveys & Surveillance: To what extent does the host country government lead & manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBBS, size estimation studies, etc.)?	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. Surveys & surveillance activities are primarily planned and implemented by external agencies, organizations or institutions ◉ C. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies ○ D. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies ○ E. Surveys & surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies	13.2 Score: 0.48	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017, p.2; http://www.tacaids.go.tz/index.php?option=com_content&view=article&id=174:goals-objectives-functions&catid=24:what-we-do&Itemid=126 http://www.nacp.go.tz/site/about/national-aids-control-program-profile http://www.nbs.go.tz/nbs/index.php?option=com_content&view=category&id=55&Itemid=145	The Tanzania AIDS Commission (TACAIDS) has the role of coordination, overseeing and guiding the multi-sectoral response; National Bureau of Statistics conducts the Tanzania HIV/AIDS and Malaria Indicator Survey on belhalf of TACAIDS; National AIDS Control Program (NACP) in the Ministry has the responsibility of leading the health sector responses of the National Multi-sectoral Strategic Framework (NMSF).
13.3 Who Finances General Population Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	13.3 Score: 0.42	MOHSW, NBS and TACAIDS budgets, MTEF 2015/16	Generally staff salaries are covered but costs pertaining to design, implementation and reporting of survey results are covered by external financial resources

13.4 Who Finances Key Populations Surveys & Surveillance: To what extent does the host country government fund the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (e.g., protocol development, printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ◉ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (approx. 90% +) is provided by the host country government	13.4 Score: 0.83	MOHSW, NBS and TACAIDS budgets, MTEF 2015/16	Funded primarily by donors through local NGOs
13.5 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic units? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age ☑ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☑ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☐ Age ☐ Sex ☐ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) ☐ Sub-national units	13.5 Score: 0.48	Tanzania HIV/AIDS and Malaria Indicator Survey 2011-12 (March 2013), TACAIDS, ZAC, NBS, OCGS, and ICF International	From the UNAIDS/Tanzania NCPI "There are still notable shortages in M&E technically qualified human resources especially at sub-regional levels which pose a challenge in managing key HIV M&E responsibilities (data management and analysis including use at center of collection)." Gender and age disaggregates for prevalece have been available within the previous HIV surveillance reports, but not for other special populations, such as military or prisoners.

13.6 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	○ A. The host country government does not collect/report viral load data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load data (answer both subsections below): According to the following disaggregates (check ALL that apply): ☑ Age ☐ Sex ☑ Key populations (FSW, PWID, MSM/transgender) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) For what proportion of PLHIV (select ONE of the following): ☑ Less than 25% ☐ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.36	Laboratory Information System (2015)	
13.7 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct IBBS and/or size estimation studies for key and priority populations? (Note: Full score possible without selecting all disaggregates.)	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM) or priority populations (Military, etc.). ◉ B. The host country government conducts (answer both subsections below): IBBS for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM)/transgender ☑ People who inject drugs (PWID) ☐ Priority populations (e.g., military, prisoners, young women & girls, etc.)	13.7 Score: 0.95	Consensus Estimates on Key Population Size and HIV Prevalence in Tanzania, National AIDS Control Programme (July 2014)	
13.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	◉ A. There is no national HIV surveillance and surveys strategy, or a national surveillance and surveys strategy exists but does not include specifics for HIV surveillance and surveys ○ B. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), but the strategy does not outline a timeline for data collection for all relevant population groups ○ C. A national HIV surveillance and surveys strategy exists (or a national surveillance and surveys strategy exists and includes specifics for HIV), and outlines a timeline for data collection for all relevant population groups	13.8 Score: 0.00		

13.9 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	○ A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of surveys & surveillance data (check all that apply): ☑ A national surveillance unit or other entity is responsible for assuring the quality of surveys & surveillance data ☐ A national, approved surveys & surveillance strategy is in place, which outlines standards, policies and procedures for data quality assurance ☑ Standard national procedures & protocols exist for reviewing surveys & surveillance data for quality and sharing feedback with appropriate staff responsible for data collection ☑ An in-country internal review board (IRB) exists and reviews reviews all protocols.	13.9 Score: 0.71	JTWG Minutes, June 17, 2015	
	Epidemiological and Health Data Score:	**4.70**		
14. Financial/Expenditure data: Government collects, tracks and analyzes and makes available financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS expenditures from all financing sources, costing, and economic evaluation, efficiency and market demand analyses for cost-effectiveness.			**Data Source**	**Notes/Comments**
14.1 Who Leads Collection of Expenditure Data: To what extent does the host country government lead & manage a national expenditure tracking system to collect HIV/AIDS expenditure data?	○ A. No tracking of public HIV/AIDS expenditures has occurred within the past 5 years ○ B. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), but planning and implementation is primarily led by external agencies, organizations, or institutions ◉ C. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with substantial external technical assistance ○ D. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA) and planning and implementation is led by the host country government, with some external technical assistance ○ E. Collection of public HIV/AIDS expenditure data occurs using a standard tool (i.e. NASA, NHA), and planning and implementation is led by the host country government, with minimal or no external technical assistance	14.1 Score: 0.83	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.	How does one measure percentage of host country leadership--number meetings called, number local staff involved, key decisions taken, loudness of voice? The current NHA tool incorporates NASA categories, but there still needs to be harmonization among various actors and streamlining of data collection and particularly analyses.
14.2 Who Finances Collection of Expenditure Data: To what extent does the host country government finance the collection of HIV/AIDS expenditure data (e.g., printing of paper-based tools, salaries and transportation for data collection, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ○ B. No financing (0%) is provided by the host country government ◉ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ○ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	14.2 Score: 0.83	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.	

14.3 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	○ A. No HIV/AIDS expenditure tracking has occurred within the past 5 years ◉ B. HIV/AIDS expenditure data are collected (check all that apply): ☑ By source of financing, such as domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others ☑ By expenditures per program area, such as prevention, care, treatment, health systems strengthening ☑ By type of expenditure, such as training, overhead, vehicles, supplies, commodities/reagents, personnel ☑ Sub-nationally	14.3 Score: 1.67	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.	
14.4 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?	○ A. No HIV/AIDS expenditure data are collected ○ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago ◉ C. HIV/AIDS expenditure data were collected at least once in the past 3 years ○ D. HIV/AIDS expenditure data are collected annually but represent more than one year of expenditures ○ E. HIV/AIDS expenditure data are collected annually and represent only one year of expenditures	14.4 Score: 0.83	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.	
14.5 Economic Studies: Does the host country government conduct health economic studies or analyses for HIV/AIDS?	○ A. The host country government does not conduct health economic studies or analyses for HIV/AIDS ◉ B. The host country government conducts (check all that apply): ☑ Costing ☐ Economic evaluation (e.g., cost-effectiveness analysis and cost-benefit analysis) ☐ Efficiency analysis (e.g., efficiency of service delivery by public and private sector, resource allocation) ☐ Market demand analysis	14.5 Score: 0.42	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017, February 2015.	Costing studies are few and not routinely updated. Verified by Y. Abbas, Dir Finance and Administration, TACAIDS
	Financial/Expenditure Data Score:	**4.58**		
15. Performance data: Government routinely collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data are analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including linkage to care, adherence and retention.			**Data Source**	**Notes/Comments**
15.1 Who Leads Collection of Service Delivery Data: To what extent is the routine collection of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government?	○ A. No system exists for routine collection of HIV/AIDS service delivery data ○ B. Multiple unharmonized or parallel information systems exist that are managed and operated separately by various government entities, local institutions and/or external agencies/institutions ○ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution ◉ D. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government with technical assistance from external agency/institution ○ E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government	15.1 Score: 1.00		TACAIDS collects non-health data through its Tanzania Output Monitoring System for HIV and AIDS (TOMSHA), National Bureau of Statistics provides Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) data for TACAIDS, and NACP collects health data. According to Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017, p.70, full integration of HIV and Health Sector data is to occur by the end of HSHSPIII in 2017.

15.2 Who Finances Collection of Service Delivery Data: To what extent does the host country government finance the routine collection of HIV/AIDS service delivery data (e.g., salaries of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance, data quality supervision, etc.)? (if exact or approximate percentage known, please note in Comments column)	○ A. No routine collection of HIV/AIDS service delivery data exists ○ B. No financing (0%) is provided by the host country government ○ C. Minimal financing (approx. 1-9%) is provided by the host country government ○ D. Some financing (approx. 10-49%) is provided by the host country government ◉ E. Most financing (approx. 50-89%) is provided by the host country government ○ F. All or almost all financing (90% +) is provided by the host country government	15.2 Score: 2.50	MOHSW, NBS and TACAIDS budgets. MTEF 2015/16	Data collection tools and maintenance are donor supported.
15.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	Check ALL boxes that apply below: ☑ A. The host country government routinely collects & reports service delivery data for: ☑ HIV Testing ☑ PMTCT ☑ Adult Care and Support ☑ Adult Treatment ☑ Pediatric Care and Support ☑ Orphans and Vulnerable Children ☑ Voluntary Medical Male Circumcision ☑ HIV Prevention ☐ AIDS-related mortality ☑ B. Service delivery data are being collected: ☐ By key population (FSW, PWID, MSM/transgender) ☐ By priority population (e.g., military, prisoners, young women & girls, etc.) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.11	National Health Management Information System through DHIS2 and CTC database (2015)	
15.4 Timeliness of Service Delivery Data: To what extent are HIV/AIDS service delivery data collected in a timely way to inform analysis of program performance?	○ A. The host country government does not routinely collect/report HIV/AIDS service delivery data ◉ B. The host country government collects & reports service delivery data annually ○ C. The host country government collects & reports service delivery data semi-annually ○ D. The host country government collects & reports service delivery data at least quarterly	15.4 Score: 0.44	JTWG minutes, June 17, 2015	

15.5 Analysis of Service Delivery Data: To what extent 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)?	○ A. The host country government does not routinely analyze service delivery data to measure program performance ◉ B. Service delivery data are being analyzed to measure program performance in the following ways (check all that apply): ☐ Continuum of care cascade for each identified priority population (e.g., military, prisoners, young women & girls, etc.), including HIV testing, linkage to care, treatment, adherence and retention ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM/transgender), including HIV testing, linkage to care, treatment, adherence and retention ☑ Results against targets ☑ Coverage of key treatment & prevention services (ART, PMTCT, VMMC, etc.) ☑ Site-specific yield for HIV testing (HTC and PMTCT) ☐ AIDS-related mortality rates ☑ Variations in performance by sub-national unit ☐ Creation of maps to facilitate geographic analysis	15.5 Score: 0.67		
15.6 Quality of Service Delivery Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS service delivery data?	○ A. No governance structures, procedures or policies designed to assure service delivery data quality exist/could be documented. ◉ B. The following structures, procedures or policies exist to assure quality of service delivery data (check all that apply): ☐ A national, approved data quality strategy is in place, which outlines standards, policies and procedures for HIV/AIDS data quality assurance ☐ A national protocol exists for routine (at least annual) Data Quality Audits/Assessments of key HIV program indicators, which are led and implemented by the host country government ☐ Standard national procedures & protocols exist for routine data quality checks at the point of data entry ☐ Data quality reports are published and shared with relevant ministries/government entities & partner organizations ☑ The host country government leads routine (at least annual) data review meetings at national & subnational levels to review data quality issues and outline improvement plans	15.6 Score: 0.27		MOHSW/NACP conducts Data Quality Assessment and publishes SOPs and protocols.
		Performance Data Score: **5.99**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D