2019 Sustainability Index and Dashboard (SID) / Responsibility Matrix (RM) Summary: Tanzania

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to characterize each country's sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to questions in each domain, the SID assesses the current state of sustainability of national HIV/AIDS responses across 17 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.

Sustainability Element Score Criteria
Dark Green Score(8.50-10.00pts) (sustainable and requires no additional investment at this time)
Light Green Score (7.00-8.49 pts) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 pts) (emerging sustainability and needs some investment)
Red Score (<3.50 pts) (unsustainable and requires significant investment)

Country Overview: Tanzania's overall performance in the area of sustainability demonstrates that there has been improvement across all domains as compared to SID 3.0 conducted in 2017. However, most of the elements require host country ownership and investments to ensure the gains achieved can be sustained. Tanzania has received substantial external financing for its national response to HIV and AIDS since the establishment of PEPFAR and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). In addition, 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 in general have prevented Tanzania from reaching its full potential for sustaining the HIV national response.

SID Process: The SID/RM 2019 process began in mid-July 2019 upon receipt of guidance released by S/GAC to countries that are required to complete the SID/RM 2019. In this year's SID, a new component known as Responsibility Matrix (RM) was added to allow countries to assess the level of responsibility across different elements of the HIV response between the host country governments, PEPFAR, GFATM and their implementing partners. The process started with a preparatory meeting between PEPFAR and UNAIDS on July 30th, 2019 to plan for SID/RM 2019. This was followed by a meeting with UNAIDS and TACAIDS that was held on August 7, 2019. The SID team initiated collection and desk review of reference documents by first consulting the documents compiled during SID 2017 for each domain.

Two stakeholder meetings were planned. The Responsibility Matrix Stakeholders Meeting took place on August 28th involving key senior-level stakeholders from the Government of Tanzania, CSOs, PEPFAR, WHO and Global Fund (GFATM). The RM meeting was followed by a wider SID 2019 stakeholders meeting which was held on September 4th and 5th, 2019 in Dar es Salaam. This two-day meeting was well attended, and participants included representatives from the GOT (Prime Minister's Office, Ministry of Health, Community Development, Gender, Elderly and Children, Tanzania Commission for AIDS, Ministry of Finance and Planning, President's Office Regional Administration and Local Government, National AIDS Control Program, National Bureau of Statistics and Medical Stores Department), Civil Society Organizations, people living with HIV , PEPFAR implementing partners, PEPFAR Technical Working Group representatives, UNAIDS, and private sector. The S/GAC Chair, Vamsi Vasireddy was in attendance and jointly with UNAIDS Country Representative officiated the meeting. An overview of the SID/RM 2019 was

presented, and participants worked in small groups according to the four domains. The group domain discussions were jointly facilitated by PEPFAR staff, UNAIDS staff and GOT representatives, and the groups were able to complete the SID matrix during the time allotted during the meeting.

Consolidation of the reference documents was done by the PEPFAR team. In order to ensure high-level consensus on the SID, a presentation of a draft was held at the Development Partners Group for AIDS (DPG –AIDS) on September 17, 2019. A second presentation was held for the MOH management team – including the PS of the Ministry of Health and the Director of Policy and Planning - by PEPFAR and UNAIDS representatives on September 19, 2019, at MOH Headquarters in Dodoma. The final draft incorporated feedback from both of these meetings and has been shared with all participating stakeholders. It was agreed that the SID/RM would serve as one of Tanzania's key strategic documents to guide future HIV/AIDS planning for the country.

Sustainability Strengths: The sustainability landscape as demonstrated by SID 2019 assessments reveals improvement from SID 2017 in all the four domains. Out of the four critical SID 2019 domains and the respective elements, the ***Governance, Leadership and Accountability domain*** has scored dark green in two elements and light green in three elements. The *Policies and Governance* element within the *Governance, Leadership, and Accountability* domain demonstrated the greatest improvement by being scored at 9.50 points compared to 5.33 points in 2017, largely due to recent developments across various platforms that has improved engagement and participation of Civil Society Organizations including strengthened involvement of CSOs and FBOs in service provision, representation in policy decisions and accountability. The adoption of key policies and guidelines through provision of updated circulars and revised National Guidelines for the Management of HIV and AIDS (2019) that happened after COP19 planning meeting in Johannesburg, that included same-day ART initiation, 6 month multi-month scripting and new HIV Testing Guidelines 2019 also contributed to the high scores. Some critical areas that will require increased efforts and attention are the policies and guidelines to ensure legal protection for all key population groups. PEPFAR Tanzania has been working closely with the Tanzanian government to address challenges around this area using diplomacy and focused program implementation efforts.

The ***National Health System and Service Delivery***, is another area of emerging sustainability that made substantial improvements in all the elements compared to SID 2017. This domain demonstrates an overall increased capacity of in-country service providers to deliver HIV services from the national level to the sub-national levels, with local experts leading in provision of technical support. The national supply chain system is showing some improvements. The holistic supply chain review conducted in 2017 showed the roadmap and responsibilities of each key player including the host Government, PEPFAR and GFATM. The country has also invested in task sharing to fill the critical gaps in HIV service delivery.

On the ***Strategic Financing and Market Openness***, there are some improvements from SID 2017 due to the government developing a strategy to mobilize domestic financing through the AIDS Trust Fund. The Market Openness element, which was new in SID 2019, has generally shown that there are no prohibitive government or donor policies for different stakeholders in provision of HIV services in Tanzania.

Other areas that demonstrated marked improvements included the *Performance Data and Financial and Expenditure Data* elements under the ***Strategic Information*** domain, which is aligned with increased GOT leadership through MOH and TACAIDS to collect HIV expenditure data and improved efforts to strengthen and harmonize information systems for data use and decision making.

Sustainability Vulnerabilities: The SID exercise also helped identify critical issues that require further investments and ownership to ensure sustainability. Within ***Governance, Leadership and Accountability*** domain, for example, despite some improvements in engagement with CSOs, FBOs, and private, not-for-profit organizations, the private for-profit and private health services providers' engagement still needs further support and incentives to participate in the planning, coordination and implementation at all levels. Even though a number of coordination structures and mechanisms are in place, further investments are needed to strengthen their capacity, consistency in implementation, and accountability to HIV epidemic control initiatives.

Engagement with the private sector is an important element of the SID. The review team found that the policies and systems to engage with the private sector do exist in Tanzania, actual implementation is inconsistent across different intervention areas and geographic locations. The Tanzania Commission for AIDS (TACAIDS) creates an enabling environment by serving as champion for multi-sectoral involvement in HIV/AIDS programming in the country. When considering the private sector within the **Governance, Leadership and Accountability** domain, the review team took into account both the private, for-profit sector, as well as the private, not-for-profit sector. FBOs primarily fit into the latter category. Tanzania has made progress engaging with the private sector, however, this has disproportionately been dominated by non-profit entities, and the government provides more channels and opportunities for this engagement. For example, faith-based facilities can achieve certain criteria or standards that enable them to receive HRH and operational cost support through existing service level agreements. Such service agreements aren't available for private, for-profit entities which may only be eligible to receive some health commodities and reporting support. Deliberate efforts to engage with private, for-profit entities are needed, especially because there is interest from within the private sector, but capacity is limited for most facilities. Further support, therefore, is required to enable engagement of the private, for-profit sector, including local commodity manufacturing companies.

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 continued 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. ARV benchmark pricing is not applied by the government because of total dependence on the USG and Global Fund for ARV procurement. Within the **National Health System and Service Delivery** domain, there is inadequate domestic financing for the procurement of ARVs, HIV test kits, condoms and supply chain related costs. The *Commodity Security and Supply Chain* showed some improvements from SID 2017, however, the Holistic Supply Chain Review revealed weaknesses that require leadership, ownership, and continued investments by the host country government to reduce donor dependence. Despite ongoing efforts to cover the critical shortage of skilled health workforce, there is an overall low production, absorption, and deployment of health workforce to areas with critical needs. This area needs serious consideration and investment by all key stakeholders including formalization of community health care workers within the government system to ensure sustainability.

Additional Observations: As discussed above, despite the overall improvement in all the elements across the domains, there are still relevant challenges related to the actual implementation and coordination at all levels. Lastly, as agreed by all stakeholders the binary nature of the questions and responses in the tool limits genuine responses that will lead to sustainability planning.

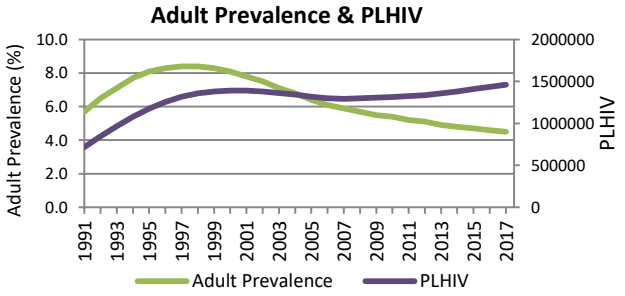
Sustainability Analysis for Epidemic Control: Tanzania

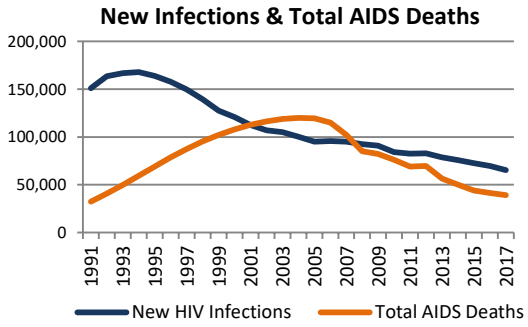
Epidemic Type: Generalized
Income Level: Low income
PEPFAR Categorization: Long-term Strategy
PEPFAR COP 19 Planning Level: $409,584,991

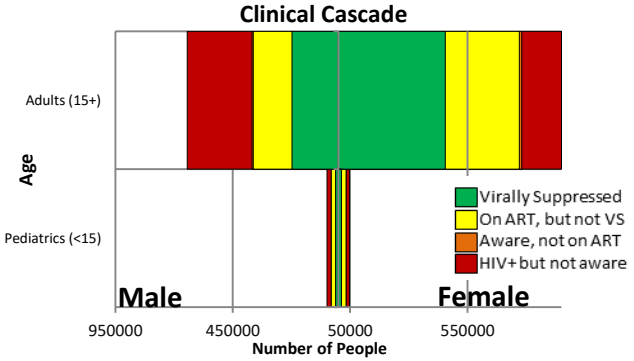
SUSTAINABILITY DOMAINS and ELEMENTS

	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	4.43	5.33	9.50	
2. Policies and Governance	3.85	6.96	7.83	
3. Civil Society Engagement	4.17	3.83	7.08	
4. Private Sector Engagement	4.86	4.13	9.03	
5. Public Access to Information	5.00	6.00	7.33	
National Health System and Service Delivery				
6. Service Delivery	3.38	3.98	6.11	
7. Human Resources for Health	5.00	5.60	6.96	
8. Commodity Security and Supply Chain	4.94	4.25	5.40	
9. Quality Management	5.19	5.62	5.76	
10. Laboratory	3.33	5.83	6.56	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	1.94	3.21	5.32	
12. Technical and Allocative Efficiencies	3.17	4.67	4.93	
13. Market Openness	N/A	N/A	9.33	
Strategic Information				
14. Epidemiological and Health Data	4.70	4.17	6.35	
15. Financial/Expenditure Data	4.58	5.00	8.33	
16. Performance Data	5.99	6.97	7.00	
17. Data for Decision-Making Ecosystem	N/A	N/A	6.33	

CONTEXTUAL DATA







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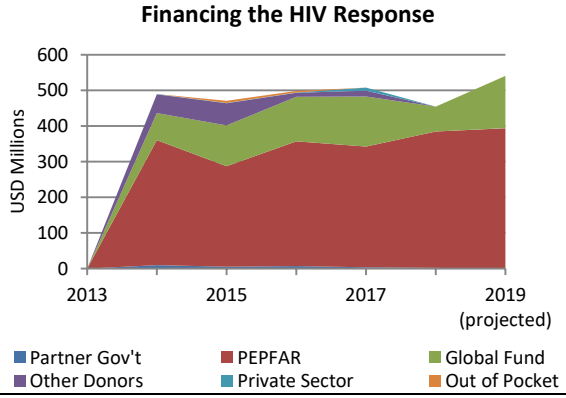
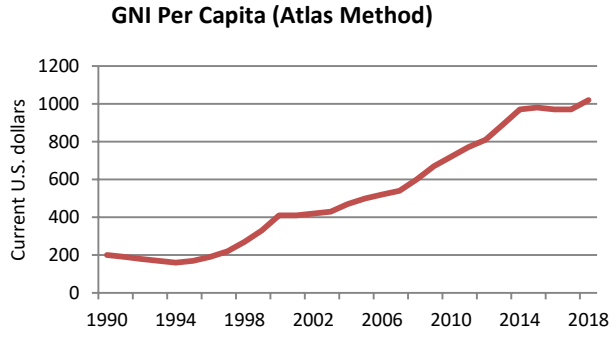
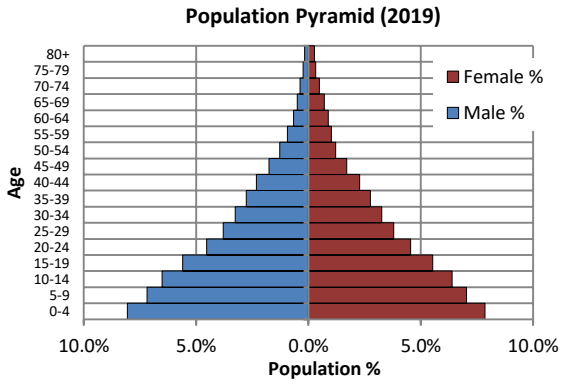


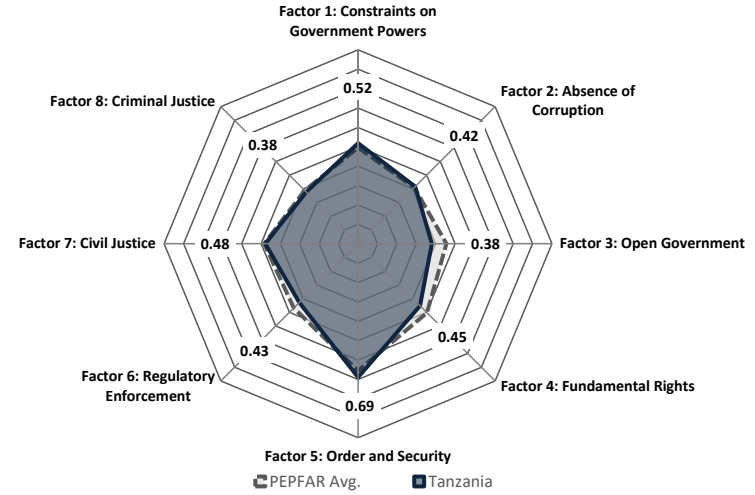


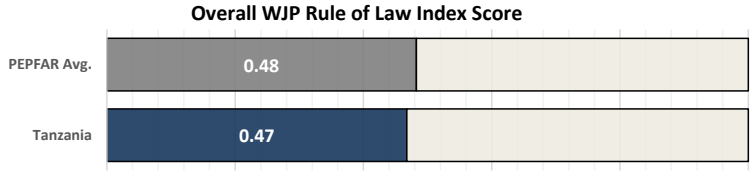


Sustainability Analysis for Epidemic Control: Tanzania

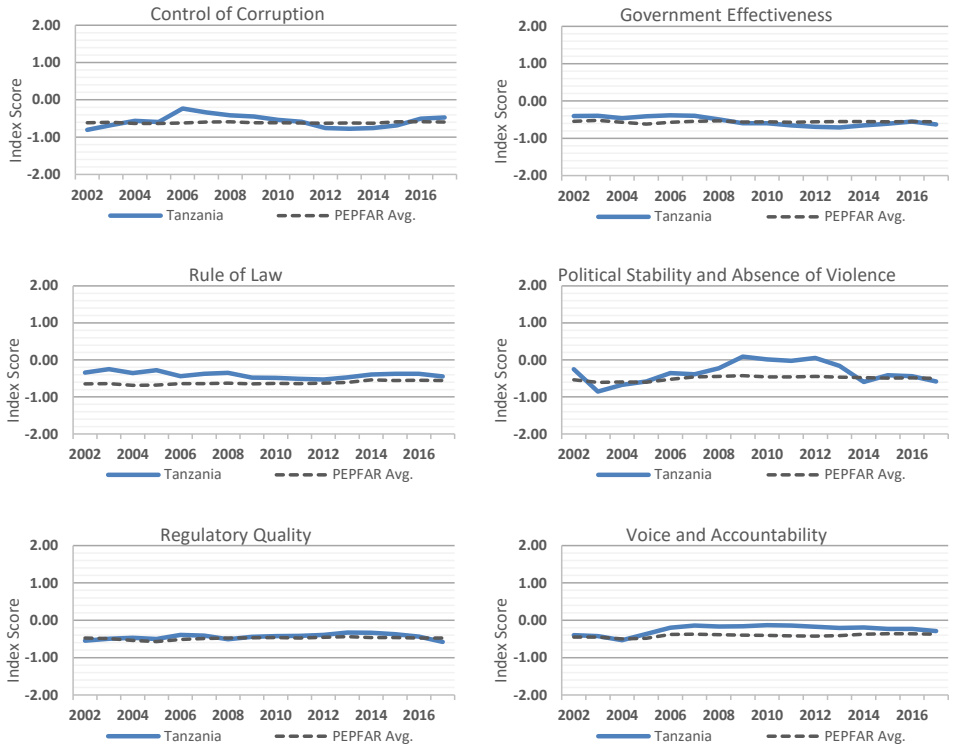
Contextual Governance Indicators

Rule of Law Index (World Justice Project)





Worldwide Governance Indicators (World Bank)



WJP's Rule of Law Index measures the general public's experience and perception across eight 'factors':

1. Constraints on Government Powers: Governmental powers are limited by both internal and external checks, including auditing and review. Governmental officials are subject to the law and sanctioned for misconduct.

2. Absence of Corruption: Government officials in all branches of government do not use public office for private gain.

3. Open Government: Citizens have open access to government information and data, complaint mechanisms, and civic participation.

4. Fundamental Rights: There is equal treatment of citizens and absence of discrimination. The rights to freedom of expression, security of the person, and due process are effectively guaranteed.

5. Order and Security: Crime and civil conflict are effectively limited. Personal grievances are not redressed through violence.

6. Regulatory Enforcement: Government regulations are effectively applied and enforced without improper influence. Due process is respected in administrative proceedings.

7. Civil Justice: Civil justice is accessible and free of discrimination, corruption and improper government influence.

8. Criminal Justice: Criminal justice is impartial, timely and effective, and free from corruption or improper government influence. There is due process of law and rights of the accused.

More information can be found at: https://worldjusticeproject.org/our-work/research-and-data/wjp-rule-law-index-2019

The World Bank Worldwide Governance Indicators (WGI) score countries based on six dimensions of governance:

1. Control of Corruption: captures perceptions of the extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as 'capture' of the state by elites and private interests.

2. Government Effectiveness: measures the quality of public services, the quality of the civil service and its independence from political pressure, the quality of policy formulation and implementation (including the efficiency of revenue mobilization and budget management), and the credibility of the government's commitment to its stated policies.

3. Rule of Law: captures perceptions of the extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, property rights, the police, and the courts, as well as the likelihood of crime and violence.

4. Political Stability and Absence of Violence: measures perceptions of the likelihood of political instability and/or politically-motivated violence, including terrorism.

5. Regulatory Quality: Measures perceptions of the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

6. Voice and Accountability: captures perceptions of the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

More information can be found at: https://info.worldbank.org/governance/wgi/

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	Tanzania National Multisectoral Strategic Framework for HIV & AIDS IV [2018/19-22/23] (costed plan) Health Sector HIV Stratategic Plan IV [2017-22] National Multisectoral Condom Strategy [2018/19-22/23] Several guidelines that describe implementation of the strategies (ART, HTS, Condom distribution, KVP etc.) Multiple circulars providing guidance in addition to guidelines (MMS, TLD, etc) HIV Investment Case for Tanzania 2.0	There is a health sector specific strategy in addition to national multisectoral strategy.

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: 2.50	Tanzania National Multisectoral Strategic Framework for HIV & AIDS IV [2018/19-22/23] (costed plan) Health Sector HIV Stratategic Plan IV [2017-22]	It is partially reflected in the acknowledgements of the documents but may also reference actual proceedings from the meetings/ correspondences. Successful engagement and participation of private sector may need clear framework (similar to CSO engagement framework)
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: 2.00	Tanzania Output Monitoring System for HIV & AIDS [TOMSHA] (has 49 indicators) Specific periodic reports to TACAIDS Annual National Response Report prepared by TACAIDS National TWGs, Multisectoral AIDS Control Committees [MACCs] at various levels of local government, Tanzania National Coordinating Mechanism [TNCM]	There is room for improvement in unifying various coordinating structures Compliance to reporting is less than perfect Engagement of private sector has room for improvement from planning to implementation phase Umbrella organizations' mandate and accountability to its constituents not always observed

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:	2.50	Comprehensive council health plans [CCHPs] NACP targets national to council to facility level based on HSHSP IV Regional HIV & AIDS Strategic Plans [RHASP] translated from NMSF IV	
		Planning and Coordination Score:	**9.50**		

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., optimal ART regimens for all populations (including TLD as recommended)?	For each category below, check yes or no to indicate if current national HIV/AIDS technical practice follows current WHO guidelines on optimal ART regimens 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: 0.91	National HIV care and treatment guidelines Several circulars supplementing the national guidelines Training package for health service providers are updated regularly Mentorship and supervision to support updates	

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 and AIDS Prevention and Contro; ACT [HAPCA] 2008 Task shifting guideline (Neema) NIMART document... National Integrated Case Management System	Policy for HIV self-testing is incorporated in national HIV testing guideline. Legislation being reviewed to allow implementation. Clause for allowing consent for testing from monors indicated in national HTS guidelines

2.3 User Fees for HIV Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any HIV services in the public sector: clinical, laboratory, testing, prevention and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☑ No, neither formal nor informal user fees exist. ☐ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.3 Score: 0.91	HIV and AIDS Prevention and Contro; ACT [HAPCA] 2008 National HIV care and treatment guidelines	In some instances PLHIV are required to pay for laboratory investigations related to HIV care when not available. Medicine for OI prevention and treatment may need to be procured when out of stock.
2.4 User Fees for Other Health Services: Are HIV infected persons expected or likely to be asked to pay user fees, either formal or informal, for any non-HIV services in the public sector, such as MCH/SRH, TB, outpatient registration, hospitalizations, and others? Note: "Formal" user fees are those established in policy or regulation by a government or institution.	Check all that apply: ☐ No, neither formal nor informal user fees exist. ☑ Yes, formal user fees exist. ☐ Yes, informal user fees exist.	2.4 Score: 0.23		
2.5 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	2.5 Score: 0.68	National HIV care and treatment guidelines Health Information policy (final form awaiting signature)	Policy for unique identification (patient registry) currently under development Policy specifically allows use in criminal cases

2.6 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 ☐ Sex work is recognized as work ☐ Other non-discrimination protections specifying sex work (note in comments)	2.6 Score: 0.23	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. Illicit Drugs Act 2015 National Guidelines for Medically Assisted Therapy	Consitution prohibits discrimination overall but no specific policy to protect the specific populations mentioned Hate crimes are criminalized but no specific protections to MSM

	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			
2.7 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	2.7 Score: 0.73	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. National Plan of Action for the prevention of Violence against Women and Children 2017-22 Law of the Child Act 2009 Sheria ya Mahusiano Mahala pa Kazi (Dennis) Standing Orders on violence in the workplace National HIV Policy	Gender desks established in police stations to facilitate friendly services.

2.8 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	2.8 Score:	0.59	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. Penal code on penalty	

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

- ☐ Yes, death penalty
- ☐ Yes, imprisonment (14 years - life)
- ☑ 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)
- ☑ No

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

- ☑ 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
- ☑ 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			
2.9 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, adolescents, 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	2.9 Score: 0.91		Government has a platform where legal servies may be acessed free of charge to the beneficiary. No direct financial disbursement.
2.10 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.	2.10 Score: 0.91	Annual audit report from Controller and Auditor General	
2.11 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.	2.11 Score: 0.91	Parliamentary Audit Committee tracks responses	
		Policies and Governance Score: 7.83		

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: 1.67	Statistics Act 2016 as ammended in 2018	
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: 1.67	Technical Working Groups Planning from village to Council level includes all stakeholders [Ward DC, Full Council] announced to public through various media District and Regional Consultative Committees [DCC and RCC]	

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: 1.67		Recent developments acsross various platforms have improved engagement of civil society along with strengthened coordination among CSOs for representation and accountability
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		
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, or regulation 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: 1.25	Medium-term expenditure framework Community Development Fund (2008) 10% of council budget allocated for women, youth, PLWD (Feb 2019 ammendment stipulating 4-4-2 distribution) Council-specific by-laws determine allocation to HIV services	Government budget execution generally not predictable
		Civil Society Engagement Score:	**7.08**	

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: 1.67	Corporation largely offer funding for Workplace Interventions covering the employees and their families Health workforce (HRH graduates) inventory at DHR of MOH PPP guideline (MOH) CEOs breakfast (Tanzania Private Sector Foundation, Association of Tanzanian Employers, and Trade Union Congrees of Tanzania)	Staffing for FBOs provided Engagement of private-for-profit can be improved through consolidating gains with FBO entities Representatives of larger constituencies are involved in national and sub-national strategic planning. Accountability to the constituents may be variable.

	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.			
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: 2.50	CSR cost allowable as cost of production to deduct from income for taxation purposes upto 50% [Section __ of the Income Tax Act] Workplace HIV Policies must align to labor laws… (need specific reference)	

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. ☑ Private Banks or lenders provide access to low interest loans prioritizing private health sector small and medium-sized enterprise (SME) development and expansion.	4.3 Score: 2.36		National supervision and mentor teams include providers from private sector but actual supervision is led by government Some facilities registered to procure commodities from Medical Stores Department, others procure through neighboring public facilities Service level agreements with few mostly with non-profit (FBO) entities. Few councils with private-for-profit facilities. No consistency of implementation.

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: 2.50		
		Private Sector Engagement Score:	**9.03**	

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 Data Transparency: Does the host country government ensure that national HIV/AIDS surveillance 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 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 data available to stakeholders and the general public within 6-12 months. ○ C. The host country government makes HIV/AIDS surveillance data available to stakeholders and the general public within six months.	5.1 Score: 1.00		
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: 1.00	Annual Public Expenditure Review includes HIV expenditures	

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 . At what level of detail is this performance data reported? [CHECK ALL THAT APPLY] ☑ National ☑ District ☑ Site-Level	5.3 Score:	1.33	Joint Annual Health Sector Review includes HIV performance Annual national response performance report submitted to cabinet "Taarifa ya Utekelezaji wa Shughuli za Serikali"	
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	Public Procurement Regulatory Act	

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	MOH health promotion unit TACAIDS NIMR Local Academia and Research Institutions	
		Public Access to Information Score:	**7.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN A

Domain B. National Health System and Service Delivery

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

6. Service Delivery: The host country government at national, sub-national and facility levels facilitates planning and management of, access to and linkages between facility- and community-based HIV services.			**Data Source**	**Notes/Comments**
6.1 Responsiveness of facility-based services to demand for HIV services: Do public facilities respond to and generate demand for HIV services to meet local needs? (Check all that apply.)	☑ Public facilities are able to tailor services to accommodate demand (e.g., modify or add hours/days of operations; add/second additional staff during periods of high patient influx; customize scope of HIV services offered; adapt organization/model of service deliver to patient flow) ☑ Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics) ☑ There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services	6.1 Score: 0.95	Service Delivery Model: Report on Mapping of Differentiated Service Delivery for HIV Care in Tanzania, MoHCDGEC, 2017.	Conceptually public health facilities both primary and tertiary facilities are decentralized and are able to coordinate and tailor HIV services to suit the population demand based on volume and proximity of high HIV locations and population. However in practice smaller health facilities have less flexibility to
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: 0.79	National Guidaline for Community Based Health Program	1. we have the natioanl guideline for the community based health care services which guide provision of Health care. 2.Existence of multisectorial AIDS committees. 3. The government is revising the Curriculum for community health workers to recognize for HIV service delivery at the community including HIV programs. 4. most of financial support for community based are provided by Donors. 5. provision of supply chain support to the community based services is mainly Condoms. 6. Government has the tools and process to do that
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 Report (NHA-2018), National AIDS Spending Assessment (NASA) 2016, Public Expenditure Review (PER)	With reference to the recent NHA the GOT is contributing 11% to HIV. In addition government invests in health facilities to deliver services such as HRH, Infrastructures and equipments to deliver HIV services

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: 0.63		There is increased capacity of host country service providers to deliver HIV services with donor supporting TA which is led by local exparts. Local knowledge based has been increasing and external assistance has been focused in selected areas that have critical shortages in both numbers and skills
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, or information is not available. ○ 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: 0.83	Tanzania Commission for AIDS August 2015. Public Expenditure Review	The GOT has established through health service delivery guidelines that KPs receives services through the general population. Health facilities and health care workers both in public and private are instructed to identify needs of KPs and attend to delivery of their services in facility set ups. There is not specific finacning for KPs service delivery and most of the financing including specific commodities is from 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: 0.32		Provision of services in managed with the HIV guideline to all HIV clients including KPs. There is a substantial donor technical assistance in the delivery of KP services that are currently provided through health facilities as an itergrated service delivery.
6.7 Management and Monitoring of HIV Service Delivery: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV service delivery activities including practice standards, quality, health outcomes, and information monitoring across all sectors. Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	6.7 Score: 0.63		HIV/AIDS services are adminsitratively managed by the Ministry of Health aunder the National AIDS Control Programme (NACP) and Prime Minister's Officer under Tanzania Commission for AIDS (TACAIDS). TACAIDS is mandated to monitor HIV/AIDS service in in all sectors (multi-sectoral HIV) and NACP provide technical standars for delivery of HIV

6.8 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	6.8 Score: 0.63	ISN CCHP	National health authorities from the Ministry of Health, TACAIDS and NACP has the cacpity and effectively plan and manage long term and short term HIV serve delivery. They jointly develop and translates policies to health authorities below them and coordinate implementation and anlyse epidemiological data to measure and monitor performance. Staffing needs currently estimated through staffing norms and the workload analyis for the general population with consideration of the worload that is added by provision of HIV services in public health facilities
6.9 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.	6.9 Score: 0.48	Functions of Regional Health management Teams (RHMT) Council Comprehencil Health Plan (CCHP) 2019, Revision	Sub-National health authorities both at the regional and council level has the cacpity and effectively plan and manage short term HIV serve delivery. They jointly develop annual bencmarks and interventions, translates and coordinate implementation of key service delivery guilines and use data to measure and monitor performance. Staffing for health fcilities is decentralized but coordinated by Public Service Act and Regulations provided at the National Level for all public servants regardless of services they offer. At the submational levels staffing norms, workload analysis which includes HIV
		Service Delivery Score	**6.11**	

7. Health Workforce: Health workforce staffing decisions for those working on HIV/AIDS are based on use of workforce 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 Health Workforce 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: 0.24	HRH country profile 2016/2017 HRH Strategic Plan, HRH Production Plan , Tanzania HRH Information system (check the links). Retention Scheme, Public Sector Pay and Incentive policy 2010 and its subsequent regulations.	Absorption and deploymentof HCWs in public health facilities is still a challenge and the country has invested in task sharing to filll gaps in service delivery. Production with reference to deployment is doing well but still there are critical shortages in public and private health facilities and particurly in some specific cadres. Distribution for HRH is not targeting only HIV alone wbut with other workload and indicators beyond HIV
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: 0.63	Task sharing guideline and task sharing training module for tutors in health institute. WHO task sharing framework. National Community Based Health Prgram, 2017	There is no system that collects data for Non formalized health workers including CHW supported by Donors, every donor who supports CHWs have their own data collection systems and processes and it is not alyways available. The GOT has officially recognize non-formalized CHWs and are allowed to provide HIV/AIDS services. This is the recent delvelopment after the formalized CHW cadre was put on hold
7.3 Health Workforce 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 and timeline for transition.	○ 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: 0.71	PEPFAR Transition Plan, 2018 PEPFAR Tanzania HCWs Inventory, 2016 and 2018 Global Fund/GOT Transition Plan	PEPFAR Tanzania has prepared a transition plan in 2018 and implementetaion of recommended actions have started for only PEPFAR supported workers. The Global Fund support HCWs and pass through governent recruitment processes with agreed upon transition plan for their ccontracted HCWs into publci service. About 80% of the recent

7.4 Domestic Funding for Health Workforce: 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	Personel Emolument Analysis	GOT support most of service providers providing HIV services in all public health facilities. The is an additional support to critical areasand points of services that is given by donors and private sector Currently CHWs are mostly supported by donors
7.5 Pre-service Training: 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: 0.71	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
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: 0.89	National Continueus Professional Development (CPD) Framework for Health care providers in Tanzania October 2015	Tanzania defines in service training as a training that is not less than two weeks and upon colpetion a HCW is awarded a certificate of competency from a recognized Training institution. For epidemic specific skills development for example Cervical Cancer Screening Training, Self Test Trainings are considered to be inservice trainings.

7.7 Health Workforce 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:	0.95	Human Capital Management Information System Human Resource for Health Information System	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. This systems is maintained and supported by the Goverment and used for all aspects of planning and hiring of newly deployed HCWs HRHIS is the system that ccaptures data of HCWs beyond public health facilities. Ministry of health human resources plan use data from this system.
7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	○ A. No, there is no entity. ◉ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ○ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	7.8 Score:	0.32		There is no single entity, and it is decentralized wth multiple level of HR functions, with limited staffing and budget capacity also varies depending on the levels
		Health Workforce Score:	**6.96**		

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	National Health Budget, 2018 and 2019, ART Supply Chain Plan	There have been allocation of budget through domestic soruces for ARVs but there is no evidacne on procuments of ARVs. No domestic funding for ARV from the domestic Government resources but private sector. There is increased interest on out of pocket procurement of ARVs from private dispensors
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	National Health Budget, 2018 and 2019, Supply Chain Plan	No evidence of domestic reources used for procurement of test Kits
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	In the past years (2 - 3 years) GOT has been budgeting and procure condoms that are subsidized and distributed through facility and community points

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: 1.52	National Pharmaceutical Action Plan for the period 2015-2020 (NPAP 2020)	Tanzania has developed a costed National Pharmaceutical Action Plan (NPAP) covering 2015-2020 period. The goal of NPAP 2020 is to improve the quality of pharmaceuticals services in Tanzania, and ensure sustainable availability and access to affordable, quality, safe, and efficacious essential medicines, vaccines and medical supplies. However, the NPAP has no component that speaks about Reverse Logistics
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: 0.42	Holistic Supply Chain Review, 2017	The Logistics Management Unit is partly supported by USG and Global Fund. LMU staff have been tranistioned to GOT recently and MSD staff are supported by GOT. Most operations are donor supported but there have been increased investment of GOT in both logistics, distribution and storage infrastructures.

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: 1.11	Holistic Supply Chain Review, 2017 eLMIS	The Pharmacetical Service Unit (PSU) at the Mininstry of Health is reponsible for making supply chain decisions in collaboration with other key stakeholders and have visibility of timely supply chain data from facilities. Lower level health facilities have the decentralized mandate and capacity to govern their supply chain needs and decisions
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: 0.83	Holistic Supply Chain Review, 2017	The NSCA has not been conducted in Tanzania. The Holistic Review did review the maturity of the supply chain, but did not provide a score. However, based on the large amount of recommendations, we believe Tanzania's supply chain would score below the top quartile.
8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	○ A. No, there is no entity. ○ B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ D. Yes, there is an entity with authority and sufficient staff and budget.	8.8 Score: 1.11	Holistic Supply Chain Review, 2017	LMU and MSD have the authority and staffing to manage and monitor supply chain services but have limited budget to fund their operations
	Commodity Security and Supply Chain Score:	**5.40**		

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: 0.67	CCHP, RHMT Plan	Government coordinates most QM services but support comes from donors on knowledge management platforms.
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	QM/QI Strategic Plan,2013-18 QM/QI Framework, 2019 (draft)	Th QM/QI strategy is in review QM/QI Framework is on final stage of reviews
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: 1.33	DHIS 2 at site, sub-national and national level CTC 3 at nation level CTC 2 at site level	QI software has been integrated in DHIS. These are government systems and reviewed by both the government and donors on a monthly basis for QI activities. Documentation of best practices is done but there are no regular scheduled sharing sessions

9.4 Health worker capacity for QM/QI: Does the host country government ensure that the health workforce has capacities to apply modern quality improvement methods to HIV/AIDS care and services?	○ A. There is no training or recognition offered to build health workforce competency in QI. ◉ B. There is health workforce competency-building in QI, including: ☐ Pre-service institutions incorporate modern quality improvement methods in curricula ☑ National in-service training (IST) curricula integrate quality improvement training for members of the health workforce (including managers) who provide or support HIV/AIDS services	9.4 Score: 1.00		No evidence on curricula update to include QI modern quality improvements
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: 1.43	QM/QI Strategic Plan,2013-18 QM/QI Framework, 2019 (draft)	Reviews are done in separte units i.e TB, MCH Health Consumers are mostly not included in QI meetings Reviews at sub-national levels are done regularly under influence of donor support There is a need for more improved documentation of QI initiatives and activities
		Quality Management Score:	**5.76**	

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: 1.33	National Health Laboratory Strategic Plan II, 2016-21	The Strategic plan is co-financed and implemented by both government and donor support
10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? Select only ONE answer.	○A. No, there is no entity. ○B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○D. Yes, there is an entity with authority and sufficient staff and budget.	10.2 Score: 0.89	National Health Laboratory Startegic Plan 2016-21 National Standard for Medical Laboratories, 2017	Lab Council and Department of Diagnostic services manage and coordinate lab services in Tanzania
10.3 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).	10.3 Score: 1.00	National Framework for Point of Care Testing Certification, 2017	There a national regulation of Lab services in the country
10.4 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	10.4 Score: 1.00		There is no adequate staffing to support complex laboratory test Government has strengthened POC to increase capacity and certification of other cadres to perform HIV and TB diagnosis

10.5 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 out ☐ Adequate specimen transport system and timely return of results	10.5 Score: 0.67	National Operational Plan for Scaling Up HIV Viral Load Testing	Rental system for viral load equipment is in use to adequatley support viral load servies and maintainance. The supply chain system is in place but not effectively enough to prevent stock outs Specimen transportation system is in place but not effective enough to support timely return of results Result Return System is not effective and providers needs additional skills to improve use of the system and reduce
10.6 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.	10.6 Score: 1.67		Most lab interventions and infrastructures are donor supported. Skilled Lab experts are funded by Government with additional supplies and lab commodities
	Laboratory Score:	**6.56**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN B

Domain C. Strategic Financing and Market Openness

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. Finally, having and effectively implementing policies that ensure leveraging markets (both nonprofit and for profit) where appropriate and enabling their participation and competition will be critical for a sustained HIV response.

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?	14%		NHA 2015/2016	Note that the GGHE includes cross cutting HIV/AIDS objective across all MDAs, Regional Secretariat and LGAS -
2. What is the per capita health expenditure all sources?	$__45		NHA 2015/2016	
3. What is the total health care expenditure all sources as a percent of GDP?	4.7__%		NHA 2015/2016	
4. What percent of total health expenditures is financed by external resources?	36.40%		NHA 2015/2016	
5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?	29%		NHA 2015/2016	NHA doesn't capture pre-payment contributions as part of OOP, however if these two are included the new number

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 (specify in comments). ☐ It includes public subsidies for the affordability of care.	11.1 Score: 0.32	**CITIZENS BUDGET 2018/2019/ AIDS TRUST FUND/Minsitry of Health Budget Speech April 2019/ Joint Health Annual Sector Policy review**	**NHIF covers non- ARV care and treatment of opportunistic infections but doesn't cover Anti Retroviral Treatment(Drugs)**

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	Ministry of Finance and Planning (MOFP) 2018/19- Budget Books Volume 4 , Vote 92(TACAIDS)	This data is sourced from the Citizen's budget. Its noted that the data presented in this budget fluctautes by year. For previous years, detailed budgets to TACAIDS, MOH, MDA, and LGAs. However for this years, budget-this breakdown was not provided.
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		There's a budget for HIV/AIDS but no specific targets.
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: 0.63	Tanzania HIV and AIDS Public Expenditure Review 2017/2018/ UNAIDS Investment Case 2019 and the Tanzania Public Expenditure Report	Please note that domestic financing for HIV is 10 % of the health budget- however the actual execution is fairly high (80-85%)- that still translates into a small budget as actual spending for HIV(as domestic funding)- The average execution is 81% however this is due to the outlier for FY2017- more funds disbursed than allocated(*perhaps due to USAID supported advocacy throigh HP+ and SIKIKA?*)

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		
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: 1.67	INVESTMENT CASE 2.0 2019	
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	DRAFT PUBLIC EXPENDITURE REVIEW 2017/18	This data is under finalisation- 74%
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: 0.63	Budget Act 2015	reallocation could occur within the vote, or outside the specific funding votes
Domestic Resource Mobilization Score:		**5.32**		

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	SPECTRUM -2019	Spectrum was published March 2019 and was utilised for different planning purposes e.g COP 2019
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		Domestic funds are not used in geographic allocation of resources. The funding is blanket / lumpsome for HIV/AIDS spending

12.3 Information on cost of service provision: Does the host country government have a system that routinely produces information on the costs of providing HIV/AIDS services, and is this information used for budgeting or planning purposes? (note: full score can be achieved without checking all disaggregate boxes).	○ A. The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services. ○ B. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services, but this information is not used for budgeting or planning. ◉ C. The host country has a system that routinely produces information on the costs of providing HIV/AIDS services AND this information is used for bugeting or planning purposes for the following services (check all that apply): ☑ HIV Testing ☐ Laboratory services ☑ ART ☑ PMTCT ☐ VMMC ☐ OVC Service Package ☐ Key population Interventions ☐ PrEP	12.3 Score: 1.60		ART costing study(2016) , HTC costing study(2015), PMTCT costing study(2016), Methadone Assisted Therapy costing studies(2018) .The MoH has utlised the ART and HTC cost findings for the Global Fund 2017 proposal development . The data for 2018 has bee used for the scale up of MAT in Tanzania.
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)	12.4 Score: 1.33		MSD (2018) - Opened up the market to both local and international competition for procurement tenders- which assisted to lower both procurement competition and procurement costs through pooled procurement.

	☑ 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 (e.g., multi-month scripting, testing modalities targeted to the population profile, etc. - specify in comments)			
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		
	Technical and Allocative Efficiencies Score:	**4.93**		

13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.				Data Source	Notes/Comments
13.1 Granting exclusive rights for services or training: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies grant exclusive rights for the government or another local provider to provide HIV services?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) polices: A. Restrict the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity (i.e., creating a monopoly arrangement for that service)? ☐ Yes ☑ No B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services? ☐ Yes ☑ No C. Grant exclusive rights to government institutions for providing health service training? ☐ Yes ☑ No	13.1 Score:	0.36	**NACP Treatment Guidelines**	
13.2 Requiring license or authorization: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies establish a license, permit or authorization process as a requirement of operation?	A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) and government facilities. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment facilities (e.g., FBOs, CBOs, or private sector) than on government facilities. B. Are health training institutions required to obtain a government-mandated license or accreditation in order to provide health service training? [SELECT ONE] ☐ No ☑ Yes, and the enforcement of the accreditation places equal burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) and government institutions. ☐ Yes, and the enforcement of the accreditation places higher burden on nongovernment institutions (e.g., FBOs, CBOs, or private sector) than on government institutions.	13.2 Score:	0.36	**Private Health Facilities(Hospitals) Regulation Act 1977**	

13.3 Limiting provision of certain direct clinical services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local providers to provide certain direct clinical services?	National government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed, local health service providers to offer the following HIV services: ☐ Prevention ☐ Testing and Counseling ☐ Treatment	13.3 Score: 0.36		
13.4 Limiting provision of certain clinical support services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of licensed local providers to provide certain clinical support services?	A. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from providing essential HIV laboratory services? ☐ Yes ☑ No B. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly arrangements in lab testing (i.e., arrangements where effectively only one lab service provider is allowed to conduct a certain essential HIV lab service)? ☐ Yes ☑ No C. National government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of licensed, local institutions from procuring or distributing the following HIV commodities and supplies [PLEASE SPECIFY TYPE IN NOTES]: ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other D. Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create monopoly supply chain arrangements for HIV commodities (i.e., arrangements where effectively only one entity is able to supply a certain essential HIV commodity)? ☐ Yes ☑ No	13.4 Score: 0.36		

13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturing industry to compete with the international market?	A. Do national government policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards? ◯ Yes ◉ No B. [IF YES] For which of the following is local manufacturing restricted? ☐ ARVs ☐ Test kits ☐ Laboratory supplies ☐ Other	13.5 Score: 0.36	Tanzania Medical Drug Authority(TMDA)	
13.6 Cost of entry/exit: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?	Do local health service facilities face higher start-up or maintenance costs compared to government or donor (e.g., PEPFAR, GFATM, etc.) supported facilities (e.g., lack of access to funds, higher accreditation fees, prohibitive contracting costs, etc.)? ☑ Yes ☐ No	13.6 Score: 0.00		This is more of a business environment(W
13.7 Geographical barriers: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies create geographical barriers for local providers to supply goods, services or labor, or invest capital?	A. Are certain geographical areas restricted to only government or donor-supported HIV service providers? ◯ Yes ◉ No B. [IF YES] Which of the following are geographically restricted? ☐ Supplying HIV supplies and commodities ☐ Supplying HIV services or health workforce labor ☐ Investing capital (e.g., constructing or renovating facilities)	13.7 Score: 0.36		
13.8 Freedom to advertise: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the freedom of local organizations to advertise or market HIV goods or services? [Note: "organizations" in this case can refer broadly to clinical service providers and also organizations providing advocacy and promotion services.]	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the freedom of nongovernment (e.g., FBOs, CBOs, or private sector) organizations to advertise or promote HIV services either online, over TV and radio, or in public spaces? ☐ Yes ☑ No	13.8 Score: 0.63		

13.9 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those polices, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY] ☑ Yes ☐ No, government service providers are held to higher standards than nongovernment service providers ☐ No, FBOs/CSOs are held to higher standards than government service providers ☐ No, private sector providers are held to higher standards than government service providers	13.9 Score: 0.63		
13.10 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?	Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES] ☐ Yes ☑ No	13.10 Score: 0.63		
13.11 Cost of service provision: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of service provision for some local providers relative to others (especially by treating incumbents differently from new entrants)?	A. Do government HIV service providers receive greater subsidies or support of overhead expenses (e.g., operational support) as compared to nongovernment (e.g., FBOs, CBOs, or private sector) HIV service providers? ☑ Yes ☐ No B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others? ☐ Yes ☑ No C. Do government health training institutions receive greater subsidies or support of overhead expenses as compared to nongovernment (e.g., FBOs, CBOs, or private sector) health training institutions? ☑ Yes ☐ No D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others? ☐ Yes ☑ No	13.11 Score: 0.31	HEALTH BASKET FUND GUIDELINES(DHFF	Government finance reforms such as the
13.12 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow HIV service providers—either groups of individuals or groups of institutions—to create structural barriers (e.g., closed network systems) that may reduce the incentive of other potential providers to provide HIV services?	13.12 Score: 1.25		

regulatory regime?	☐ Yes ☑ No			
13.13 Publishing of provider information: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies require or encourage information on local providers' outputs, prices, sales or costs to be published?	A. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require nongovernment (e.g., FBOs, CBOs, or private sector) health service facilities to publish more data than government facilities on the following [CHECK ALL THAT APPLY]: ☐ HIV service caseload ☐ Procurement of HIV supplies/commodities ☐ Expenses B. National government or donor (e.g., PEPFAR, GFATM, etc.) policies require HIV commodity suppliers to publish data on the following [CHECK ALL THAT APPLY]: ☐ Distribution ☐ Sales/Revenue ☐ Production costs	13.13 Score: 1.25		
13.14 Patient choice: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies limit the ability of patients to decide which providers or products to use?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies restrict the ability of patients or specific groups of patients to choose: A. Which HIV service providers they use? ☐ Yes ☑ No B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)? ☐ Yes ☑ No	13.14 Score: 1.25		
13.15 Patient mobility: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies reduce mobility of patients between HIV service providers by increasing the explicit or implicit costs of changing providers?	Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies impose costs or other barriers that restrict a patient's ability to transfer from a government HIV service provider to a nongovernment (e.g., FBO, CBO, or private sector) HIV service provider? ☐ Yes ☑ No	13.15 Score: 1.25		
	Market Openness Score:	**9.33**		

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.

14.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**
14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis and interpretation; data storage and retrieval; and quality assurance across all sectors. Select only ONE answer.	○ No, there is no entity. ○ Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget ◉ Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. ○ Yes, there is an entity with authority and sufficient staff and budget.	14.1 Score: 0.56	TACAIDS (http://www.tacaids.go.tz/en/goals-objectives-functions/english/about/goals-objectives-functions) NACP (http://www.nacp.go.tz/site/about/national-aids-control-program-profile) NBS (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 (NBS) conducts the Tanzania demographic and health surveys, including the 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
14.2 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 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	14.2 Score: 0.42	NBS Website: (http://www.nbs.go.tz/nbs/index.php?option=com_content&view=category&id=55&Itemid=145) THIS 2016/17: (https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/hiv-and-malaria-survey) TDHS-MIS 15/16 (same link as above) MIS 2017: (https://dhsprogram.com/what-we-do/survey/survey-display-529.cfm)	NBS leads implementation of General Population Surveys and MoHCDGEC leads health surveillance activities. NBS has recently implemented THIS 2016/17, with substantial TA from external agencies. . NBS has also recently implemented TDHS-MIS (2015/16)and MIS (2017) NACP and Muhimbilli are planning to implement 2019 Adult Drug Resistance with Global Fund support. * Important to note that current practice of using external substantial Technical assistance may not be
14.3 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	14.3 Score: 0.42	NACP: (http://nacp.go.tz/site/about/national-aids-control-program-profile) IBBS 2017	NACP leading on implementaiton of key population surveys. NACP currently implementing IBBS and Size estimation 2019 with NBS and TACAIDS. NACP soon to release Geographical Mapping and Size estimates for KPS (2017) NACP in collaboration with Muhimbili Univerisity implemented IBBS 2017 (FSW, MSM, PWID) NACP completing a MAT take home dose survey and implementation science (2016 - 2019)

14.4 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	14.4 Score: 0.83	THIS (overall budget versus GOT input ex Salary of workers) THIS: 20% GOT, (refer to attachment with cost estimates)	Estimates were prepared taking into account input value of salaries for data collection covered by GOT and inputs to activities in country supported by external financing.
14.5 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	14.5 Score: 0.42	Tanzania HIV Investment case (analysis of GOT and external support to Tanzania HIV Aids response) : Domestic contribution to HIV is 8.6%	According to overall financing for HIV using expenditure reviews financing in general climed just above 10%. Financing for key population surveys and sureillance still has a higher level of external funding.

14.6 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?	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	14.6 Score: 0.58	THIS 2016/17: (https://www.nbs.go.tz/index.php/en/census-surveys/health-statistics/hiv-and-malaria-survey) Refer to attached document: - CONSENSUS ESTIMATES ON KEY POPULATION SIZE AND HIV PREVALENCE IN TANZANIA - IBBS 2017	THIS survey and IBBS Survey provide prevalence data by fine age disaggregates, sex, key population and sub-national units. (Link) THIS survey provides incidence by course age disaggregates and sex.

14.7 Comprehensiveness of Viral Load Coverage Data: To what extent does the host country government collect/report viral load coverage data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage is known, please note in Comments column)	○ A. The host country government does not collect/report viral load coverage data or does not conduct viral load monitoring ◉ B. The host country government collects/reports viral load coverage data (answer both subsections below): Government collects/report viral load coverage data 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 does the government collect/report viral load coverage data (select one of the following): ☐ Less than 25% ☐ 25-50% ☐ 50-75% ☑ More than 75%	14.7 Score: 0.63		NACP manages a patient monitoring system that supports both facility and national use of HIV treatment data including viral load results. MOH and NACP collect viral load coverage data by region and facility through DHIS2. Possible to analyze viral load coverage data using client level data systems for finder disaagregates.
14.8 Comprehensiveness of Key and Priority Populations Data: To what extent does the host country government conduct integrated behavioral surveillance (either as a standalone IBBS or integrated into other routine surveillance such as HSS+) and 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 (or other integrated behavioral surveillance) 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)	14.8 Score: 0.83	IBBS conducted in 2017, 2018	NACP implements both IBBS and size estimation studies covering the FSW, MSM, PWID and Other priority populations. Transgender and Prisoners are not currently identifed in the KVP guidelines.

14.9 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	14.9 Score: 0.83		The national HIV and M&E strategies, and Research Agenda has clear timelines for surveillance data collection activities
14.10 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.	14.10 Score: 0.83	NBS: Tanzania Master Statistical Plan and NBS Quality Assurance Documents (see attached documents) NIMR IRB:	NBS is responsible for assuring the quality of surveys data. MOH surveillance unit overseas quality of surveillance aactivities National HIV TWG exists to oversee the data quality review process, and the NIMR has the IRB that over sees the approval and ethical review process of the protocols
Epidemiological and Health Data Score:		**6.35**		

15. 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**
15.1 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	15.1 Score: 1.67	TACAIDS with substantial external technical assistance from UANIDS: (see attachments) NASA (National AIDS Spending Assessment) 2014/15, Zanzibar 2019 implemented by ZAC with support from UNAIDS National Health Accounts (2018), MOH independently implements with some external assisstance from WHO and USAID. (see attached)	Collection of public HIV/AIDS expenditure data occurs using standard tools including NASA and NHA and planning and implementaition is led by the host country government with substantial Technical assistance.
15.2 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	15.2 Score: 3.33	National Health Accounts collects HIV/AIDS expenditure data by source, per program area, by type of expenditure and sub-nationally. NHA last completed for mainland for 2015-16 public available, currently working on finalizing for 2018 (see attached)	HIV/AIDS expenditure data are collected through NHA.
15.3 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	15.3 Score: 3.33	Pending..	National Expenditure review done every year. Available via TACAIDS website. Currently available for 2016/17.
		Financial/Expenditure Data Score: 8.33		

16. Performance data: Government routinely collects, reports, 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, and viral load testing coverage and suppression.			**Data Source**	**Notes/Comments**
16.1 Who Leads Collection and Reporting of Service Delivery Data: To what extent is the routine collection and reporting of HIV/AIDS service delivery data institutionalized in an information system and managed and operated by the host country government at the national level?	○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	16.1 Score: 1.33	Public Portal Link: https://hmisportal.moh.go.tz/hmisportal/#/pages/home HSSPIII Review (see attached) MTR review for HSSP IV draft report has been prepared (see attached) HSSP IV: http://www.moh.go.tz/en/strategic-plans?download=25:health-sector-strategic-plan-iv-2015-2020	NACP fully manages and operates a patient monitoring system including CTC2 database at facility level and national client level data in CTC3. All aggregate data for all services reported into GOT DHIS HMIS System: Public Portal Link: HSSPIII Review: MOHSW website: MTR review for HSSP IV draft report has been prepared (IRene to share).
16.2 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	16.2 Score: 0.83	Tanzania HIV Investment Case	Tanzania HIV Investment Case: Overall estimate of GOT financing for HIV sector Majority of data clerks/M&E staff, printing & distribution of paper-based tools, electronic reporting system maintenance are externally funded.

16.3 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.)	16.3 Score: 1.33	HMIS Portal: https://hmisportal.moh.go.tz/hmisportal/#/pages/home NACP Surveillance Report	The GOT routinely collects and reports service delivery data for all of the mentioned categories within its DHIS/HMIS reporting system. All data available to stakeholders, some data available publicly via portal. NACP collets aggregate summaries of counseling and testing and linkage to ART data by key population. This includes FSW, PWID, MSM but not TG or prisoners. For priority populations it includes AGYW, cliesnts of sex workers, non-injecting drug users, and mobile populations but not miltary.
16.4 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	16.4 Score: 1.33	GOT DHIS	NACP HTS and KVP reporting is monthly and available within MOH DHIS2/HMIS. HIV Care and treatment has recenty started a weekly upload of client level data from health facilities.

16.5 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, viral suppression, 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, and viral load ☐ Continuum of care cascade for each relevant key population (FSW, PWID, MSM, TG, prisoners), including HIV testing, linkage to care, treatment, adherence and retention, and viral load ☑ Results against targets ☑ Coverage or recent achievements 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	16.5 Score: 0.83	Documents: - Annual HIV Program Report, 2018 - Annual Health Statistcal Bulletin 2018 - Sample District Health Profile - MTR Analytical Report (attached) - GOT MOH HMIS Portal: https://hmisportal.moh.go.tz/hmisportal/#/pages/home - PMTCT Scorecard: https://hmisportal.moh.go.tz/hmisportal/#/pages/downloads/scorecards/pmtct/pmtct_scorecard_2018	The GOT routinely analyzes service delivery data to measure program performance. Annual data is summarized in Annual Health Statistical Bulletin for the health sector. NACP produces annual surveillance and annual care and treatment reports. NACP sets and reviews targets for regions and councils including ART PMTCT, VMMC. NACP and PEPFAR are jointly reviewing site specific yield fo rHIV testing. Teams are reviewing variations in performance by sub-national unit and creating mapts to facilitate geographical analysis.
16.6 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	16.6 Score: 1.33	NACP Data Quality Guidelines (Prosper) M&E Data Quality Review tool (General Health sEctor tool covers HIV indicators) (Walter to provide copy) HIS Policy (Walter) HMIS Manual (Prosper) Auditor report (Data Quality) - M&E Data Review meetings at national and sub-national levels: Agenda item on national performance profile, (prosper to provide report)	The Health sector has M&E Data Quality review tools to guide data quality. NACP has HIV specific data quality guidelines. MOH has a draft HIS Policy that is near complete and pending signature for approval. Auditor General office carries out an audit of health data and produces an annual report on data quality.
		Performance Data Score:	**7.00**	

17. Data for Decision-Making Ecosystem: Host country government demonstrates commitment and capacity to advance the use of data in informing government decisions and cultivating an informed, engaged civil society.			**Data Source**	**Notes/Comments**
17.1 Civil Registration and Vital Statistics (CRVS): Is there a CRVS system in place that records births and deaths and is fully operational across the country? Is CRVS data made publically available in a timely manner?	○ A. No, there is not a CRVS system. ◉ B. Yes, there is a CRVS system that... (check all that apply): ☑ records births ☑ records deaths ☐ is fully operational across the country [IF YES] How often is CRVS data updated and made publically available (select only one)? ☑ A. The host country government does not make CRVS data available to the general public, or they are made available more than one year after the date of collection. ☐ B. The host country government makes CRVS data available to the general public within 6-12 months. ☐ C. The host country government makes CRVS data available to the general public within 6 months.	17.1 Score: 0.67		There is a CRVS system that is recording births and deaths. The definition of fully operational across the country is not clear. The system is in place and a method for birth and death registration is available. Currently there is still low coverage for both brith and death registration. For future versions, please break down in more detail and define fully operational. Data from the CRVS system is not available pubically.
17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? Do national polices protect privacy of Unique ID information?	Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services? ◉ A. No, there is no national Unique Identification system used to track delivery of services for HIV/AIDS or other health services. ○ B. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS, but not other health services. ○ C. Yes, there is a national Unique Identification system used to track delivery of services for HIV/AIDS and other health services. [IF YES to B or C] Are there national policies, procedures and systems in place that protect the security and privacy of Unique ID information? ☐ Yes ☐ No	17.2 Score: 0.00	All activities are currently on hold pending final approval from MOH.	Currently all clients on treatment have a CTC Number that is used to track delivery of HIV/AIDS treatmetn services. The GOT has developed a National Health Identificaiton Standard that was endorsed by eGOV. The standard has been implemented within the HIV data systems and consultation meetings have been convened across MOH, PORALG, EGOV and RITA to review standard. The GOT has also prepared detailed requirements to build National Health Client Register and requirements have been endorsed by eGOV and contract is in place to build and deploy registry which will provide secure unique

17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	○ A. No, there is no central integration of HIV/AIDS data with other relevant administrative data. ◉ B. Yes, national HIV/AIDS administrative data is integrated and joined with administrative data on the following: ☑ a. TB ☑ b. Maternal and Child Health ☑ c. Other Health Data (e.g., other communicable and non-communicable diseases) ☐ d. Education ☑ e. Health Systems Information (e.g., health workforce data) ☐ f. Poverty and Employment ☑ g. Other (specify in notes)	17.3 Score: 1.67	National Adminstrative data is available via the MOH DHIS2/HMIS system. It includes HIV/AIDS administrative data integrated with TB, MCH, Communicable and Non-communicable disease, Health Systems, and Other data. Other: Logistics data for tracer drugs and commodities, star rating quality assessments, community health fund and national health insurance fund coverage, population data,	Education and Poverty and Employment. Survey data is integrated. Routine Program is not.
17.4 Census Data: Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?	○ A. No, the host country government does not collect census data at least every 10 years ○ B. Yes, the host country government regularly collects census data, but does not make it available to the general public. ◉ C. Yes, the host country government regularly collects census data and makes it available to the general public. [IF YES to C only] Data that are made available to the public are disaggregated by: ☑ a. Age ☑ b. Sex ☑ c. District	17.4 Score: 2.00	NBS link to Census data: https://www.nbs.go.tz/index.php/en/census-surveys/population-and-housing-census	GOT regularly collects census data and makes it availble to the general public including disaggregation by Age, Sex and District.
17.5 Subnational Administrative Units: Are the boundaries of subnational administrative units made public (including district and site level)?	○ A. No, the country's subnational administrative boundaries are not made public. ○ B. Yes, the host country government publicizes district-level boundaries, but not site-level geocodes. ◉ C. Yes, the host country government publicizes district-level boundaries and site-level geocodes.	17.5 Score: 2.00	National Health Facility Registry: http://moh.go.tz/hfrportal/	Tanzania has a National Health Facility Registry that is the master source for health facility geocodes. NBS does share shape files for district lelvel boundaries. PORALG and Gates Foundation are currently working on an
	Data for Decision-Making Ecosystem Score:	**6.33**		

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D