2017 Sustainability Index and Dashboard Summary: Tanzania

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years 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 updated 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 full potential for sustaining the national response.

SID Process: The SID 3.0 process began in mid-October 2017 with a desk review and collection of required documents. Additionally a preparatory meeting between PEPFAR and UNAIDS to plan for SID 3.0 co-facilitation, occurred in early October prior to the stakeholders' meeting which was held on October 19th. Prior to the stakeholders meeting, the PEPFAR Coordination Office informed the Government of Tanzania (GOT) regarding this activity and requested representation from the GOT (Ministry of Health, Tanzania Commission for AIDS, Ministry of Finance, and National AIDS Control Program). The stakeholders meeting was well attended, and participants included GOT, Civil Society Organizations, and people living with HIV representatives, PEPFAR implementing partners, PEPFAR Technical Working Group representatives, UNAIDS, and private sector. The participants worked in groups according to the four domains. Consolidation of the documents was done with support from the HQ TDY who also helped to resolve pending issues that needed additional follow up to reach consensus as per group notes gathered in the tool. Three additional side consultations with CSOs, private sector and key population experts were held. A presentation of the first SID 3.0 draft to the donor group Development Partners Group for Health was made on November 1st. Another presentation to share the draft with the MOH management team (chaired by the Permanent Secretary) was done by PEPFAR and UNAIDS on

November 4th. The final draft has been shared with all stakeholders for future reference. An agreement to use SID 3.0 as one of the key strategic documents for the country was made by all the stakeholders involved.

Sustainability Strengths: The sustainability landscape, as demonstrated by both the SID 2.0 and SID 3.0 assessments reveals that most of the domains are emerging areas for sustainability that required and will continue to require some or significant investments. Out of the four critical SID 3.0 domains and the respective elements, none scored within the green color range (7-10 points) over the past 2 years (2015-2017). The *Policies and Governance* element within the ***Governance, Leadership, and Accountability*** domain demonstrated the greatest improvement, largely resulting from the adoption of key policies and guidelines, such as the National Guidelines for the Management of HIV and AIDS (2017), the National Guidelines for Comprehensive Package for HIV Interventions for Key and Vulnerable Populations (2017), national policies on Test and Start that streamlined same-day ART initiation, and emerging work through demonstration projects on self-testing. Some critical areas that will require increased effort and attention are the policies and guidelines to ensure legal protection for all key population groups. PEPFAR Tanzania has been working closely with the host government to address challenges around this area using diplomacy and focused program implementation efforts.

Another area of emerging sustainability that made substantial improvements compared to the previous year is the element on *Laboratory Services* under the ***National Health System and Service Delivery*** domain. The element displayed tremendous gains due to implementation of the National Health Laboratory Strategic Plan II: 2016-2021. A National Health Laboratory Policy and a National Standards for Medical Laboratories Policy were also drafted. Furthermore, lab services to support viral suppression were expanded. Critical human resource shortages of laboratory personnel to conduct testing and supply chain challenges related to the timely supply of reagents for the expanding lab network systems are continued risks that should be carefully monitored and supported through future investments. Other areas that demonstrated marked improvements included the *Performance Data* element under the ***Strategic Information*** domain, which is aligned with increased GOT efforts to strengthen information systems for data use and decision making.

Sustainability Vulnerabilities: While some marginal improvements have been made in the domain related to ***Strategic Investments, Efficiency, and Sustainable Financing***, this is one of the weakest scoring domains across the sustainability landscape**.** The national budgets do include funding for HIV/AIDS, but the overall ability to ensure that sufficient resources are committed to meet the needs in Tanzania remains a continual challenge**.** Only a small percentage of the national HIV response is financed with domestic resources. Data on government resources allocated to highest burden geographic areas is unavailable, and the last HIV/AIDS Public Expenditures Review (PER) has not been updated since it was last conducted in 2013/14. ARV benchmark pricing is not applied by the government because of total dependence on the USG and Global Fund for ARV procurement. The fiscal environment, together with the elements of domestic resource mobilization and *Technical and Allocative Efficiencies* scoring is currently unsustainable, thus presenting an area for increased investment.

Across all the elements, the private sector engagement within the ***Governance, Leadership, and Accountability*** domain witnessed the greatest drop. While there is reasonable engagement with private health service providers and private training institutes, employers and the commercial sector have not been forthcoming in supporting HIV and AIDS efforts as there have been fewer incentives for the private sector to be engaged for the needed support. In contrast, the USG has been successful in getting in-kind support under the PPP arrangement from the telecommunication companies to pivot the mhealth portfolio to meet the 90-90-90 goals.

The *Commodity Security and Supply Chain* element also exhibited a decline, although critical efforts during the past two years, such as the Holistic Supply Chain Review (a joint collaboration with the Global Fund), the development of a National HIV Supply Plan, and direct support to the Logistics Management Unit within the Ministry of Health yielded positive results. Despite those improvements, the review revealed weaknesses not previously identified which lowered the score for supply chain maturity. This score is an estimate as Tanzania has never conducted a National Supply Chain Assessment using SCMS's tool. There continues to be unsustainable dependence on the USG and Global Fund for supply chain and commodities financing.

Additional Observations: As discussed above, the *Domestic Resource Mobilization* element showed marginal improvements rising from 1.94 (SID 2.0) to 3.21 (SID 3.0). However, four new categories were added into this element in SID 3.0 (11.1, 11.5, 11.7 and 11.8), which accounts for an additional 2.04 possible points. While the four new categories may be a more accurate reflection of the element, the significant rise from SID 2.0 to SID 3.0 is misleading. In fact, the Domestic Budget (11.2) score dropped from 1.11 to 0.48.

Similarly, the responses to all the *Planning and Coordination* categories were nearly identical for SID 2.0 and SID 3.0, but the difference in the weighting in 1.1 increased its score from 1.60 (SID 2.0) to 2.50 (SID 3.0).

Sustainability Analysis for Epidemic Control: Tanzania

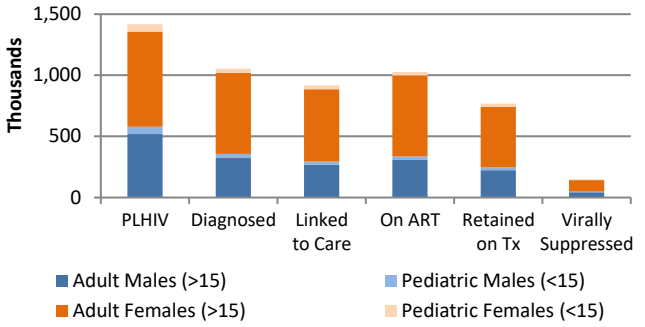
Epidemic Type: Generalized
Income Level: Low income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 17 Planning Level: $482,859,944

SUSTAINABILITY DOMAINS and ELEMENTS

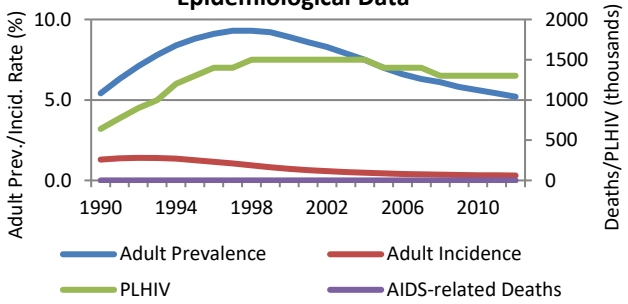
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43	5.33		
2. Policies and Governance	3.85	6.96		
3. Civil Society Engagement	4.17	3.83		
4. Private Sector Engagement	4.86	4.13		
5. Public Access to Information	5.00	6.00		
National Health System and Service Delivery				
6. Service Delivery	3.38	3.98		
7. Human Resources for Health	5.00	5.60		
8. Commodity Security and Supply Chain	4.94	4.25		
9. Quality Management	5.19	5.62		
10. Laboratory	3.33	5.83		
Strategic Investments, Efficiency, and Sustainable Financing				
11. Domestic Resource Mobilization	1.94	3.21		
12. Technical and Allocative Efficiencies	3.17	4.67		
Strategic Information				
13. Epidemiological and Health Data	4.70	4.17		
14. Financial/Expenditure Data	4.58	5.00		
15. Performance Data	5.99	6.97		

CONTEXTUAL DATA

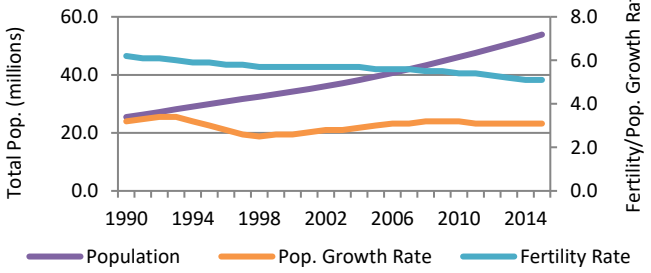
National Clinical Cascade



Epidemiological Data

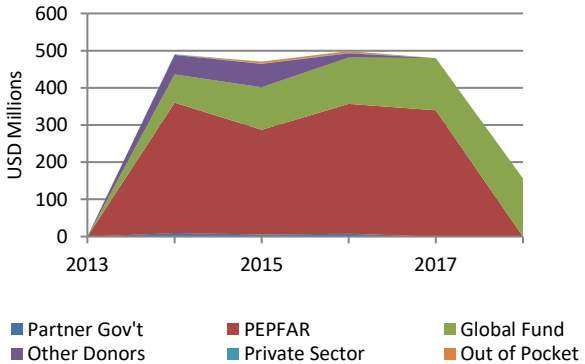


Population and Fertility

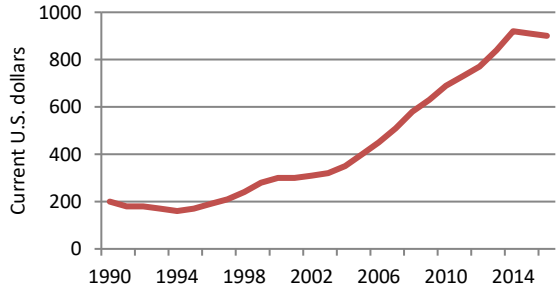


CONTEXTUAL DATA

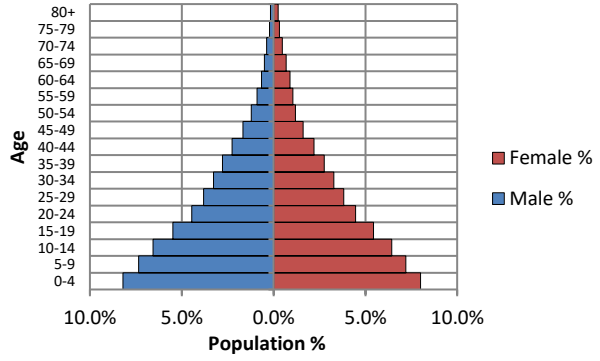
Financing the HIV Response



GNI Per Capita (Atlas Method)



Population Pyramid (2017)



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 finances, widely disseminates program progress and results, provides accurate information and education on HIV/AIDS, and supports mechanisms for eliciting feedback. Relevant government entities take actions to create an enabling policy and legal environment, ensure good stewardship of HIV/AIDS resources, create space for and promote participation of the private sector, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

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 has measurable targets. ☑ 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 ☑ Strategy (or separate document) includes considerations and activities related to sustainability	1.1 Score: 2.50	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017. National Aids Control Programme. April 2014 Costing of the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017 Draft Health Sector HIV and AIDS Strategic Plan 2017–2022 (HSHSP IV) under development National Aids Control Programme Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS (2013/14 – 2017/18)	The third Health Sector HIV and AIDS Strategic Plan that is ending this year was costed. Currently stakeholder's discusions to review the ending strategy is ongoing. There are plans to cost it when the final draft has been approved. Key population is included in the national strategies however there are challenges around implementation. Both National HSHSP- III and IV have a section on vulnerable children under impact mitigation. However there is an entire OVC Action Plan (which is ending in 2017) is being implemented by the Social welfare department. A new draft action plan is currently being developed. National Multisectoral Framework (NMSF) has a section on Resources Mobilization, Disbursement and Management. The strategy outlined by the GOT include establishment of the AIDS Trust Fund which has been established and the government has started allocating funding, LGAs to allocate funds for HIV and institutionalization of the NHA.

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	Third Health Sector HIV and AIDS Strategic Plan (HSHSP- III) 2013 – 2017. National Aids Control Programme. April 2014 Draft Health Sector HIV and AIDS Strategic Plan 2017–2022 (HSHSP IV) under development National Aids Control Programme	Participation of private sector was not very broad. Private sector was represented by ATE (Association of Tanzania Employees) which is not typical representative of the private sector.

1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented 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 (including health care providers and/or other private sector partners) ☑ 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	Health sector data including Tanzania National Multisectoral HIV Monitoring and Evaluation System: Guidelines for the Tanzania Output Monitoring System For Non-Medical HIV And AIDS Interventions (TOMSHA). Version 2.7, TACAIDS, Www.Tacaids.Go.Tz TOMSHA captures community HIV/AIDS and non clinical services. Data collection is done on quarterly basis.	There is limitation in documentation of what each partner organization and donors are doing. No systematic way of tracking and updating their activities on regular basis. At regional level, TACAIDS has regional coordinators who coordinates HIV activities. Challenge remains on tracking them on regular basis and ensuring that they report back to regional coordinators. Quarterly meetings with donors to discuss implementation take place through DPG-Health and DPG-AIDS. TWGs (Thematic areas) are in place however there are areas that need improvements i.e. maintaining the meeting schedules and improvements on coordination between GOT and all stakeholders (donors). Deduplication of activities is still a challenge
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 either checkbox under option B)	◉ A. There is no formal link between the national plan and sub-national service delivery. ○ B. There is a formal link between the national plan and sub-national service delivery. (Check the ONE that applies.) ☐ Sub-national units have performance targets that contribute to aggregate national goals or targets. ☐ The central government is responsible for service delivery at the sub-national level.	1.4 Score: 0.00	COP17 documents and Global fund 2017 application documents. PEPFAR Tanzania COP approval slides: Slide no 18	One national target has been developed which PEPFAR and NACP (Global fund) are using the same treatment target to reach PLHIV. A meeting to work on national target was facilitated during COP17 planning and was attended by UNAIDS, NACP, PEPFAR, Global Fund. LGAs are responsible for service delivery where central level is responsible for
	Planning and Coordination Score: 5.33			

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 WHO guidelines for initiation of ART, i.e. Test and START for all populations?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines for each of the following: A. Adults (>19 years) ☑ Yes ☐ No B. Pregnant and Breastfeeding Mothers ☑ Yes ☐ No C. Adolescents (10-19 years) ☑ Yes ☐ No D. Children (<10 years) ☑ Yes ☐ No	2.1 Score: 1.11	National Guidelines for the Management of HIV and AIDS. May 2017, NACP.	

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? Note: If one of the listed policies differentiates policy for specific groups, please note in the Notes/Comments column.	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 ☑ Policies that permit HIV self-testing ☑ Policies that permit pre-exposure prophylaxis (PrEP) ☑ Policies that permit post-exposure prophylaxis (PEP) ☑ Policies that allow HIV testing without parental consent for adolescents, starting at age 15 ☑ Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent	2.2 Score: 0.83	HIV Prevention and Control Act (2008) National Task sharing policy guidelines for Health Sector Services in Tanzania (Jan 2016) National Guidelines for the Management of HIV and AIDS, Sixth Edition. May 2017, NACP. URT, National Guideline for Comprehensive package of HIV Interventions for Key and Vulnerable Populations, April 2017 URT, MOHSW: National Most Vulnerable Children M&E Plan. Departmenmt of Social Welfare, January 2015. URT, MOHSW: national Costed Plan of Action for most Vulnerable Children (NCPA II). 2013-2017 National Comprehensive Guidelines on HIV Testing Services, Final Draft September 2017. NACP, Ministry Of Health, Community Development, Gender, Elderly, and Children.	To facilitate the rapid rollout of the CHW cadre, in 2015 the MoHCDGEC included the new CHW position in the existing MA Scheme of Service (SoS) and developed a national training curriculum, which comprises the functions of the MA, CHWs and para-social workers (PSWs). Standalone CHW curriculum and SoSare critical to ensure effective recruitment, deployment and retention of the CHW cadre at the community level and to meet the needs of the community. Task sharing policy allows for CHWs to dispense ARVs, however community level dispensing it not yet included in the SDM guidelines. The New SDM policy allows stable patients to have a max of 2 months refills at a facility. Self testing is in demonstration stage. It is included in the HTS guideline that is currently being developed. PrEP is mentioned in the policy as a relevant HIV prevention services and currently is being implemented as a demostration. It is going to be scaled up later. HIV Testing for under 18 demographic is allowed under a "mature-minor" clause that is prone to interpretation by health workers.

2.3 Data Protection: Does the country have policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?	The country has policies in place that (check all that apply): ☑ Govern the collection of patient-level data for public health purposes, including surveillance ☐ Govern the collection and use of unique identifiers such as national ID for health records ☑ Govern the privacy and confidentiality of health outcomes matched with personally identifiable information ☐ Govern the use of patient-level data, including protection against its use in crimincal cases	2.3 Score: 0.56	URT, The Functions and Organisation structure of the MOHSW, June, 2011. President's Office Public Service Management. http://www.nimr.or.tz/wp-content/uploads/2017/09/Guidelines-of-Ethics-for-Health-Research-in-Tanzania2.pdf National Information and Communications Technologies Policy. March 2003. The United Republic Of Tanzania Ministry Of Communications and Transport ICT Policy draft, January 2016. Ministry of Health, Community Development, Gender, The Elderly and children. National Health Policy. October, 2003, Ministry Of Health.	A new draft policy has been developed and currently is being reviewed by stakeholders. Draft standard for identification within the electronic systems exists. Unique identifier system for anonymous services is in development stage (NACP). PEPFAR COP funding.
2.4 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations?	Check all that apply: Transgender people (TG): ☐ Constitutional prohibition of discrimination based on gender diversity ☐ Prohibitions of discrimination in employment based on gender diversity ☐ A third gender is legally recognized ☐ Other non-discrimination provisions specifying gender diversity (note in comments) Men who have sex with men (MSM): ☐ Constitutional prohibition of discrimination based on sexual orientation ☐ Hate crimes based on sexual orientation are considered an aggravating circumstance ☐ Incitement to hatred based on sexual orientation prohibited ☐ Prohibition of discrimiation in employment based on sexual orientation ☐ Other non-discrimination provisions specifying sexual orientation Female sex workers (FSW): ☐ Constitutional prohibition of discrimination based on occupation	2.4 Score: 0.19	URT, National Guideline for Comprehensive package of HIV Interventions for Key and Vulnerable Populations, April 2017 The Report on the Legal Environment Assessment (LEA) in Response To HIV and AIDS Within the United Republic Of Tanzania. 2015 TACAIDS, ZAC, UNDP	Tanzania Mainland and Zanzibar have both enacted specific HIV and AIDS legislations. However, the majority of the population is ignorant of these laws and their HIV and AIDS related rights. According to LEA report; The Legal Frameworks of both parts of Tanzania have legislations that contain (i) provisions which counter the efforts against the spread of HIV and AIDS, (ii) Certain practices which are devised to facilitate accessibility of HIV/ AIDS services are in fact promoting stigma and discrimination (iii) Still, there are practices at family and community levels that discriminate and stigmatize PLHIV and KPs at a higher risk of contracting HIV (iv) There are Legal framework gaps in the subsisting HIV/AIDS legislations that counter the effectiveness of HIV and AIDS interventions. These include laws which criminalize and seek to sanction certain conducts of KP such as the Penal Code8, Drugs and Prevention of Illicit Trafficking in Drugs Act9. Applications of these laws either further/fuels the cycle of vulnerability to HIV while at the same time hinder proper HIV and AIDS national response.

	☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments) People who inject drugs (PWID): ☐ Specific antidiscrimination laws or other provisions for people who use drugs (specify in comments) ☑ Explicit supportive reference to harm reduction in national policies ☑ Policies that address the specific needs of women who inject drugs			
2.5 Legal Protections for Victims of Violence: Does the country have protections in place for victims of violence?	The country has the following to protect key populations and people living with HIV (PLHIV) from violence: ☑ General criminal laws prohibiting violence ☐ Specific legal provisions prohibiting violence against people based on their HIV status or belonging to a key population ☑ Programs to address intimate partner violence ☑ Programs to address workplace violence ☐ Interventions to address police abuse ☐ Interventions to address torture and ill treatment in prisons ☑ A national plan or strategy to address gender-based violence and violence against women that includes HIV ☑ Legislation on domestic violence ☑ Criminal penalties for domestic violence ☑ Criminal penalties for violence against children	2.5 Score: 0.78	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. The Report on the Legal Environment Assessment (LEA) in Response To HIV and AIDS Within the United Republic Of Tanzania. 2015 TACAIDS, ZAC, UNDP	While we have provisions for PLHIV but we do not have such provisions for KPs The rights of women and girls are specifically provided for in various legislations (Marriage Act, Penal Act of 2004), there are still practices and other laws that undermine women and girls HIV and AIDS related rights and increases their vulnerability to abuse and thus fueling the spread of HIV. The loopholes within the legal framework are such as lack of specific gender law to categorically outlaw gender based violence. Example the Penal Act, No.6 of 2004 Section 125(1), does not criminalize marital rape even in the circumstances where husband is infected with HIV/AIDS.

2.6 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?	**For each question, select the most appropriate option:** Are transgender people criminalized and/or prosecuted in the country? ☐ Both criminalized and prosecuted ☐ Criminalized ☐ Prosecuted ☑ Neither criminalized nor prosecuted Is cross-dressing criminalized in the country? ☐ Yes ☐ Yes, only in parts of the country ☐ Yes, only under certain circumstances ☑ No Is sex work criminalized in your country? ☑ Selling and buying sexual services is criminalized ☐ Selling sexual services is criminalized ☐ Buying sexual services is criminalized ☐ Partial criminalization of sex work ☐ Other punitive regulation of sex work ☐ Sex work is not subject to punitive regulations or is not criminalized. ☐ Issue is determined/differs at subnational level	2.6 Score: 0.72	Note: This question is adapted from questions asked in the revised UNAIDS NCPI (2016). If your country has completed the new NCPI, you may use it as a data source to answer this question. The Report on the Legal Environment Assessment (LEA) in Response To HIV and AIDS Within the United Republic Of Tanzania. 2015 TACAIDS, ZAC, UNDP	Tanzania doesn't recognise Transgender. There are punitive laws that prohibit Sex work in Tanzania and so transactional sex in Tanzania is prohibited and people who engage in this business are frequently arrested but not charged for prostitution but rather loitering and other offences. Section 145 of the Penal code states that; Every male who facilitate or/engage in prostitution activities will be subjected to punitive measures including imprisonment/or corporal punishment. Zanzibar Penal Acts instructs imprisonment for three years due to sex work.

Does the country have laws criminalizing same-sex sexual acts?

- [ ] Yes, death penalty
- [ ] Yes, imprisonment (14 years - life)
- [x] Yes, imprisonment (up to 14 years)
- [ ] No penalty specified
- [ ] No specific legislation
- [ ] Laws penalizing same-sex sexual acts have been decriminalized or never existed

Does the country maintain the death penalty in law for people convicted of drug-related offenses?

- [ ] Yes, with high application (sentencing of people convicted of drug offenses to death and/or carrying out executions are a routine and mainstreamed part of the criminal justice system)
- [ ] Yes, with low application (executions for drug offenses may have been carried out in recent years, but in practice such penalties are relatively rare)
- [ ] Yes, with symbolic application (the death penalty for drug offenses is included in legislation, but executions are not carried out)
- [x] No

Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?

- [x] Yes
- [ ] No, but prosecutions exist based on general criminal laws
- [ ] No

Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?

- [ ] Yes
- [x] No

	Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people? ☐ Yes, promotion ("propaganda") laws ☑ Yes, morality laws or religious norms that limit LGBTI freedom of expression and association ☐ No			
2.7 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	2.7 Score: 0.56	Social welfare department The Report on the Legal Environment Assessment (LEA) in Response To HIV and AIDS Within the United Republic Of Tanzania. 2015 TACAIDS, ZAC, UNDP	No stand alone efforts to educate KPs on rights to accessing HIV services. Legal strucures exist for refferals and accessing legal services (free services). Social welfare section has been given mandate to provide linkage services and law enforcement. The government has established Police gender desk (in major police posts) that assists women and girls in reporting gender based violence related offences.
2.8 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.	2.8 Score: 1.11	Controller and Auditor General Annual (CAG) Reports	Audit is done as part of routine government operations on annual basis. and not just specific to HIV/AIDS. Actual audit reports could not be obtained for submission (government documents).
2.9 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.	2.9 Score: 1.11		CAG reports are presented to the parliament for discussion and action.
		Policies and Governance Score: 6.96		

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, Organizations in Tanzania, Annual Report 2009 The state of CSOs in Tanzania, Annual Report 2010	A few CSOs that exist are partially involved in providing oversight (The law doesn't prevent them, but it does not happen as desired)
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 ☐ Service delivery	3.2 Score: 0.83	Meeting minutes and presentations from the Joint Thematic Working Groups for HIV/AIDS.	Invitation is extended in an adhoc manner depending on activity to be done at a particular time.

3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	○ A. Civil society does not actively engage, or civil society engagement does not impact policy, programming, and budget decisions related to HIV/AIDS. ◉ B. Civil society's engagement impacts HIV/AIDS policy, programming, and budget decisions (check all that apply): ☑ In policy design ☑ In programmatic decision making ☑ In technical decision making ☑ In service delivery ☐ In HIV/AIDS basket or national health financing decisions	3.3 Score: 1.33	Report on Mapping of Differentiated Service Delivery for HIV Care in Tanzania. 2017, Ministry of Health, Community Development, Gender, Elderly and Children.	
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 (not including Global Fund grants through government Principal Recipients). ○ 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 through government Principal Recipients).	3.4 Score: 0.83	Local government guideline and budgetting process.	Minimal level support/funding provided to CSOs to implement activities at community level.
3.5 Civil Society Enabling Environment: Are there laws, policies, or regulations in place which permit CSOs to be funded from a government budget for HIV services through open competition (from any Ministry or Department, at any level - national, regional, or local)? Note: This sometimes referred to as "social contracting" or "social procurement."	◉ A. There is no law, policy, ore rgulation which permits CSOs to be funded from a government budget for HIV Services through open competition (not to include Global Fund or other donor funding to government that goes to CSOs). ○ B. There is a law, policy or regulation which permits CSOs to be funded from a government budget for HIV services. Check all that apply: ☐ Competition is open and transparent (notices of opportunities are made public) ☐ Opportunities for CSO funding are made on an annual basis ☐ Awards are made in a timely manner (within 6-12 months of announcements) ☐ Payments are made to CSOs on time for provision of services	3.5 Score: 0.00	The State of Civil Society, Organizations in Tanzania, Annual Report 2009 The state of CSOs in Tanzania, Annual Report 2010	
		Civil Society Engagement Score: **3.83**		

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 the host country government have formal channels and opportunities for diverse private sector entities (including service delivery, corporations, and private training institutions) to engage and provide feedback on its HIV/AIDS policies, programs, and services? (If option B is true, check all subsequent boxes that apply.)	○ A. There are no formal channels or opportunities for private sector engagement. ◉ B. There are formal channels or opportunities for private sector engagement. i. The following private sector stakeholders formally contribute input into national or sub-national processes for HIV/AIDS planning and strategic development (check all that apply): ☑ Corporations ☐ Employers ☑ Private training institutions ☑ Private health service delivery providers ii. Stakeholders contribute in the following ways (check all that apply): ☑ The private sector contributes technical expertise into HIV program planning ☑ Data and strategic input into supply chain management for HIV commodities ☐ Service delivery and/or client satisfaction data from private service delivery providers is included in health sector and HIV program planning ☐ Data on staffing in private health service delivery providers ☐ Data on private training institution's human resources for health (HRH) graduates and placements are included in health sector and HIV program planning ☐ For technical advisory on best practices and delivery solutions	4.1 Score: 1.18	Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) http://slideplayer.com/slide/8484527/ National TIIS which private training institutions have access http://www.tiis.go.tz/about-tiis 1 Tanzania Third National Multi-Sector Strategic Framework for HIV and AIDS (2013/14 – 2017/18) NMSF III	There is a reporting mechanism for private sector to report to the government through district system; however there is no specific disaggrates that tells the data source is from the private sector. eLMIS is a district system and not accessible to private sector. They have to report through the district (ie they cant access the system on their own; have to go through their districts). Same for HRH issues: Private sector doesnt have their own HRH reporting system. They use government system (MTUHA) which they can access at their institutions and their data is used for placement i.e. to place applicants from private institutions into government facilities. TOMSHA is the system that TACAIDS and the districts use to monitor all the HIV activities in the community (not at health facilities). It is managed by TACAIDS. It is a very ambitious and elaborate paper-based reporting system with several distinct paths of data transmission. It relies heavily on the participation of the Community HIV and AIDS Coordinators at District level to collect quarterly reports and channel them to TACAIDS. TACAIDS claims that it receives reports at least once a year from 66 percent of organizations that have been trained in TOMSHA (cumulative 1,800 reports since 2007). However, in interviews with five CHACs in Iringa, Tanga, and Kilimanjaro Region, the OIG team only identified two who were participating in TOMSHA reporting. Both of them stated that only about 20 percent of organizations in the district were submitting reports. TOMSHA is a system under development. The effort required to bring it to a level where it can generate valid information is enormous. The main constraint to the system is that it relies on the participation of

	iii. The national HIV/AIDS strategic plan explicitly addresses private sector's role in the HIV/AIDS response (check all that apply): ☑ The national HIV/AIDS strategic plan has a specific section that specifies the private sector's role in the HIV/AIDS response. ☐ A recent (within past 4 years) market analysis informs the private sector strategy that is included in the HIV/AIDS strategic plan ☐ The government and private sector effectively coordinates and executes a total market approach for HIV service delivery, which accounts for whether people are able and/or willing to pay for HIV services.			the CHACs who are agents of the Ministry of Community Development, Gender, and Children and report to the District Community Development Department and the District Executive Director. Their participation in TOMSHA reporting is quasi-voluntary. There is a discussion about integrating TOMSHA in the Tanzania Local Government Monitoring and Evaluation System. Without this integration, it will be very difficult for the system to fully develop and to survive in the long-term
4.2 Enabling Environment for Private Corporate Contributions to HIV/AIDS Programming: Does the host country government have systems and policies in place that allow for private corporate contributions to HIV/AIDS programming?	Check all that apply: ☐ Tax policies and incentives are designed to encourage corporate social responsibility efforts from companies who are contributing financial commitments and/or non-financial resources (including, but not limited to, product donations, expertise, and employee staff time). ☐ The host country government has in-house expertise in contracting services to private sector corporations when appropriate and necessary (e.g., transportation and waste management). ☑ The host country government has standards for reporting and sharing data across public and private sectors. ☑ Regulations help ensure that workplace programs align with the national HIV/AIDS program (e.g., medical leave policies, on-site testing, on-site prevention and education, anti-discrimination policies). ☐ There are strong linkage and referral networks between on-site workplace programs and public health care facilities.	4.2 Score: 1.00	1 The Tanzania Commission for AIDS (Amendment) Act, No. 11, 31st October, 2014 2 Tanzania Third National Multi-Sector Strategic Framework for HIV and AIDS (2013/14 – 2017/18) NMSF III	1 There are no tax incentives for commercial sector to contribute resources to HIV activities. 2 There are regulations for workplace programs; however the government acknowledges a death of private sector workplace programs (NMSF III p. 27). Two members from private sector are included in the board of Trustees of the AIDS Trust Fund. Some corporate companies contribute i.e. for mobile operators (mhealth program) they contribute through zero rating as a corporate social rensposibility. Usually the government charge tax even for products that are procured for donations.

4.3 Enabling Environment for Private Health Service Delivery: Does the host country government have systems and policies in place that allow for private health service delivery? Note: Full score possible without checking all boxes.	○ A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services. ○ B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years. ◉ C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply): ☑ Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications. ☑ Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting. ☐ Joint (i.e., public-private) supervision and quality oversight of private facilities. ☐ The government offers tax deductions for private facilities delivering HIV/AIDS services. ☐ The government offers tax deductions for private training institutions. ☑ The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores ☐ The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services. ☐ HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes ☐ There are open competitions for private health care providers to compete for government service contracts ☑ There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming ☑ The government effectively regulates the flow of subsidized commodities into the private sector.	4.3 Score: 1.94	Strategic Plan for the Private Sector's Response to HIV and AIDS and health promotion at the workplace. 2013-2015, Association of Tanzania Employers, Tanzania Private Sector Foundation. MSD policy for procurement Service Agreements with government	Government does have service delivery agreements with some private hospitals to provide HIV service. Reporting system does not call for data reporting from private institutions. New products can be registered through TFDA however suppliers state that, registration is expensive and lengthy. (Check with TFDA on evidence for this and put as a reference). Note TFDA does not have procedures in place to fasttrack registration of supply kits. Private sector can pay for that. Formal contracting or service level agreements is only done with Faith Based Organisations. Government does not conduct supportive supervision to monitor services only NGOs do conduct those visits. Private sector access ARVs from public sector and are allowed to buy other commodities related to HIV to supplement what they get from the public sector.

4.4 Private Sector Capability and Interest: Does the private sector possess the capability to support HIV/AIDS services, and do private sector stakeholders demonstrate interest in supporting the national HIV/AIDS response?	◉ A. The host country government does not leverage the skill sets of the private sector for the national HIV/AIDS response. ○ B. The private sector does not express interest in or actively seek out opportunities to support the national HIV/AIDS response. ○ C. The private sector has expertise and has expressed interest in or actively seeks out (check all that apply): ☐ Market opportunities that align with and support the national HIV/AIDS response ☐ Opportunities to contribute financial and/or non-financial resources to the national response (including business skills, market research, logistics, communication, research and development, product design, brand awareness, and innovation)	4.4 Score: 0.00	1 Private Sector Mapping Study Report to TPSF and ATE by Deloitte August 2015. 2 Tanzania Third National Multi-Sector Strategic Framework for HIV and AIDS (2013/14 – 2017/18) NMSF III 3 Assessing the Sustainable Delivery of HIV Services in Tanzania through the Private Sector, SHOPS Plus, Abt Associates Inc, 2017 4 HP Plus study of private sector willingness to contribute	1 The Private Sector HIV Mapping Study revealed declining interest among employers/corporations to support HIV activities. 2 Only 2% of HIV/AIDS financing comes from the private sector, which are primarily in-kind investments by a few large companies (NMSF III, p. 36). 3 A study in Dar and Njombe (Abt 2017) found underutilized capacity among private health facilities to provide HIV services. However, the government will need to proactively support differentiated care models needed to scale-up private sector provision of pediatric and adult ART. Primarily due to PEPFAR intervention, MOUs have been developed between Government and mobile phone operators to provide zero rated text message services for PEPFAR funded programs.
		Private Sector Engagement Score: 4.13		

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 and analyses are made available to stakeholders and general public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS surveillance and survey data available to stakeholders and the general public, or they are made available more than one year after the date of collection. ◉ B. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within 6-12 months. ○ C. The host country government makes HIV/AIDS surveillance and survey data available to stakeholders and the general public within six months.	5.1 Score: 1.00	Minutes of the 7th PHIA Steering Committee Meeting, TACAIDS Conference Room, Friday 17th February 2017	THIS/PHIA results is scheduled to be disseminated on World AIDS day (1st Dec) which is about 12 months since data collection started. General public gets access to analysed data/findings through mass media through the National Bureau of Statistics (NBS). Institutions (i.e. research, NGOs, Universities etc) that are more interested in secondary data analysis can request data from NBS by writing a formal request to the NBS Director General.
5.2 Expenditure Transparency: Does the host country government make annual HIV/AIDS expenditure data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not track HIV/AIDS expenditures. ◉ B. The host country government does not make HIV/AIDS expenditure data available to stakeholders and the general public, or they are made available more than one year after the date of expenditures. ○ C. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within 6-12 months after date of expenditures. ○ D. The host country government makes HIV/AIDS expenditure data available to stakeholders and the general public within six months after expenditures.	5.2 Score: 0.00	National Health Accounts(NHA-2017), National AIDS Spending Assessment (NASA) 2016, Public Expenditure Review (PER)	HIV/AIDS expenditure review is done as part of governement general operations. This year (2017) there will be HIV specific expenditure review. The last PER was conducted in 2012/2013
5.3 Performance and Service Delivery Transparency: Does the host country government make annual HIV/AIDS program performance and service delivery data available to stakeholders and the public in a timely and useful way?	○ A. The host country government does not make HIV/AIDS program performance and service delivery data available to stakeholders and the general public or they are made available more than one year after the date of programming. ◉ B. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within 6-12 months after date of programming. ○ C. The host country government makes HIV/AIDS program performance and service delivery data available to stakeholders and the general public within six months after date of programming .	5.3 Score: 1.00		Verified by Richard Ngirwa-TACAIDS director of planning and policy: The national response report is usually submitted to the parliament.

5.4 Procurement Transparency: Does the host country government make government HIV/AIDS procurements public in a timely way?	○ A. The host country government does not make any HIV/AIDS procurements. ○ B. The host country government makes HIV/AIDS procurements, but neither procurement tender nor award details are publicly available. ○ C. The host country government makes HIV/AIDS procurements, and tender, but not award, details are publicly available. ◉ D. The host country government makes HIV/AIDS procurements, and both tender and award details available.	5.4 Score: 2.00	https://www.ppra.go.tz/	Stakeholders confirmed that, HIV/AIDS procurements and tender and award are made available for the public.
5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	○ 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.nacp.go.tz/	MOH-NACP is the National HIV/AIDS Control program and one of its mandate is to share HIV/AIDS information to the general public. In addition to program data reported by the program manager on regular basis, in 2006 GOT created a NACP website which has been a platform for enhancing Tanzanians access to information on HIV, AIDS and STI.s, generated in Tanzania.
		Public Access to Information Score: 6.00		

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: 1.11	Service Delivery Model: Report on Mapping of Differentiated Service Delivery for HIV Care in Tanzania, MoHCDGEC, 2017.	Conceptually, yes. But practically, not always the case, higher volume can adjust, but smaller may not be able to .Differenciated care : decentralized services, and fast track in facilities. Use of community for distribution of ART is not part of the updated guidelines. Health care workers do go into the community, however. Demand Generation does include index testing, focused work in hot spots to support key populations,
6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV services? (Check all that apply.)	The host country has standardized the following design and implementation components of community-based HIV/AIDS 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/AIDS services in communities ☐ Providing official recognition to skilled human resources (e.g. community health workers) working and delivering HIV services in communities ☑ 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: 0.93	Key and vulnerable population guidelines 2nd edition, Mapping Differenctiated Service Delivery, Guideline for community health workers, HSSPIV, HRH strategic plan, Task sharing guideline community based health service providers (CBHSP) Guidelines	Through the Quality Improvement Teams and the Community Health Management Team, civil society has a voice. However, key populations engagement is limited, especially for FSW and MSM. The opinion is that because key populations are part of civil society, their voice is heard. There is a new guideline for key and vulnerable populations. New CHW Cadre and but permits to finance them not yet allocated. community development officers and social workers exists, hose there are not being leveraged.
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 (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 ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services ◉ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services	6.3 Score: 0.83	National Health Accounts(NHA-2017), National AIDS Spending Assessment (NASA) 2016, Public Expenditure Review (PER)	Current version of NHA states 11% supported with domestic sources, however, this is because DOD's data is missing. This answer is going to change.

6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	○ A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. ◉ B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. ○ C. Host country institutions deliver HIV/AIDS services with some external technical assistance. ○ D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.	6.4 Score: 0.37	Health Budget Speech, 2017 National Health Accounts(NHA-2017)	
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 (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. ○ B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. ○ C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. ○ D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. ○ E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.	6.5 Score: 0.00	Tanzania Commission for AIDS August 2015. Public Expenditure Review	Key populations receive services through general population services. Health care workers are instructed to identify needs of Key Populations and address them. However this is all financed by external donors.
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 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	
6.7 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	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.	6.7 Score: 0.19	CCHP Guidelines and Implementation Plans	

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:	0.19	CCHP Guidelines and Implementation Plans	
		Service Delivery Score	**3.98**		

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 clinical health worker supply adequate to enable the volume and quality of HIV/AIDS services needed for sustained epidemic control at the facility and/or community site level?	Check all that apply: ☐ The country's pre-service education institutions are producing an adequate supply and skills mix of clinical health care providers ☐ The country's clinical health workers are adequately deployed to, or distributed within, facilities and communities with high HIV burden ☐ The country has developed retention schemes that address clinical 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: 0.28	Tanzania HRH country profile 2012/2013. Staffing levels for MoHSW departments, health facilties, health service facilities, health training institutes and agencies 2014-2019 revised edition. http://www.tiis.go.tz/about-tiis	The Ministry of health is currently updating the HRH country profile for 2016/2017, where the report is expected to released in November 2017. This can be compared with the information form the Tanzania Institution Information System (TIIS)
7.2 Role of Community-based Health Workers (CHWs): To what extent are community-based health workers' roles and responsibilities specified for HIV/AIDS service delivery?	Check all that apply: ☑ There is a national community-based health worker (CHW) cadre that has a defined role in HIV/AIDS service delivery (e.g., through a national strategy or task-sharing framework/guidelines). ☐ Data are made available on the staffing and deployment of CHWs, including non-formalized CHWs supported by donors. ☑ The host country government officially recognizes non-formalized CHWs delivering HIV/AIDS services.	7.2 Score: 0.74	Community Based Health Service Guidelines	The government has established a pre-service training program for CHWs. According to the report provided by the director of HRH in a panel discussion during Benjamin Mkapa stakeholders meeting that took place in Dar es Salaam on November 9th, the gobernment is aiming at having 24,0000 CHCWs by 2020 to deliver various community services including HIV/AIDS services. The main challenge remains to be how to raise the wedge bill to cater for this need due to the fact that, the government has other priority cadres that they are intending to hire during this critical time after about two years of hiring freeze.
7.3 HRH transition: What is the status of transitioning PEPFAR and/or other donor supported HIV/AIDS health worker salaries to local financing/compensation? Note in comments column which donors have transition plans in place.	○ 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	7.3 Score: 0.28	PEPFAR HRH Invenntory 2016	HRH inventory limited to PEPFAR supported HRH

7.4 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)? (if exact or approximate percentage known, please note in Comments column)	○ 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	7.4 Score: 2.50	Analysis of USG-Supported HRH Inventory in Tanzania, FY 2016 Health sector Budget speech 2017.	
7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	○ 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 PLHIV ☐ Institutions track student employment after graduation to inform planning	7.5 Score: 0.69	Curriculum for Nursing and Midwifery recently updated and includes HIV content (NTA level 4-6) 2015, Curriculum for Clinical Assistants/Clinical Officers (NTA level 4-6) 2016, Curriculum for Medical Laboratory Sciences (NTA level 4-6) 2015, Curriculum for Pharmacutical Technicians (NTA level 4 -6) 2016.	The curriculum have been updated within the last 3 years. For example the CA/CO(NTA level 4-6) has been reviewed in 2016 to include HIV, VMMC and some KP related content, and sent to NACTE (National Council for Technical Education) for verification, where the the MoH has just received the reults in October 2017 for further action. For the nursing curriculum (NTA level 4 -6) it was updated in 2015, For pharmacy curriculum (NTA level 4 -6) it was adjusted in 2016 to include JIV competencies. For laboratory the curriculum was updated in April 2014 with minor adjustments made in 2015 (to include some of the competencies of HIV, QI, etc), whereby processes are underway to perform a comprehensive review of the curriculum in November 2017. Some of the curriculum may not contain content of HIV stigma while others may, due to their various levels of clinical relevancy/depth and client interaction (e.g, from certificate to diploma to Master level)

7.6 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)	7.6 Score: 0.28	Continual Professional Development Plan 2015	This is not budgeted for by the government currently. All in-service training is implemented by donors

7.7 HR Data Collection and Use: Does the country systematically collect and use 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)	7.7 Score: 0.83	Human Capital Management Information System http://www.utumishi.go.tz/utumishiweb/index.php?option=com_content&view=article&id=13&Itemid=151&lang=en	Human Capital Management Information Systems- HCMIS; is an integrated Human Resource and Payroll management system. It was implemented about ten years ago as a tool for effective management of HR and Payroll in the Public Service.
	Human Resources for Health Score	**5.60**		

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	Health Budget, ART supply Plan	The AIDS Trust Fund did set aside funds to by contrimoxazole and other OI medicine, but no funds for ART.
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	Health Budget, ART Supply Plan	All support is through PEPFAR or Global Fund
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: 0.42	Health Budget, RCHS Supply Plan Holistic Supply chain Review: Abridged Report June 2017	All support is through PEPFAR or Global Fund.

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	Holistic Supply Chain Review, National HIV Supply Plan, and LMU Transition recomendations, e-Government MSD ERP recommendations, Comprehensive supportive supervision checklist. Enviornmental Health Unit	
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: 0.21	Holistic Supply Chain Review, Personell emolument	The Logistics Management Unit is currently supported by USG and Global Fund. But MSD staff are supported by GOT.

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	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	MSD strategic plan, eLMIS	
8.7 Assessment: Was an overall score of above 80% achieved on the 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 within the last three years. ◉ B. A comprehensive assessment has been done within the last three years 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 within the last three years and the score was higher than 80% (for NSCA) or in the top quartile for the assessment	8.7 Score: 1.11	Holistic Review of Supply Chain	The NSCA has not been conducted in Tanzania. The Holistic Review did review the maturity of the supply chain, but did notprovide a score. However, based on the large amount of recommendations, we believe Tanzania's supply chain would score below the top quartile.
	Commodity Security and Supply Chain Score:	**4.25**		

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: 1.33	Tanzania Quality Improvement Framework, National Health and Social Welfare Quality Improvement Strategic Plan 2013-2018, National Guideline for Quality Improvement for HIV (?), Essential Interventions for HIV AIDS services	
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 utilized ◉ C. There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized. ○ D. There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.	9.2 Score: 1.33	National Guideline for Quality Improvement for HIV (verify last update is 2016)	Though the guidelines exist, and there are Quality Improvement Teams, in practice, not all facilities use these guidelines. Some staff have not fully internalized principles of quality improvement. However, there is a greater aware ness about it than in the past.
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 through sharing and implementation of best practices across HIV/AIDS sites at all levels	9.3 Score: 0.67	Star Rating assessment Reports and Report on Quality Improvement Plans (QIPs)- Morogoro Region (26th -30th September 2017)	facility assesssments are being conducted by the MOH through the Star Rating initiative. Data collected is analyzed and findings are used to inform facility remediation plan. Facility performance based on star rating approach contribute towards accreditation of these facilities. The MOHCDGEC in collaboration with EGPAF through CDC funding have developed Quality Improvement Monitoring System (added into DHIS2) to facilitate and fast track implementation of Quality Improvement plan (QIPs) developed after assessing health facilities through star rating approach.

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: 2.00	Revised Curricula for Clinical Assistants, Clinical Officers, and nurses.	
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 include 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: 0.29	National Guideline for Quality Improvement for HIV	There is a focal person for QI at the Regional Level. Site level QI is inconsistent, but when present functions very well.
	Quality Management Score:	**5.62**		

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 ◉ F. National laboratory strategic plan has been developed, approved, costed, and implemented	10.1 Score: 1.67	National Health Laboratory Strategic Plan II 2016-2021, Ministry of Health, Community Development, Gender, Elderly and Children (April 2016)	
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	ASLM SLIPTA Assessment Report - Cohort 1-5,2011-2016, National Laboratory Quality Assurance Framework, National POCT Certification Framework	From Level II Laboratories and above.
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 by rapid testing and point-of-care testing ☑ Routine laboratory testing, including chemistry, hematology, microbiology, serology, blood banking, and malaria ☐ Complex laboratory testing, including HIV viral load, CD4 testing, and molecular assays ☑ TB diagnosis	10.3 Score: 1.25	National Health Laboratory Strategic Plan II 2016-2021, Ministry of Health, Community Development, Gender, Elderly and Children (April 2016); NACP Program- Strategic plan and Annual report, NTLP program- Stategic plan and Annual report, Draft National Standard for Medical Laboratory,Draft National Health Laboratory Policy	There is critical shortage of Laboratory personnel to conduct complex Laboratory testing eg. Molecular Biology Teating

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 HIV viral load instruments ☑ All HIV viral load laboratories have an instrument maintenance program ☐ Sufficient supply chain system is in place to prevent stock outs ☐ Adequate specimen transport system and timely return of results	10.4 Score: 0.83	National Staregic Plan for Scaling up HIV Viral Load Testing to support HIV/AIDS Prevention, Care and Treatment 2015 and Operational Plan 2015	The current National Operational Plan to support care and treatment of HIV/AIDS requires VL testing services to be provided from the Regional to National Hospital Laboratory.
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	MOHCDGEC MTEF buddget 2017/2018, Laboratory support program Annual Progress Report, NBTS Annual Progress Report	Laboratory reagents and consumables and Personnel Renumerations and Laboratory Buildings, Administrative and Operational Cost
		Laboratory Score:	**5.83**	

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.

Fiscal Context for Health and HIV/AIDS This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.			**Data Source**	**Notes/Comments**
1. What percentage of general government expenditures goes to health?	7%		NHA 2015 (draft report)	Decrease from previous year - The draft NHA states the domestic contribution is 11%; however, a data review demonstrated the proportion will drop significantly in the final version and will certainly be below the 10% threshold
2. What is the per capita health expenditure all sources?	$40		NHA 2015 (draft report)	Decrease from previous year
3. What is the total health care expenditure all sources as a percent of GDP?	4%		NHA 2015 (draft report)	Decrease from previous year
4. What percent of total health expenditures is financed by external resources?	37%		NHA 2015 (draft report)	Decrease from previous year
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	26%		NHA 2015 (draft report)	Increase from previous year

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 Long-term Financing Strategy for HIV/AIDS: Has the host country government developed a long-term financing strategy for HIV/AIDS?	Check all that apply: ☐ A. Yes, there is a universal, comprehensive financing scheme that integrates social health insurance, public subsidies, and national budget provisions for public health aspects (e.g., disease surveillance). It includes the following (check all that apply): ☐ ARVs are covered ☐ Non-ARV care and treatment is covered ☐ Prevention services are covered ☑ B. Yes, there is an affordable health insurance scheme available (check one of the following). ☐ It covers 25% or less of the population. ☑ It covers 26 to 50% of the population. ☐ It covers 51 to 75% of the population. ☐ It covers more than 75% of the population. ☑ C. The affordable health insurance scheme in (B.) includes the following (check all that apply): ☐ ARVs are covered. ☑ Non-ARV care and treatment services are covered. ☐ Prevention services are covered. ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.32	PER 2015/16 (draft report) and Minister of Health parliamentary speech National Health Insurance Fund: NBAA Seminar on Retirement and Social Security: Roles of Pension and Medical Insurance Schemes in Tanzania: Challenges and Prospects. Presented by Raphael T. Mwamoto Director of Operations (NHIF) National Health Insurance Fund website: http://www.nhif.or.tz/index.php/about-us/profile	C is checked because opportunitistic infections are covered According to the 2017 Minister of Health's budget speech given at the Parliament; between 2015 and 2017 health insurance coverage has increased to reach 28% of the Tanzanian population.

11.2 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	11.2 Score: 0.48	The United Republic of Tanzania Ministry Of Finance Government Budget for Financial Year 2016/17 Citizens' Budget Edition ("Shs 80.8 billion is for the prevention and treatment of HIV/AIDS")	Latest public citizen's budget is 2016/17. No citizen's budget for current fiscal year (2017/18).
11.3 Annual Goals/Targets: To what extent does the national budget contain HIV/AIDS goals/targets?	◉ A. There are no HIV/AIDS goals/targets articulated in the national budget ○ B. There are HIV/AIDS goals/targets articulated in the national budget. ☐ The goals/targets are measurable. ☐ Budget items/programs are linked to goals/targets. ☐ The goals/targets are routinely monitored during budget execution. ☐ The goals/targets are routinely monitored during the development of the budget.	11.3 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	
11.4 HIV/AIDS 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. There is no HIV/AIDS budget, or information is not available. ○ B. 0-49% of budget executed ○ C. 50-69% of budget executed ○ D. 70-89% of budget executed ○ E. 90% or greater of budget executed	11.4 Score: 0.00	PER 2015/16 (draft report)	

11.5 Donor Spending: Does the Ministry of Health or Ministry of Finance routinely, and at least on an annual basis, collect all donor spending in the health sector or for HIV/AIDS-specific services?	○ A. Neither the Ministry of Health nor the Ministry of Finance routinely collects all donor spending in the health sector or for HIV/AIDS-specific services. ○ B. The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services. ◉ C. The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.	11.5 Score: 0.95	NHA 2015 (draft report)	
11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)? (if exact or approximate percentage known, please note in Comments column)	○ A. None (0%) is financed with domestic funding. ◉ B. Very liitle (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	NHA 2015 (draft report) Rapid Budget Analysis 2014 Health Sector, Prepared for DPG – Health By Omar Balsara Consultant, UNICEF	Currently the draft NHA states the proportion of HIV financing that's domestic is 11%, but we know that DOD has not yet submitted their data and when DOD's data is included the final amount will be less than 10% threshold (which falls under the red score). We will revisit the scores in the near future once we have all the data from USG into the tool.
11.7 Health Budget Execution: What was the country's execution rate of its budget for health in the most recent year's budget?	○ A. There is no budget for health or no money was allocated. ○ B. 0-49% of budget executed. ○ C. 50-69% of budget executed. ◉ D. 70-89% of budget executed. ○ E. 90% or greater of budget executed.	11.7 Score: 0.63	PER 2015/16 (draft report)	Please note the health basket fund execution rate was 89%; however, the non-basket fund execution rate was 18%.
11.8 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 is seldom used. ○ C. There is a policy/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.	11.8 Score: 0.00	Rapid budget analysis 2014	
	Domestic Resource Mobilization Score:	**3.21**		

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? If yes, please note in the comments section when the model was last used and for what purpose (e.g., for Global Fund concept note development) (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: 2.00	GFATM HIV proposal 2017 Tanzania Investment Case, 2016	Government uses estimates and projections from Spectrum (AIM and Goals) to the develop fastrack investment case scenarios. The investment case helped to guide development of GF Concept Note and AIDS Trust Fund (Domestic Resources) allocation. ATF disbursement allocation is 55% for care and treatment, 25% for prevention and remaining for Enablers. During the Costing of The NMSF unit costs were developed and reviewed for their suitability as inputs for the GOALS Model.
12.2 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.	12.2 Score: 0.00	PER 2015/16 (draft report)	

12.3 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 have/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 ☑ Laboratory services ☑ ART ☑ PMTCT ☑ VMMC ☐ OVC Service Package ☑ Key population Interventions	12.3 Score: 2.00	Tanzania Investment Case, 2016.	With exception of OVC, modelling the Investment Case used unit costs for various interventions in the NMSF III to estimate programme impacts and resource needs. This information has guided the national planning and resource mobilisation and allocation as stated in element 12.1.
12.4 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)	12.4 Score: 0.67	National HIV treatment guidelines	

12.5 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.	12.5 Score:	0.00	Quantification report and supply plan 2016/17	
		Technical and Allocative Efficiencies Score:	**4.67**		

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, Tanzania HIV Indicator Survey (THIS) on behalf 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: 0.24	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 National AIDS Control Programme in the Ministry of Health has the role of coordinating, overseeing and guiding the Health sector response ; has the responsibility of conducting surveys and surveillances eg Integrated Bio-Behavioral Survey Among People Who Inject Drugs in Dar es Salaam (2014), Formative assessment to inform an Integrated Bio-behavioral Surveillance among MSM in Mwanza, Tanzania, HIV AND STI BIOLOGICAL AND BEHAVIORAL SURVEY, 2013 (A study of Female Sex Workers in seven Regions: Dar es Salaam, Iringa, Mbeya, Mwanza, Shinyanga, Tabora and Mara),Prevalence of Human Immunodeficiency Virus, other sexually transmitted infections and health-related perceptions, reflections, experiences and practices among men having sex with men in Dar es Salaam (2012)

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 2016/17	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: 0.42	MOHSW, NBS and TACAIDS budgets, MTEF 2016/17	Funded primarily by donors through local and International NGOs. Generally staff salaries are covered but costs pertaining to design, implementation and reporting of survey results are covered by external financial resources

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.) refers to prevalence data. (B.) refers to incidence data: ☑ A. The host country government collects at least every 5 years HIV prevalence data disaggregated by: ☑ Age (at coarse disaggregates) ☑ Age (at fine disaggregates) ☑ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ Sub-national units ☐ B. The host country government collects at least every 5 years HIV incidence disaggregated by: ☐ Age (at coarse disaggregates) ☐ Age (at fine disaggregates) ☐ Sex ☐ Key populations (FSW, PWID, MSM, TG, prisoners) ☐ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☐ Sub-national units	13.5 Score: 0.48	Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS/THIS) conducted every four years coordinated by TACAIDS, ZAC, NBS, OCGS	THMIS was not collecting incidence data, however incidence data will be available in the on-going Tanzania HIV Impact Study (THIS). There is no routine national level prevalence or incidence data collected for key populations.

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, TG, prisoners) ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) For what proportion of PLHIV (select ONE of the following): ☐ Less than 25% ☑ 25-50% ☐ 50-75% ☐ More than 75%	13.6 Score: 0.60	Laboratory Information System (2017)	
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.) Please note most recent survey dates in comments section.	○ A. The host country government does not conduct IBBS or size estimation studies for key populations (FSW, PWID, MSM, TG, prisoners) 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 (TG) ☑ People who inject drugs (PWID) ☐ Prisoners ☑ Priority populations (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) Size estimation studies for (check ALL that apply): ☑ Female sex workers (FSW) ☑ Men who have sex with men (MSM) ☐ Transgender (TG) ☑ People who inject drugs (PWID) ☐ Prisoners ☐ Priority populations (AGYW, clients of sex workers, miliitary, mobile populations, non-injecting drug users)	13.7 Score: 0.83	Consensus Estimates on Key Population Size and HIV Prevalence in Tanzania, National AIDS Control Programme (July 2014); Integrated Bio-Behavioral Survey Among People Who Inject Drugs in Dar es Salaam, Ministry of Health and Social Welfare (April 2014); Report for Rapid Formative Assessment in Preparation for HIV Biological and Behavioral Surveillance Among Female Sex Workers in Dar es Salaam, Tanzania (August 2009); Prevalence of HIV, Hepatitis C, and Depression Among People Who Inject Drugs in the Kinondoni Municipality in Dar Es Salaam, Tanzania (July 2014); Prevalence of the Human Immunodeficiency Virus, Other Sexually Transmitted Infections, and Health-Related Perceptions, Reflections, Experiences and Practices Among Men Having Sex with Men in Dar es Salaam; Mapping of People Who Use Drugs and People Who Inject Drugs in Selected Regions of Tanzania, Drug Control Commission (June 2015); Assessment of Risk Practices and Infectious Disease Among Drug Users in Temeke District, Dar es Salaam, Tanzania, Medecins du Monde (2011); Sexual Practices and Perceived Susceptibility to HIV Infection among Men Who Have Sex with Men in Dar Es Salaam, Mainland Tanzania (2012)	

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		The strategy is under development
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 all protocols.	13.9 Score: 0.71	http://www.nimr.or.tz/wp-content/uploads/2017/09/Guidelines-of-Ethics-for-Health-Research-in-Tanzania2.pdf	National surveys have TWGs and Steering Committees responsible for data quality. National Institute for Medical Research is responsible for ethical reviews and clearance
	Epidemiological and Health Data Score:	**4.17**		

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: 1.67	Tanzania Commission for AIDS. 2013/14 HIV and AIDS Public Expenditure Review Tanzania Mainland , Dar es Salaam, National AIDS Spending Assessment 2013/14 and 2014/15 Report, National Health Expenditure reports (conducted every year)	Technical assistance on NHA provided by USAID and WHO
14.2 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	14.2 Score: 1.67	Tanzania Commission for AIDS. 2013/14 HIV and AIDS Public Expenditure Review Tanzania Mainland , Dar es Salaam, National AIDS Spending Assessment 2013/14 and 2014/15 Report, National Health Expenditure reports (conducted every year)	
14.3 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	14.3 Score: 1.67	Tanzania Commission for AIDS. 2013/14 HIV and AIDS Public Expenditure Review Tanzania Mainland , Dar es Salaam, National AIDS Spending Assessment 2013/14 and 2014/15 Report, National Health Expenditure reports	National Health Accounts (NHA) study and Public Health Expenditure (PER) has been insitutionalised in MoH and TACAIDS and are conducted every year. NASA is conducted but not regular
		Financial/Expenditure Data Score: 5.00		

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	DHIS2 Health sector data including Tanzania Tanzania National Multisectoral HIV Monitoring and Evaluation System : Guidelines for the Tanzania Output Monitoring System For Non-Medical HIV And AIDS Interventions (TOMSHA). Version 2.7, TACAIDS, Www.Tacaids.Go.Tz	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/THIS) data. NACP collects health data.
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: 1.67	MOHSW, NBS and TACAIDS budgets. MTEF 2015/16 PEPFAR HRH Inventory 2016	Data collection tools, data clerks, some printing, 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, TG, prisoners) ☑ By priority population (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users) ☑ By age & sex ☑ From all facility sites (public, private, faith-based, etc.) ☐ From all community sites (public, private, faith-based, etc.)	15.3 Score: 1.33	National Health Management Information System through DHIS2 and CTC2 database URT, MOHCDGE KVP Quarterly reporting Form. This is a National KP reporting tool in DHIS2 TOMSHA (a tool for reporting community services)	Data for KPs is collected by the Implementing Partners. Tools for data collection have been harmonised The national quarterly summary report captures service delivery to KVP and is used by the implementing partners to submit to NACP their quarterly reports. This form is incorporated into the DHIS2.

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: 1.33		
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 (AGYW, clients of sex workers, military, mobile populations, non-injecting drug users), including HIV testing, linkage to care, treatment, adherence and retention ☑ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), 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: 0.83		Annual health statitics bulletin, district health profiles. many different score cards example MNCH score card. Care and Treatment reports, surveillance reports Health sector performnace profile where annual targets compared to results. Triangulation report supported by UCSF. 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/THIS) data. NACP collects health data. The KVP tools collect continum care cascade data through treatment. Viral Suppression (A proxy to adherence) is being incorporated.
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: 0.80	National Guidelines for Health Data Quality Assessment November 2016	MOHSW/NACP conducts Data Quality Assessment and publishes SOPs and protocols.
		Performance Data Score: **6.97**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D