2021 Tanzania Sustainability Index and Dashboard

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool completed every two years by PEPFAR teams and partner stakeholders to sharpen the understanding of each country’s sustainability landscape and to assist PEPFAR and others in making informed HIV/AIDS investment decisions. Based on responses to more than 100 questions, 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 completed over time, it will allow stakeholders to track progress and gaps across these key components of financial and programmatic sustainability. In addition, since 2019, stakeholders can assess and understand the distribution of HIV-related activities and responsibilities using Responsibility Matrix tool that has been included in the SID.

**Sustainability Element Score Criteria**

<table>
<thead>
<tr>
<th>Score Criteria</th>
<th>Score Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dark Green Score</td>
<td>8.50-10.00pts</td>
</tr>
<tr>
<td>(sustainable and requires no additional investment at this time)</td>
<td></td>
</tr>
<tr>
<td>Light Green Score</td>
<td>7.00-8.49pts</td>
</tr>
<tr>
<td>(approaching sustainability and requires little or no investment)</td>
<td></td>
</tr>
<tr>
<td>Yellow Score</td>
<td>3.50-6.99pts</td>
</tr>
<tr>
<td>(emerging sustainability and needs some investment)</td>
<td></td>
</tr>
<tr>
<td>Red Score</td>
<td>&lt;3.50 pts</td>
</tr>
<tr>
<td>(unsustainable and requires significant investment)</td>
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**Country Overview:** Tanzania’s performance on the 2021 SID demonstrates the presence of strong systems to support a sustainable HIV control response. Since the inception of the SID in 2015, we have seen gradual improvement across all elements and domains, although the changes since 2019 have plateaued. The SID elements are grounded in the goal of host country ownership. While donor investments seek to build and promote systems that are sustainable, Tanzania still receives substantial external financing for its national response to HIV/AIDS, primarily from PEPFAR and the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). While cross-cutting investments have strengthened the health system, insufficient host country investment in both HIV and the health sector, more broadly is preventing Tanzania from reaching its full potential for sustaining the HIV program.

**SID Process:** The SID/RM 2021 process began in mid-July 2021 with S/GAC’s release of guidance for the SID and Responsibility Matrix (RM). In the context of COVID-19, the PEPFAR/Tanzania team adapted a virtual process for planning and execution. In August, PEPFAR/Tanzania established a SID/RM Steering Committee consisting of representatives from PEPFAR, UNAIDS, and TACAIDS. This committee was responsible for overseeing all SID processes including identifying leaders for all SID Domain discussions, setting up and facilitating all virtual stakeholder meetings, gathering reference documents, compiling SID scores, and drafting the final report.

Three stakeholder meetings were held. First, the Responsibility Matrix Stakeholders Meeting was held on September 21, 2021. Senior representatives from the Government of Tanzania (MOHCDGEC, PORALG, MOFP, and TACAIDS), CSOs, PEPFAR, the private sector, WHO, UNAIDS, Global Fund (GFATM) and People Living with HIV convened for a half-day meeting. Using the RM from 2019 as a starting point, each component was reviewed by the group and updated appropriately. A wider virtual SID 2021 Stakeholders Meeting was held on September 22-23, 2021. With over 80 people in attendance participants, which included technical representatives from the Government of Tanzania, civil society organizations, people living with HIV, PEPFAR implementing partners, PEPFAR staff, UNAIDS, and the private sector, divided into
domain-based discussion groups to review and update all SID elements. The robust group domain discussions were jointly facilitated by PEPFAR, UNAIDS, and Government of Tanzania representatives. Finally, on October 20, 2021, a SID finalization stakeholder meeting was held. At this meeting, the preliminary SID results were shared for feedback and final input. The final draft of the SID will be shared with all stakeholders for reference during ongoing HIV sector strategic planning and in anticipation of COP 22 planning.

**Sustainability Strengths:**
The sustainability landscape as demonstrated by SID 2021 assessments reveal areas of slight improvements and some areas of slight decline as compared to SID 2019 across the four domains.

The **Governance, Leadership and Accountability** domain scored dark green in three elements (Planning and Coordination, Private Sector Engagement, and Public Access to Information) and light green in one element (Policies and Governance). The strengths under this domain include the presence of the national multi-year strategy to respond to HIV, the system for planning and coordination which is participatory across stakeholders, and engagement of the private sector in both policy and strategy. The policies and guidelines for service delivery are also aligned to international standards as per WHO guidance. The process of reviewing the National Multi-Sectoral Strategy and development of the Health Sector HIV Strategy to align with the Global AIDS Strategy and Political Declaration is currently underway.

The **National Health System and Service Delivery** domain is another area of emerging sustainability, but few changes were noted from the SID 2019 scores. Improvements were observed for **Quality Management** (6.71 compared to 5.76 during SID 2019) due to increased accountability in service delivery at health facilities which has improved quality management of HIV services. The National Quality Improvement Framework has also been implemented successfully. Improvement and utilization of the DHIS-2 system, to capture data on various programs including HIV, and supervision visits have improved the capacity of healthcare workers to identify quality gaps and take action accordingly.

On the **Strategic Financing and Market Openness** domain, there were some improvements from SID 2019, with the highest scoring section being **Market Openness** (9.5). Achieving this score was due in part to the fact that there are no policies that limit the ability of licensed private providers from offering HIV services, or that limit the ability of local manufacturing of HIV commodities if they are pre-qualified by WHO.

Other areas of strength under the **Strategic Information** domain include **Financial/Expenditure Data** (8.33). This score is based on the strong GOT leadership, through MOH and TACAIDS, to collect HIV expenditure data as well as efforts to strengthen and harmonize information systems for data use and decision making. While this is not an increase from SID 2019 (the score remained the same), the strength is still worth noting.

**Sustainability Vulnerabilities:**
Several critical issues require further investigation, investments, and transfer of ownership to ensure sustainability.

Within the **Governance, Leadership and Accountability** domain, it is noted that ART and other HIV commodities, including PSM are heavily externally funded. There is an acute lack of resources to implement the Public Private Partnership Act which provides for an AIDS Trust Fund (ATF) to fund HIV activities through government budget. The GOT provides medicines for opportunistic infections based on
the essential medicines list. In times of stock-out, clients are offered prescriptions and must access the medication elsewhere. This highlights a need for improvement in the supply chain systems. The recently developed CSO Engagement Strategy provides an opportunity to strengthen collaboration.

On the **Strategic Financing and Market Openness domain**, there was a decline for Technical and Allocative Efficiencies (3.60 compared to 4.93 during SID 2019) due to the lack of systems that could provide routine costing data through the Government of Tanzania. For the Domestic Resource Mobilization section (5.48), while national budgets have explicit funding for HIV/AIDS, only a small percentage of the national HIV response is financed with domestic resources, and often the funds budgeted aren’t disbursed. Data UNAIDS’ Investment Case (2019), and the draft reports of the National Health Accounts (2019/ 2020) indicate that external sources (PEPFAR and Global Fund) account over 90% of financing for HIV/AIDS.

For the **National Health System and Service Delivery domain**, the overall improvements since SID 2017 (total scores: SID 2017 (25.29), SID 2019 (30.80), SID 2021 (30.01)) demonstrates an increased capacity service providers to deliver HIV services, however, no significant improvements were observed in the 2019 and 2021 SID. This underscores the need for strategic thinking amongst stakeholders and national authorities. A call to action for more domestic funding for systems strengthening and human resources in service delivery is needed. Specific areas to note include:

- **Service Delivery (6.59 compared to 6.11 during SID 2019)**: Differentiated service delivery modules are being implemented in the country for HIV services. Community structures for HIV services have improved in the past two years, but challenges remain in the domestic financing for HIV services as per recent National AIDS Spending Assessment (NASA) report which affects both planning and monitoring of HIV services.

- **Laboratory (4.98 compared to 6.56 in SID 2019)**: The National Laboratory Strategic Plan 2016-2021 is operational (with laboratory being a directorate at the Ministry of Health) which helps to institute national regulations and standards for laboratory services in the country. Nevertheless, funding for laboratory strengthening is quite insufficient with less than 50% coming from domestic resources. The number of laboratory technicians and scientists is also inadequate to support the whole country. A scale up plan for viral load services is externally driven and focuses on reaching people and maintenance of testing capacities. The drop in score from SID 2019 implies the need for further investment to sustain these structures and systems for laboratory strengthening.

Under the **Strategic Information domain**, the area with a declining score was **Performance Data (6.50 compared to 7.00 during SID2019)**. While the Government of Tanzania plays a key role in collection and reporting on service delivery through CTC2, CTC2, and the DHIS HMIS systems, the resources needed to collect service delivery data by the Government of Tanzania is not a straightforward calculation. Many data collection technicians, from council levels and upwards, are supported by government, but at facility level, operational costs are also covered by implementing partners (funded through PEPFAR or Global Fund).

**COVID-19 Implications and Observations:**
Tanzania is experiencing devastating human, economic, social and health challenges relating to the COVID-19 pandemic. Although proactive steps by the Ministry, in coordination with partners and donors has helped minimize service disruptions, people living with HIV (PLHIV) experience ongoing challenges navigating constrained health care facilities. In addition, supply chain and shipping challenges during the pandemic and reduced health seeking behavior for fear of contracting COVID-19, has impacted service
utilization by PLHIV and prevention services for those at risk of HIV. Great efforts have gone into maintaining treatment access during the COVID-19 pandemic and scale-up of multi-month ARVs dispensing as well as community ARV refills have helped mitigate the impact on the national HIV program.

In April 2021, the newly sworn President formed a task force of experts to advise on the continued COVID19 response, which is now guided by science. National vaccination campaigns commenced in August 2021 and scale-up that includes a focus on health care workers will impact the safety of services at health facilities.
Sustainability Analysis for Epidemic Control: Tanzania

Epidemic Type: Generalized
Income Level: Lower middle income

**Governance, Leadership, and Accountability**

<table>
<thead>
<tr>
<th>Element</th>
<th>2015 (SID 2.0)</th>
<th>2017 (SID 3.0)</th>
<th>2019 (SID 4.0)</th>
<th>2021</th>
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<tbody>
<tr>
<td>1. Planning and Coordination</td>
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<td>5.33</td>
<td>9.50</td>
<td>9.79</td>
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<tr>
<td>2. Policies and Governance</td>
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<td>3. Civic Society Engagement</td>
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<td>5. Public Access to Information</td>
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**National Health System and Service Delivery**

<table>
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<tr>
<th>Element</th>
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<th>2019 (SID 4.0)</th>
<th>2021</th>
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<tr>
<td>6. Service Delivery</td>
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<td>7. Human Resources for Health</td>
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<td>8. Commodity Security and Supply Chain</td>
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<td>4.25</td>
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<td>9. Quality Management</td>
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<td>5.62</td>
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<td>10. Laboratory</td>
<td>3.33</td>
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**Strategic Financing and Market Openness**

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<th>2021</th>
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<td>11. Domestic Resource Mobilization</td>
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<td>5.48</td>
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<td>12. Technical and Allocative Efficiencies</td>
<td>3.17</td>
<td>4.67</td>
<td>4.93</td>
<td>3.60</td>
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<tr>
<td>13. Market Openness</td>
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<td>9.33</td>
<td>9.50</td>
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**Strategic Information**

<table>
<thead>
<tr>
<th>Element</th>
<th>2015 (SID 2.0)</th>
<th>2017 (SID 3.0)</th>
<th>2019 (SID 4.0)</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. Epidemiological and Health Data</td>
<td>4.70</td>
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<td>6.35</td>
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<td>15. Financial/Expenditure Data</td>
<td>4.58</td>
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</tr>
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<td>16. Performance Data</td>
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<td>7.00</td>
<td>6.50</td>
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<td>17. Data for Decision-Making Ecosystem</td>
<td>N/A</td>
<td>N/A</td>
<td>6.33</td>
<td>6.43</td>
</tr>
</tbody>
</table>

**Financing the HIV Response**

**GNI Per Capita (Atlas Method)**

**Clinical Cascade**

**Population Pyramid (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.

   - **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 all epidemiologically significant 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

     - NMSF IV - not costed - The Case investment has been costed
     - HSSHIP - Not costed Part of it has been costed
     - Operational Plan for the HSHSP IV - Investment Case

     - 2-year Implementation plan for HSHSP is costed
     - Investment case based on NMSF-IV is costed

     - No significant score changes from 2019, the strategy is similar to previous version.

   - Tanzania has the multiyear national strategy to respond to HIV

   - The planning and coordination processes are in place and very participatory with all stakeholders

   - 1.1 Score: 2.29

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):
     - It is 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)

   - HSSHIP IV

   - 1.2 Score: 2.50

   - Stakeholder participation report for the HSHSP IV to indicate the participants/ (Use the list of contributors from the document itself)
### 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:
    - 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.

### 1.4 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.

### Planning and Coordination Score: 9.79

**Check your score here:**

1.3 Score: 2.50

1.4 Score: 2.50

### 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.**

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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults (&gt;19 years)</td>
<td>HIV Care and Treatment Guidelines</td>
<td>Policies and guidelines for service delivery are aligned to international standards as per WHO</td>
</tr>
</tbody>
</table>
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)?

- [ ] Yes
- [ ] No

B. Pregnant and Breastfeeding Mothers

- [ ] Yes
- [ ] No

C. Adolescents (10-19 years)

- [ ] Yes
- [ ] No

D. Children (<10 years)

- [ ] Yes
- [ ] No

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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?

- [ ] 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

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Clinic visits for stable clients is at least every 6 months

Consent was only required for testing and not for treatment. After addressing consent for testing no further consent is needed.

2.2 Score: 0.77
### 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.

**Score:** 0.83

**Tanzania Health Policy 2017 - 2027**

PLHIV are exempt from fees, however in cases where medicines for optimistic infections are out of stock, clients are offered prescriptions to access the medicines elsewhere, often at a cost.

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<thead>
<tr>
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<tr>
<td></td>
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### 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.

**Score:** 0.42

**Tanzania Health Policy 2017 - 2027**

PLHIV are exempt from fees, however in cases where medicines for optimistic infections are out of stock, clients are offered prescriptions to access the medicines elsewhere, often at a cost.

<table>
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</tr>
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</table>

### 2.5 Data Protection:

Does the country have policies in place that (check all that apply):

- Policies that permit integrated management of HIV program with other diseases of public health importance (e.g. HIV/COVID-19)
- 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
- Policies that permit TB screening and TPT for PLHIV
- Policies that allow for integrated management of HIV program with other diseases of public health importance (e.g. HIV/COVID-19)
- Policies that allow HIV-infected adolescents, starting at age 15, to seek HIV treatment without parental consent
- Policies that permit TB screening and TPT for PLHIV
- Policies that allow integrated management of HIV program with other diseases of public health importance (e.g. HIV/COVID-19)

**Score:** 0.67

**Tanzania Health Policy 2017 - 2027**

Based on discussion with multiple stakeholders during SID workshop.

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</table>

There are policies that govern the data management processes and include privacy and confidentiality of Personal Identifiable Information.
policies in place that support the collection and appropriate use of patient-level data for health, including HIV/AIDS?

| 2.6 Legal Protections for Key Populations: Does the country have laws or policies that specify protections (not specific to HIV) for specific populations? |
|---|---|---|
| Transgender people (TG): | ☐ Constitutional prohibition of discrimination based on gender diversity | | 2.6 Score: 0.07 | Drugs and prevention of illicit traffic in drugs act | - NCPI Tanzania 2020 |
| | ☐ 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 discrimination 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) | | | | |
| People who inject drugs (PWID): | | | | | |

Tanzanian Laws are for the general population as per the URT Constitution 1977 RE 2002 section 8 and section 13 (equality before the law).
- Constitution prohibits discrimination for all, not specified to specific populations.
- Drugs and prevention of illicit traffic in drugs act provides protection against criminalization for individuals who are addicted.
- Draft policy provides special provisions for women who are addicted.
- Tanzania laws provides for protection for the general population and prohibits discrimination for all but not specified to specific population - these have not recently changed.
2.7 Legal Protections for Victims of Violence:
Does the country have protections in place for victims of 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

2.8 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

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.
- NCPI Tanzania report 2020

Legal provision does not specify for key populations - no significant changes from 2019 noted.

2.7 Score: 0.58

Legal provision does not specify for key populations - no significant changes from 2019 noted.

2.8 Score: 0.50
### Sex Work

- **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

- **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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No, but prosecutions exist based on general criminal laws</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the country have laws criminalizing the transmission of, non-disclosure of, or exposure to HIV transmission?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the country have policies restricting the entry, stay, and residence of people living with HIV (PLHIV)?</td>
<td>Yes</td>
<td></td>
<td>No</td>
</tr>
<tr>
<td>Does the country have other punitive laws affecting lesbian, gay, bisexual, transgender, and intersex (LGBTI) people?</td>
<td>Yes, promotion (“propaganda”) laws</td>
<td>Yes, morality laws or religious norms that limit LGBTI freedom of expression and association</td>
<td>No</td>
</tr>
</tbody>
</table>

### 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, all epidemiologically significant key populations, adolescents, and those who may access HIV services about these rights?

| To educate PLHIV about their legal rights in terms of access to HIV services | Yes |
| To educate key populations about their legal rights in terms of access to HIV services | No |
| National law exists regarding health care privacy and confidentiality protections | No |
| Government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found | Yes |

#### 2.9 Score: 0.42

- **HAPCA RE 2020**
- **Public Health Act 2008**

The term legal rights needs to be clarified in the larger group. This was discussed during the workshop and while no significant changes have been noted since SID 2019, the interpretation may have seen changes in the score.

### 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: 0.83

- **CAG reports Annually**
### 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?

- **Score: 0.83**

  - 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.

### 2.12 Innovation Regulation: Does the host government have a timely and effective formal regulatory and registration process for the introduction of new products, technologies, and solutions in support of HIV programming?

- **Score: 0.42**

  - A. No, no formal processes exist
  - B. Yes, effective but not always timely
  - C. Yes, timely but not always effective
  - D. Yes, both timely and effective

### Policies and Governance Score: 7.18

### 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.

<table>
<thead>
<tr>
<th>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?</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
</table>
| 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 | based on discussion with multiple stakeholders during SID workshop |

| Check A, B, or C; if C checked, select appropriate disaggregates: | 3.2 Score: 1.67 | based on discussion with multiple stakeholders during SID workshop |
| 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. | | |
### 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)?

| 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 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

### 3.4 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.

| 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). |

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3.3 Score: 1.67

3.4 Score: 0.83

**Kili Challenge Funds -**

TACAIDS to give the document showing the % based on discussion with multiple stakeholders during SID workshop.
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

Civil Society Engagement Score: 6.67

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.

- 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

AIDS Business Coalition of Tanzania (ABCT) no longer exists. Association of Tanzania Employer and Tanzania Private Sector were coordinating private sector HIV/AIDS activities, but they no longer are doing so. Christian Social Services Commission is currently coordinating HIV/AIDS activities for the FBO network under a bilateral project with USAID. The Association of Private Health Facilities of Tanzania are now less active in promoting HIV/AIDS activities because of reduced...
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.)

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).

4.2 Score: 1.00

Based on discussion with multiple stakeholders during SID workshop.

There are formal Channels and Opportunities for Private sector engagement - no significant changes from 2019, but score may reflect intricacies of the situation.
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.

- There are strong linkage and referral networks between on-site workplace programs and public health care facilities.
- 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.

A. Private health service delivery providers are not legally allowed to deliver HIV/AIDS services.

B. The host country government plans to allow private health service delivery providers to provide HIV/AIDS services in the next two years.

C. Private health service delivery providers are legally allowed to deliver HIV/AIDS services. In addition (check all that apply):

- Policies are in place to ensure that private providers receive, understand, and adhere to national guidelines/protocols for ART, and appropriate quality standards and certifications.
- Systems are in place for service provision and/or research reporting by private facilities to the government, including guidelines for data reporting.
- Joint (i.e., public-private) supervision and quality oversight of private facilities.
- The government offers tax deductions for private facilities delivering HIV/AIDS services.
- The government offers tax deductions for private training institutions.
- The private sector is eligible to procure HIV/AIDS and/or ART commodities via public sector procurement channels and/or national medical stores.
- The host country government has formal contracting or service-level agreement procedures to compensate private facilities for HIV/AIDS services.
- HIV/AIDS services received in private facilities are eligible for reimbursement through national health insurance schemes.
- There are open competitions for private health care providers to compete for government service contracts.
- There is a systematic and timely process for private company registration and/or testing of new health products (e.g., drugs, diagnostic kits, medical devices, etc.) that support HIV/AIDS programming.
- The government effectively regulates the flow of subsidized commodities into the private sector.

4.3 Score: 1.57

PSSF
NHIF
4.4 Score: 1.20

The warehousing has been for the malaria program.

4.5 Score: 1.67

There are formal Channels and Opportunities for Private sector engagement.

4.4 Supply Chain: Does the host country government have systems and policies in place that allow for utilizing the private sector for health commodity supply chain functions?

- A. No systems and policies are in place that allow for utilizing the private sector for health commodity supply chain functions.
- B. Yes, systems and policies are in place, but they are not being implemented, and they apply to the following areas (check all that apply):
  - Data visibility
  - Warehousing
  - Sourcing & Procurement
  - Oversight & Performance management of the third-party logistics & capacity building (i.e. 4PL Logistics management)
  - Sourcing & Procurement

- C. Yes, systems and policies are in place and are being implemented, and they apply to the following areas (check all that apply):
  - Data visibility
  - Warehousing
  - Sourcing & Procurement
  - Oversight & Performance management of the third-party logistics & capacity building (i.e. 4PL Logistics management)

4.5 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

Legal Acts:
- TMDA Act 2019
- MSD Act
- Pharmacy Act
- GF - malaria
- The courier services
- The warehousing has been for the malaria program
4.6 Private Sector Engagement Governance: Is there a national policy, plan, strategy or framework in place for the use of private sector engagement* that is utilized for the HIV/AIDS response?

*Private sector engagement is a strategic approach to planning and programming where country governments consult, strategize, align, collaborate, and implement with the private sector for greater scale, sustainability, and effectiveness to achieve epidemic control.

| A. There is no national policy, plan, strategy, or framework in place for the use of private sector engagement partnerships that are utilized for the HIV/AIDS response. | 4.6 Score: 1.67 |
| B. There is a national policy, plan, strategy, or framework in place, but it is not being implemented. |
| C. A national policy, plan, strategy, or framework is being implemented and applies to the following areas (check all that apply): |
| Service Delivery |
| HRH |
| Data Systems |

Private Sector Engagement Score: 8.50

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 publicly. Efforts are made to ensure public has access to data through print distribution, websites, radio or other methods of disseminating information.

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: 2.00

Source of Data

Notes/Comments

DHIS CTC 3 Macro

5.2 Expenditure Transparency: Does the host country government make annual 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.

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.

5.2 Score: 1.00

Source of Data

Notes/Comments

NASA Annual Audit Report
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 within 6-12 months after 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

5.4 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.

5.5 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

5.3 Score: 1.56

5.4 Score: 2.00

5.5 Score: 2.00

World AIDS Day Symposium
TNCM progress review Meeting Quarterly
TACAIDS progress report to Parliament

PPRA
NACP and MSD through GF

TACAIDS
MOHCDGEC/ Health Promotion Section/Unit
C. There is a government institution that is responsible for, and is providing, scientifically accurate information on HIV/AIDS.
## 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. all 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.

<table>
<thead>
<tr>
<th>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.)</th>
<th>6.2 Score:</th>
<th>6.2 Score:</th>
<th>6.1 Score:</th>
</tr>
</thead>
<tbody>
<tr>
<td>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)</td>
<td>0.95</td>
<td>Availability of MSD National tracking register HIV testing there is also linkage tool [HIV testing link] [linkage tool] Availability of CBHS guidelines and electronic information systems to track service delivery</td>
<td>Mobile clinics can be done subject to availability of funds. In some busy clinics HCWs are working extra hours due to limitation of HRH</td>
</tr>
<tr>
<td>Public facilities are able to situate services in proximity to high-HIV burden locations or populations (e.g., mobile clinics)</td>
<td>0.79</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is evidence that public facilities in high burden areas and/or serving high-burden populations generate demand for HIV services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 6.2 Responsiveness of community-based HIV/AIDS services: Has the host country standardized the design and implementation of community-based HIV/AIDS services through (check all that apply):

- [ ] Formulated 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
- [x] 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)

<table>
<thead>
<tr>
<th>6.2 Score:</th>
<th>0.79</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>The host country has standardized the following design and implementation components of community-based HIV/AIDS services through (check all that apply):</td>
<td>Availability of MSD National tracking register HIV testing there is also linkage tool [HIV testing link] [linkage tool] Availability of CBHS guidelines and electronic information systems to track service delivery</td>
<td>Limitation of funding results to inadequate planning and operationalization of the community based HIV/AIDS services Weak/Inadequate supply chain system to support community based services, as a result it is difficult to track access and utilization of HIV commodities in the community hence a threat on sustainable plan on HIV commodities beyond Health Facilities. Linkage system is there, extended from health services to the community through community outreach service There is still room for improvement to support the system</td>
<td></td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>6.3 Score:</th>
<th>0.83</th>
<th>NASA 2020 report National Health Account report 2017 Public Expenditure review</th>
<th>According to the NASA 2020 report we are at 4%, but NASA reports does not directly measure expenditures in HIV service delivery, rather it measures budgets and disbursements from National to Districts and vice versa.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Host country institutions provide no (0%) financing for delivery of HIV/AIDS services</td>
<td>0.83</td>
<td>NASA 2020 report National Health Account report 2017 Public Expenditure review</td>
<td>According to the NASA 2020 report we are at 4%, but NASA reports does not directly measure expenditures in HIV service delivery, rather it measures budgets and disbursements from National to Districts and vice versa.</td>
</tr>
<tr>
<td>B. Host country institutions provide minimal (1-9%) financing for delivery of HIV/AIDS services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Host country institutions provide some (10-49%) financing for delivery of HIV/AIDS services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Host country institutions provide most (50-89%) financing for delivery of HIV/AIDS services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Host country institutions provide all or almost all (90%+) financing for delivery of HIV/AIDS services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section</td>
<td>Question</td>
<td>Options</td>
<td>Score</td>
</tr>
<tr>
<td>---------</td>
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</tr>
<tr>
<td>6.4</td>
<td>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?</td>
<td>- A. HIV/AIDS services are primarily delivered by external agencies, organizations, or institutions. &lt;br&gt; - B. Host country institutions deliver HIV/AIDS services but with substantial external technical assistance. &lt;br&gt; - C. Host country institutions deliver HIV/AIDS services with some external technical assistance. &lt;br&gt; - D. Host country institutions deliver HIV/AIDS services with minimal or no external technical assistance.</td>
<td>0.32</td>
</tr>
<tr>
<td>6.5</td>
<td>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 all epidemiologically significant key populations (i.e. without external financial assistance from donors)? (if exact or approximate percentage known, please note in Comments column)</td>
<td>- A. Host country institutions provide no or minimal (0%) financing for delivery of HIV/AIDS services to key populations, or information is not available. &lt;br&gt; - B. Host country institutions provide minimal (approx. 1-9%) financing for delivery of HIV/AIDS services to key populations. &lt;br&gt; - C. Host country institutions provide some (approx. 10-49%) financing for delivery of HIV/AIDS services to key populations. &lt;br&gt; - D. Host country institutions provide most (approx. 50-89%) financing for delivery of HIV/AIDS services to key populations. &lt;br&gt; - E. Host country institutions provide all or almost all (approx. 90%+) financing for delivery of HIV/AIDS services to key populations.</td>
<td>0.83</td>
</tr>
<tr>
<td>6.6</td>
<td>Domestic Provision of Service Delivery for all epidemiologically significant 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?</td>
<td>- A. HIV/AIDS services to key populations are primarily delivered by external agencies, organizations, or institutions. &lt;br&gt; - B. Host country institutions deliver HIV/AIDS services to key populations but with substantial external technical assistance. &lt;br&gt; - C. Host country institutions deliver HIV/AIDS services to key populations with some external technical assistance. &lt;br&gt; - D. Host country institutions deliver HIV/AIDS services to key populations with minimal or no external technical assistance.</td>
<td>0.63</td>
</tr>
<tr>
<td>6.7</td>
<td>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.</td>
<td>- A. No, there is no entity. &lt;br&gt; - B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget. &lt;br&gt; - C. Yes, there is an entity with authority and sufficient staff, but not a sufficient budget. &lt;br&gt; - D. Yes, there is an entity with authority and sufficient staff and budget.</td>
<td>0.63</td>
</tr>
<tr>
<td>6.8</td>
<td>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):</td>
<td>- Translate national policies/strategies into sub-national level HIV/AIDS strategic plan and response activities. &lt;br&gt; - Use epidemiologic and program data to measure effectiveness of sub-national level programs in delivering needed HIV/AIDS services in right locations. &lt;br&gt; - Assess current and future staffing needs based on HIV/AIDS program goals and budget realities for high burden locations.</td>
<td>0.95</td>
</tr>
</tbody>
</table>

**Note:** The scores are indicative of the level of provision according to the criteria set by the respective reports.
### 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?

- **Check all that apply:**
  - 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.

<table>
<thead>
<tr>
<th>Service Delivery Score</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.9 Score: 0.63</td>
<td>Spectrum training and data use CCHP</td>
<td>Engagement in planning meeting is there but not harmonious, last meeting warning before engagement, no room for preparations</td>
</tr>
</tbody>
</table>

### 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.

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: 0.71 | Pre service production report, retention guide from local government Sikika Report on Human Resource for Health WAD initiative on retention: retention manual Retention Scheme and HCW production Report plus HRH Strategic Plan | Production has been adequate but absorption might not be satisfactorily. BMF has been doing excellent job in retaining HCWs, training opportunities for those in hard to reach areas. There are some efforts that have started on the redistribution of healthcare workers based on geographical and disease burden There some customized retention schemes in the facilities. |

### 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: 0.71 | Pre service production report, retention guide from local government Sikika Report on Human Resource for Health WAD initiative on retention: retention manual Retention Scheme and HCW production Report plus HRH Strategic Plan | Production has been adequate but absorption might not be satisfactorily. BMF has been doing excellent job in retaining HCWs, training opportunities for those in hard to reach areas. There are some efforts that have started on the redistribution of healthcare workers based on geographical and disease burden There some customized retention schemes in the facilities. |

### 7.2 Role of Community-based Health Workers (CHWs):

To what extent are community-based

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).
7.3 Score: 0.24

7.4 Score: 2.50

7.5 Score: 0.48

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.

7.3 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.

O A. There is no inventory or plan for transition of donor-supported health workers

O B. There is an inventory of donor-supported health workers, but no official plan to transition these staff to local support

O C. There is an inventory and plan for transition of donor-supported workers, but it has not yet been implemented

O D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan

O E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated

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)

O A. Host country institutions provide no (0%) health worker salaries

O B. Host country institutions provide minimal (approx. 1-9%) health worker salaries

O C. Host country institutions provide some (approx. 10-49%) health worker salaries

O D. Host country institutions provide most (approx. 50-89%) health worker salaries

O E. Host country institutions provide all or almost all (approx. 90%+) health worker salaries

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.

O 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)

O 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

O C. Pre-service education institutions have updated HIV/AIDS content within the last three years (check all that apply):

□ There has been efforts from the specific projects that have been transitioned to local but no national plan

□ SID 2021 acknowledged that it is the efforts from the specific projects that have managed to create the transitioning of local staff but not the existence of the national plan.

Personnel emmolent Analysis

Majority of HCWs employees are employed by the GOT

Reviews made in 2015/16 have been under assessment in past 3 years to ensure they meet the intended challenges.

The reviewed curriculum for Nursing and Midwifery that 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 Pharmaceutical Technicians (NTA level 4-6) 2016.

The 2019 and 2021 responses should be similar.
### 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
  - [ ] The host country government requires continuing professional development, a form of in-service training, for re-licensure for key clinicians
  - [ ] 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)

### 7.7 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)

### 7.8 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?*

- A. No, there is no entity.
- B. Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget.

**Scores**

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.6 In-service Training</td>
<td>0.36</td>
</tr>
<tr>
<td>7.7 Health Workforce Data Collection and Use</td>
<td>0.95</td>
</tr>
<tr>
<td>7.8 Management and Monitoring of Health Workforce</td>
<td>0.63</td>
</tr>
</tbody>
</table>

**Notes**

- Data in Trainsmart are questionable due to the fact there is no incentives for using it within the National system.
- Decreased since SID 2019 could be due to differing stakeholder groups on the interpretation of this question.
## Health Workforce Score: 6.51

### Data Source
- **Notes/Comments**
  - National Pharmaceutical Action Plan (2015-2020). While there is waste disposal amongst the strategic objectives, but not mention of reverse logistics...

### 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.

<table>
<thead>
<tr>
<th>8.1 ARV Domestic Financing</th>
<th>8.2 Test Kit Domestic Financing</th>
<th>8.3 Condom Domestic Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the estimated percentage of ARV procurement funded by domestic sources?</strong></td>
<td><strong>What is the estimated percentage of HIV Rapid Test Kit procurement funded by domestic sources?</strong></td>
<td><strong>What is the estimated percentage of condom procurement funded by domestic (not donor) sources?</strong></td>
</tr>
<tr>
<td>(Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</td>
<td>(Domestic sources includes public sector and private sector but excludes donor and out-of-pocket funds)</td>
<td>Note: The denominator should be the supply of free or subsidized condoms provided to public or private sector health facilities or community based programs.</td>
</tr>
<tr>
<td>(if exact or approximate percentage known, please note in Comments column)</td>
<td>(if exact or approximate percentage known, please note in Comments column)</td>
<td>(if exact or approximate percentage known, please note in Comments column)</td>
</tr>
<tr>
<td>A. This information is not known.</td>
<td>A. This information is not known</td>
<td>A. This information is not known</td>
</tr>
<tr>
<td>B. No (0%) funding from domestic sources</td>
<td>B. No (0%) funding from domestic sources</td>
<td>B. No (0%) funding from domestic sources</td>
</tr>
<tr>
<td>C. Minimal (1-9%) funding from domestic sources</td>
<td>C. Minimal (1-9%) funding from domestic sources</td>
<td>C. Minimal (1-9%) funding from domestic sources</td>
</tr>
<tr>
<td>D. Some (10-49%) funding from domestic sources</td>
<td>D. Some (10-49%) funding from domestic sources</td>
<td>D. Some (10-49%) funding from domestic sources</td>
</tr>
<tr>
<td>E. Most (50-89%) funded from domestic sources</td>
<td>E. Most (50-89%) funded from domestic sources</td>
<td>E. Most (50-89%) funded from domestic sources</td>
</tr>
<tr>
<td>F. All or almost all (approx. 90%) funded from domestic sources</td>
<td>F. All or almost all (approx. 90%) funded from domestic sources</td>
<td>F. All or almost all (approx. 90%) funded from domestic sources</td>
</tr>
</tbody>
</table>

| 8.4 Score: 1.52 | **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.** |

| A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP). | Human resources | **Notes/Comments** |
| B. There is a plan(SOP) that includes the following components (check all that apply): | | No Government resources for procurement of ARVs, Check with private sector suppliers, few known to be available |

- A. This information is not known.
- B. No (0%) funding from domestic sources
- C. Minimal (1-9%) funding from domestic sources
- D. Some (10-49%) funding from domestic sources
- E. Most (50-89%) funded from domestic sources
- F. All or almost all (approx. 90%) funded from domestic sources
- A. This information is not known.
- B. No (0%) funding from domestic sources
- C. Minimal (1-9%) funding from domestic sources
- D. Some (10-49%) funding from domestic sources
- E. Most (50-89%) funded from domestic sources
- F. All or almost all (approx. 90%) funded from domestic sources
- A. This information is not known.
- B. No (0%) funding from domestic sources
- C. Minimal (1-9%) funding from domestic sources
- D. Some (10-49%) funding from domestic sources
- E. Most (50-89%) funded from domestic sources
- F. All or almost all (approx. 90%) funded from domestic sources
- A. This information is not known.
- B. No (0%) funding from domestic sources
- C. Minimal (1-9%) funding from domestic sources
- D. Some (10-49%) funding from domestic sources
- E. Most (50-89%) funded from domestic sources
- F. All or almost all (approx. 90%) funded from domestic sources
- A. This information is not known.
- B. No (0%) funding from domestic sources
- C. Minimal (1-9%) funding from domestic sources
- D. Some (10-49%) funding from domestic sources
- E. Most (50-89%) funded from domestic sources
- F. All or almost all (approx. 90%) funded from domestic sources

- 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):
- C. Yes, there is an entity with authority and sufficient staff, but not sufficient budget.
- D. Yes, there is an entity with authority and sufficient staff and budget.

- 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):
- C. Yes, there is an entity with authority and sufficient staff, but not sufficient budget.
- D. Yes, there is an entity with authority and sufficient staff and budget.

- A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).
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- C. Yes, there is an entity with authority and sufficient staff, but not sufficient budget.
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- A. There is no plan or thoroughly annually reviewed supply chain standard operating procedure (SOP).
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- 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):
- C. Yes, there is an entity with authority and sufficient staff, but not sufficient budget.
- D. Yes, there is an entity with authority and sufficient staff and budget.
8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?

- Training
- Warehousing
- Distribution
- Reverse Logistics
- Waste management
- Information system
- Procurement
- Forecasting
- Supply planning and supervision
- Site supervision

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)?

- 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.

8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?

- 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

8.7 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?

- 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

NPAP 2021-2026 commenced after finalization of Health Sector Strategic Plan V (HSSP V).
### 8.8 Management and Monitoring of Supply Chain:

Does an administrative entity, such as a national office or Bureau/a, 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.

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A.</td>
<td>No, there is no entity.</td>
</tr>
<tr>
<td>☐ B.</td>
<td>Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget.</td>
</tr>
<tr>
<td>☐ C.</td>
<td>Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</td>
</tr>
<tr>
<td>☐ D.</td>
<td>Yes, there is an entity with authority and sufficient staff and budget.</td>
</tr>
</tbody>
</table>

**Score:** 1.11

- **Data Source:** Rama to share a report
- **Notes/Comments:** The entity is LMU within the Chief Pharmacist Office

### Commodity Security and Supply Chain Score:

| Score | 5.22 |

### 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

#### 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?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A.</td>
<td>The host country government does not have structures or resources to support site-level continuous quality improvement.</td>
</tr>
<tr>
<td>☐ B.</td>
<td>The host country government:</td>
</tr>
<tr>
<td>☐ 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.</td>
<td></td>
</tr>
<tr>
<td>☐ Has a budget line item for the QM program</td>
<td></td>
</tr>
<tr>
<td>☐ 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</td>
<td></td>
</tr>
</tbody>
</table>

**Score:** 1.33

- **Data Source:** The Tanzania Quality improvement Framework in health care 2011-2016. Community Quality Improvement Framework 2018
- **Notes/Comments:** There is directorate of quality at the Ministry and also at NACP, the issue has been funding.

### 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.)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A.</td>
<td>There is no HIV/AIDS-related QM/QI strategy</td>
</tr>
<tr>
<td>☐ B.</td>
<td>There is a QM/QI strategy that includes HIV/AIDS, but it is not utilized</td>
</tr>
<tr>
<td>☐ C.</td>
<td>There is a current QM/QI strategy that includes HIV/AIDS program specific elements, and it is partially utilized.</td>
</tr>
<tr>
<td>☐ D.</td>
<td>There is a current HIV/AIDS program specific QM/QI strategy, and it is fully utilized.</td>
</tr>
</tbody>
</table>

**Score:** 1.33

- **Data Source:** QI guidelines National Supervision checklist
- **Notes/Comments:** However, there is no objective scale to measure utilization status of the QI strategies

### 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

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ A.</td>
<td>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.</td>
</tr>
<tr>
<td>☐ B.</td>
<td>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):</td>
</tr>
<tr>
<td>☐ 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</td>
<td></td>
</tr>
</tbody>
</table>

**Score:** 1.33

- **Data Source:** DHS 2 at site, sub-national and national level CTC 3 at nation level CTC 2 at site level ECHO sessions National QI forum
- **Notes/Comments:** There has been insufficient capacities at the sub-national levels on the QI implementations, however, the IPs has been critical
<table>
<thead>
<tr>
<th>Decision Making, Policy, or Priority Setting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 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</td>
</tr>
<tr>
<td>☐ 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</td>
</tr>
</tbody>
</table>

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 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 |

9.5 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 |

| The sub-national QM structures: |
| ☐ Provide coordination and support to ensure continuous quality improvement in HIV/AIDS care and services |
| ☐ Regularly convenes meetings that includes health services consumers |
| ☐ Routinely review national, sub-national and clinical outcome data to identify and prioritize areas for improvement |

| The site-level QM structures: |
| ☐ Undertake continuous quality improvement in HIV/AIDS care and services to identify and prioritize areas for improvement |

| Quality Management Score: 6.71 |

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.

| ☐ 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 |

| Data Source |
| National Health Laboratory Strategic Plan 2016-21 |

<p>| Notes/Comments |
| At the national level, the QM does not include the health service consumers in their meetings |</p>
<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Options</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.2</td>
<td>Management and Monitoring of Laboratory Services</td>
<td>- 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.</td>
<td>0.89</td>
</tr>
<tr>
<td>10.3</td>
<td>Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites</td>
<td>- Regulations do not exist to monitor minimum quality of laboratories in the country. - Regulations exist, but are not implemented (0% of laboratories and POCT sites regulated). - Regulations exist, but are minimally implemented (approx. 1-9% of laboratories and POCT sites regulated). - Regulations exist, but are partially implemented (approx. 10-49% of laboratories and POCT sites regulated). - Regulations exist and are mostly implemented (approx. 50-89% of laboratories and POCT sites regulated). - Regulations exist and are fully or almost fully implemented (approx. 90%+ of laboratories and POCT sites regulated).</td>
<td>1.00</td>
</tr>
<tr>
<td>10.4</td>
<td>Capacity of Laboratory Workforce</td>
<td>- There are not adequate qualified laboratory personnel to achieve sustained epidemic control. - There are adequate qualified laboratory personnel to perform the following key functions:  - 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</td>
<td>0.00</td>
</tr>
<tr>
<td>10.5</td>
<td>Viral Load Infrastructure</td>
<td>- No (0%) laboratory services are financed by domestic resources.</td>
<td>1.67</td>
</tr>
</tbody>
</table>
### 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)

- 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.

| Laboratory Score: | 5.42 |

Fao systems strengthening is through donor support.

**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.

#### 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.

<table>
<thead>
<tr>
<th>Fiscal Context for Health and HIV/AIDS</th>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>This section will not be assigned a score, but will provide additional contextual information to complement the questions in Domain C.</td>
<td>Health Budget Brief: Mainland Tanzania 2020</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
<tr>
<td>1. What percentage of general government expenditures goes to health?</td>
<td>7%</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
<tr>
<td>2. What is the per capita health expenditure all sources?</td>
<td>$41</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
<tr>
<td>3. What is the total health care expenditure all sources as a percent of GDP?</td>
<td>4.20%</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
<tr>
<td>4. What percent of total health expenditures is financed by external resources?</td>
<td>33%</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
<tr>
<td>5. What percent of total health expenditures is financed by out of pocket spending net of household contributions to medical schemes/pre-payment schemes?</td>
<td>31%</td>
<td>NHA Draft Report 2020; NHA draft will soon be validated, signing and launch by December</td>
</tr>
</tbody>
</table>

#### 11.1. Domestic Resource Mobilization: 11.1 Score: 0.44

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.
<table>
<thead>
<tr>
<th>Section</th>
<th>Question</th>
<th>Options</th>
<th>Notes</th>
</tr>
</thead>
</table>
| 11.1 Long-term Financing Strategy for HIV/AIDS | Has the host country government developed a long-term financing strategy for HIV/AIDS? | - It covers 26 to 50% of the population.  
- It covers 51 to 75% of the population.  
- It covers more than 75% of the population.  
- 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. | | |
| 11.2 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 | | |
| 11.3 Annual Goals/Targets | To what extent does | 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. | | |

**Score: 11.2**  
**Score: 0.95**  
**Score: 11.3**  
**Score: 0.71**

**Budget Speech 2021/2022**  
**Health sector profile report 2019/2020 NHIF Report?**  
**Prevention services covered by Health Insurance scheme includes treatment of STIs**
the national budget contain HIV/AIDS goals/targets?

- 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.

### 11.4 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)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>There is no HIV/AIDS budget, or information is not available.</td>
</tr>
<tr>
<td>B.</td>
<td>0-49% of budget executed</td>
</tr>
<tr>
<td>C.</td>
<td>50-69% of budget executed</td>
</tr>
<tr>
<td>D.</td>
<td>70-89% of budget executed</td>
</tr>
<tr>
<td>E.</td>
<td>90% or greater of budget executed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>National AIDS Spending Assessment 2021</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00</td>
<td></td>
<td>There was simply a difference in interpretation of the question from 2019 to 2021 and representation in the stakeholders represented.</td>
</tr>
</tbody>
</table>

### 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?

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>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.</td>
</tr>
<tr>
<td>B.</td>
<td>The Ministry of Health or Ministry of Finance routinely collects all donor spending for only HIV/AIDS-specific services.</td>
</tr>
<tr>
<td>C.</td>
<td>The Ministry of Health or Ministry of Finance routinely collects all donor spending all the entire health sector, including HIV/AIDS-specific services.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>National AIDS Spending Assessment 2021</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.95</td>
<td></td>
<td>NHA 2020 (MoHCDGEC) NASA 2021 (TACAIDS/UNAIDS) NHA draft will soon be validated, signing and launch by December</td>
</tr>
</tbody>
</table>

### 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)

<table>
<thead>
<tr>
<th>Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>None (0%) is financed with domestic funding.</td>
</tr>
<tr>
<td>B.</td>
<td>Very little (approx. 1-9%) is financed with domestic funding.</td>
</tr>
<tr>
<td>C.</td>
<td>Some (approx. 10-49%) is financed with domestic funding.</td>
</tr>
<tr>
<td>D.</td>
<td>Most (approx. 50-89%) is financed with domestic funding.</td>
</tr>
<tr>
<td>E.</td>
<td>All or almost all (approx. 90%+) is financed with domestic funding.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Score</th>
<th>National AIDS Spending Assessment 2021</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.83</td>
<td></td>
<td>NASA 2021 The selection does not take into account the GoT contribution above site e.g HR, running costs, infrastructure etc Usually NASA is planned to be conducted after every 2 years, but implementation depends on availability of resources In the past there was considerable private sector support and domestic fund mobilization for HIV/AIDS but coordinated private sector HIV/AIDS mobilization of funds and support no longer exists. For example, AIDS Business Coalition of Tanzania <a href="https://d-nb.info/1097414760/34">https://d-nb.info/1097414760/34</a> and Tripartite Plus Forum for HIV and AIDS <a href="https://www.genderhealth.org/files/p">https://www.genderhealth.org/files/p</a></td>
</tr>
</tbody>
</table>
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

Sector analysis (MoFP) 2019/2020
Public Expenditure Review 2019/2020

11.8 Data-Driven Reprogramming: Do host country government policies/systems allow for reprogramming 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: 0.95

Budget Act 2015
Reprogramming of the budget is being done after every six months and is guided by the law. Budget revision is being guided by data generated from review of the implementation progress but also on any new emerging priorities

Domestic Resource Mobilization Score: 5.48

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)

12.1 Score: 2.00

Investment case 2.0
HSSP V

Investment case 2.0 was used to inform the development of Global Fund NFM-3 grant
### 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.** The host country DOES NOT have a system that routinely produces information on the costs of providing HIV/AIDS services.
  - 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.

- **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 budgeting 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

**12.2 Score:** 0.00

Based on discussion with multiple stakeholders during SID workshop

It was noted that during resource allocation, consideration is usually done and one of the factors that is used to inform resource allocation is the disease burden; however there is no available data to conclude what percentage is allocated based on disease burden.

### 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.** Information not available.

- **B.** No resources (0%) are targeting the highest burden geographic areas.

- **C.** Minimal resources (approx. 1-9%) are targeting the highest burden geographic areas.

- **D.** Some resources (approx. 10-49%) are targeting the highest burden geographic areas.

- **E.** Most resources (approx. 50-89%) are targeting the highest burden geographic areas.

- **F.** All or almost all resources (approx. 90%+) are targeting the highest burden geographic areas.

**12.3 Score:** 0.00

Based on discussion with multiple stakeholders during SID workshop

There is no system that routinely provides costing data, rather individual costing studies supported by partners

There was simply a difference in interpretation of the question from 2019 to 2021 and representation in the stakeholders represented.
12.4 Improving Efficiency: Has the partner country achieved any of the following efficiency improvements through actions taken within the last three years?

- 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.
- Implemented strategic purchasing (e.g. through contracting and payment incentives) to encourage delivery of HIV services in line with population needs
- Improved procurement competition

Integrated HIV/AIDS into national or subnational insurance schemes (private or public – need not be within last three years)

Integrated HIV into primary care services with linkages to specialist care (need not be within last three years)

Integrated TB and HIV services, including ART initiation in TB treatment settings and TB screening and treatment in HIV care settings (need not be within last three years)

Integrated HIV and MCH services, including ART initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings (need not be within last three years)

Developed and implemented other new and more efficient models of HIV service delivery (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?

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.

Technical and Allocative Efficiencies Score: 3.60
### 13. Market Openness: Host country and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.

**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?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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)?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>B. Mandate that only government facilities have the exclusive right to provide any one aspect of HIV prevention, testing, counseling, or treatment services?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>C. Grant exclusive rights to government institutions for providing health service training?</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**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?

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Are health facilities required to obtain a government-mandated license or accreditation in order to provide HIV services? [SELECT ONE]</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>B. Are health training institutions required to obtain a license or accreditation in order to provide health service training? [SELECT ONE]</td>
<td>Yes</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

**Data Source**

- HAPCA 2008, (INCLUDING THE 2020 REVISION)
- HIV POLICY 2001
- Assessment Tool for Health Facilities to provide HIV Care and Treatment services
- GOVERNMENT NOTICE No. 155 published on 10/6/2005
- THE NATIONAL COUNCIL FOR TECHNICAL EDUCATION ACT, 1997 (No. 9 of 1997), REGULATIONS, (Made under Section 11 and 24(1)(g)).
- THE NATIONAL COUNCIL FOR TECHNICAL EDUCATION (REQUIREMENTS TO OFFER DEGREE PROGRAMMES) REGULATIONS, 2005
- GOVERNMENT NOTICE NO.41 published on 18/1/2002
- THE NATIONAL COUNCIL FOR TECHNICAL EDUCATION (ACCREDITATION AND RECOGNITION REGULATIONS, 2001)

**Notes/Comments**

Accrediation of facilities to provide HIV services requires a facility to meet a set of criteria that has been set by MoHCDGEC through NACP. The criteria is uniform and applies to all facilities government vs non government.
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 health service providers to offer the following HIV services:

- Prevention
- Testing and Counseling
- Treatment

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

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 policies restrict the production of HIV commodities and supplies by local manufacturers beyond international standards?

- Yes
- No

13.5 Limits on local manufacturing: Do national government policies limit the ability of the local manufacturers to meet the standards required for the international market?

- Yes
- No
<table>
<thead>
<tr>
<th>Question</th>
<th>Description</th>
<th>Result</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>13.6 Cost of entry/exit:</strong></td>
<td>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies significantly raise the cost of entry or exit by a local provider?</td>
<td></td>
<td>National Guideline for Management of HIV and AIDS</td>
</tr>
<tr>
<td><strong>13.7 Geographical barriers:</strong></td>
<td>Are certain geographical areas restricted to only government or donor-supported HIV service providers?</td>
<td></td>
<td>National Guideline for Management of HIV and AIDS</td>
</tr>
<tr>
<td><strong>13.8 Government policy limits on innovative financing:</strong></td>
<td>Do national government policies limit the use of innovative financing mechanisms (including blended financing deals, social impact bonds, pay for success models, etc.) and market-based/market-shaping solutions as part of the domestic response to HIV/AIDS?</td>
<td></td>
<td>AIDS Trust Fund Resource Mobilization Strategy</td>
</tr>
<tr>
<td><strong>13.9 Donor policy limits on innovative financing:</strong></td>
<td>Do donor policies limit the use of innovative financing mechanisms (including blended financing deals, social impact bonds, pay for success models, etc.) and market-based/market-shaping solutions as part of the domestic response to HIV/AIDS?</td>
<td></td>
<td>The Global Fund Grant Regulations 2014</td>
</tr>
</tbody>
</table>

For which of the following is local manufacturing restricted?

- ARVs
- Test kits
- Laboratory supplies
- Other

The process for pre-qualification usually takes long.
<table>
<thead>
<tr>
<th>13.10 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?</th>
<th>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?</th>
<th>The Global Fund Grant Regulations 2014</th>
<th>13.10 Score: 0.63</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.11 Quality standards for HIV services: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those policies, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY]</th>
<th>Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies, and the enforcement of those policies, hold all HIV service providers (government-run, local private sector, FBOs, etc.) to the same standards of service quality? [CHECK ALL THAT APPLY]</th>
<th>Basic Standard for Health Facilities (4 volumes)</th>
<th>13.11 Score: 0.63</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No, government service providers are held to higher standards than nongovernment service providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No, FBOs/CBOs are held to higher standards than government service providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No, private sector providers are held to higher standards than government service providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.12 Quality standards for HIV commodities: Do national government policies set standards for product quality that provide an advantage to some commodity suppliers over others?</th>
<th>Do national government policies set product quality standards on HIV commodities that advantage some suppliers over others? [IF YES, PLEASE EXPLAIN IN NOTES]</th>
<th>There was simply a difference in interpretation of the question from 2019 to 2021 and representation in the stakeholders represented.</th>
<th>13.12 Score: 0.63</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.13 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)?</th>
<th>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?</th>
<th>Awaiting comments and supporting documents from colleagues in Private sector</th>
<th>13.13 Score: 0.16</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local HIV service providers over others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ No</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13.14 Self-regulation: Do national government or donor (e.g., PEPFAR, GFATM, etc.) policies allow for the creation of a self-regulatory or co-regulatory regime?</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>---</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Does the national government selectively subsidize certain nongovernment (e.g., FBOs, CBOs, or private sector), local health service training institutions over others?</td>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.15 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?</th>
</tr>
</thead>
<tbody>
<tr>
<td>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]:</td>
</tr>
<tr>
<td>- HIV service caseload</td>
</tr>
<tr>
<td>- Procurement of HIV supplies/commodities</td>
</tr>
<tr>
<td>- Expenses</td>
</tr>
<tr>
<td>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]:</td>
</tr>
<tr>
<td>- Distribution</td>
</tr>
<tr>
<td>- Sales/Revenue</td>
</tr>
<tr>
<td>- Production costs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>13.16 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?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Which HIV service providers they use?</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>B. Which HIV supplies/commodities they use (e.g., ARVs, PrEP, condoms, needles, etc.)?</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

Based on discussion with multiple stakeholders during SID workshop.

The Global Fund Grant Regulations 2014  
PEPFAR Five Years Strategic Plan  
National Guideline for the management of HIV and AIDS 2019

When it comes to ARVs and PrEP, the patients cannot decide which ARVs to use, service providers have to adhere to the guidance provided by the national guideline.  
For condoms, from the TMA, there are public sector condoms that are procured centrally, the patients cannot decide which brand to use, but there is also the social marketed condoms which the clients are free to choose whichever brand they wish to use.
<table>
<thead>
<tr>
<th>13.17 Patient mobility: 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?</th>
<th>13.17 Score: 1.25</th>
<th>National Guideline for the management of HIV and AIDS 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Market Openness Score: 9.50</td>
<td></td>
</tr>
</tbody>
</table>

- **Yes**
- **No**
**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 all key populations, PUHIV, HIV incidence, HIV prevalence, viral load and AIDS-related mortality rates.

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>TACAIDS <a href="http://www.tacaids.go.tz/en/goals-objectives-functions/english/about/goals-objectives-functions">http://www.tacaids.go.tz/en/goals-objectives-functions/english/about/goals-objectives-functions</a></td>
<td>Budget reallocations to the various institutions below have not changed from 2019. Supplemental funding is received from development partners, namely PEPFAR and the Global Fund. 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 Framework (NMSF). The health sector response, current priorities and roles and responsibilities are being updated in the THSSP V 2021-2016 (to be completed by December 2021).</td>
</tr>
<tr>
<td>NACP <a href="http://www.nacp.go.tz/site/about/national-aids-control-program-profile">http://www.nacp.go.tz/site/about/national-aids-control-program-profile</a></td>
<td></td>
</tr>
<tr>
<td>THSSP IV <a href="http://www.nacp.go.tz/site/download/HSHSPIV.pdf">http://www.nacp.go.tz/site/download/HSHSPIV.pdf</a></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

- **14.1 Score: 0.56**

<table>
<thead>
<tr>
<th>No, there is no entity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, there is an entity, but it has limited authority, insufficient staff, and insufficient budget.</td>
</tr>
<tr>
<td>Yes, there is an entity with authority and sufficient staff, but not a sufficient budget.</td>
</tr>
<tr>
<td>Yes, there is an entity with authority and sufficient staff and budget.</td>
</tr>
</tbody>
</table>

### 14.2 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of surveys and surveillance activities? Select only ONE answer.

- **14.2 Score: 0.63**

<table>
<thead>
<tr>
<th>A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Surveys &amp; surveillance activities are primarily planned and implemented by external agencies, organizations or institutions</td>
</tr>
<tr>
<td>C. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</td>
</tr>
<tr>
<td>D. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</td>
</tr>
</tbody>
</table>


THSSP IV: [http://www.nacp.go.tz/site/download/HSHSPIV.pdf](http://www.nacp.go.tz/site/download/HSHSPIV.pdf)

NBS leads implementation of General Population Surveys and MoHCDGEC leads health surveillance activities. After NBS implementation of the THSSP 2016/17, with substantial TA from external agencies, TDHS-MIS (2015/16, and MIS (2017), NACP and Muhimbili University also implemented the 2019 Adult Drug Resistance, with Global Fund support. In the time that has followed, technical
14.3 Score: 0.63

Expertise at the government level has continued to improve and the practice of using external substantial technical assistance has decreased as PEPFAR and GOT work together to leverage local expertise in the development and planning on follow up THIS and PHIA surveillance activities.

NACP leads on implementation of key population surveys:
- 2017/2018 IBBS Surveys for KP (FSW, MSM, PWID) - in collaboration with Muhimbili University
- 2019 Key Populations Size estimation activity with NBS and TACAIDS.
- NACP Geographical Mapping and Size estimates for KPS (2017)
- NACP MAT take home dose survey and implementation science (2016 - 2019)

Estimates were prepared taking into account input value of salaries for data collection covered by GOT and inputs to activities in countries supported by external financing.

Need to confirm responses with NACP KP representative.

14.4 Score: 0.83

Tanzania HIV Investment case (analysis of GoT and external support to Tanzania HIV/AIDS response): Domestic contribution to HIV is 8.6%

Need to confirm responses with NACP KP representative.

Previously the '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 climbed just above

<table>
<thead>
<tr>
<th>14.3 Who Leads Key Population Surveys &amp; Surveillance: To what extent does the host country government lead &amp; manage planning and implementation of the HIV/AIDS portfolio of key population epidemiological surveys and/or behavioral surveillance activities (IBSS, size estimation studies, etc.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</td>
</tr>
<tr>
<td>B. Surveys &amp; surveillance activities are mainly planned and implemented by external agencies, organisations or institutions</td>
</tr>
<tr>
<td>C. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with substantial technical assistance from external agencies</td>
</tr>
<tr>
<td>D. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, with some technical assistance from external agencies</td>
</tr>
<tr>
<td>E. Surveys &amp; surveillance activities are planned and implemented by the host country government/other domestic institution, without minimal or no technical assistance from external agencies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14.4 Who Finances General Population Surveys &amp; 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.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. No HIV/AIDS general population surveys or surveillance activities have been conducted within the past 5 years</td>
</tr>
<tr>
<td>B. No financing (0%) is provided by the host country government</td>
</tr>
<tr>
<td>C. Minimal financing (approx. 1-9%) is provided by the host country government</td>
</tr>
<tr>
<td>D. Some financing (approx. 10-49%) is provided by the host country government</td>
</tr>
<tr>
<td>E. Most financing (approx. 50-89%) is provided by the host country government</td>
</tr>
<tr>
<td>F. All or almost all financing (90% +) is provided by the host country government</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>14.5 Who Finances Key Populations Surveys &amp; 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</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. No HIV/AIDS key population surveys or surveillance activities have been conducted within the past 5 years</td>
</tr>
<tr>
<td>B. No financing (0%) is provided by the host country government</td>
</tr>
<tr>
<td>C. Minimal financing (approx. 1-9%) is provided by the host country government</td>
</tr>
</tbody>
</table>
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 survey and IBBS Survey provide prevalence data by fine age disaggregates, sex, key population and sub-national units. (Link)

THIS survey provides incidence by coarse age disaggregates and sex. The time period of 5 years limits the options for studies/surveys focused on key populations. There have been some studies conducted for key populations, but these have not been done on a regular basis. Information on impact survey results should be included here, as these are conducted on a more consistent basis.

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 development, printing of paper-based tools, salaries and transportation for data collection, etc.)?

(If exact or approximate percentage known, please note in Comments column)

- 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

14.7 Score: 0.63

89.9% of PLHIV on treatment are currently being monitored for Viral Load Outcomes according to DHIS2/CTC3 database information

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 finer disaggregates.
### 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.

<table>
<thead>
<tr>
<th>For what proportion of PLHIV does the government collect/report viral load coverage data (select one of the following):</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Less than 25%</td>
</tr>
<tr>
<td>□ 25-50%</td>
</tr>
<tr>
<td>□ 50-75%</td>
</tr>
<tr>
<td>□ More than 75%</td>
</tr>
</tbody>
</table>

**14.8 Score:** 0.73

**2017/2018 IBBS**

- NACP implements both IBBS and size estimation studies covering the FSW, MSM, PWID and Other priority populations (specifically Clients of Sex Workers);
- Transgender and Prisoners are not currently identified in the KVP guidelines.
- Changes in scoring from SID 2019 to SID 2021 are a direct result of modified selections for available size estimation studies for targeted populations; specifically, size estimation studies have not been updated for all priority populations listed (AGYW, Clients of Sex Workers, Military, Mobile Populations and Non Injecting Drug Users), therefore this question was not ticked for this year’s activities.

### 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)?

<table>
<thead>
<tr>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
</tr>
<tr>
<td>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</td>
</tr>
</tbody>
</table>

**14.9 Score:** 0.83

Based on discussion and consensus during the SID workshop

- **NACP** implements both IBBS and size estimation studies covering the FSW, MSM, PWID and Other priority populations (specifically Clients of Sex Workers);
- Transgender and Prisoners are not currently identified in the KVP guidelines.
- Changes in scoring from SID 2019 to SID 2021 are a direct result of modified selections for available size estimation studies for targeted populations; specifically, size estimation studies have not been updated for all priority populations listed (AGYW, Clients of Sex Workers, Military, Mobile Populations and Non Injecting Drug Users), therefore this question was not ticked for this year’s activities.

### 14.10 Quality Assurance:

A. No governance structures, procedures or policies designed to assure surveys & surveillance data quality exist/could be documented.

**14.10 Score:** 0.83

NBS: Tanzania Master Statistical Plan and NBS Quality Assurance Documents (see attached documents)

NBS is responsible for assuring the quality of surveys data.
### 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 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.

<table>
<thead>
<tr>
<th>NIMR IRB/ Ethics Committee protocol:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIMR Act of 1979</td>
</tr>
<tr>
<td>NIMR_RESEARCH_POLICY_REGULATION S_2015</td>
</tr>
</tbody>
</table>

**Epidemiological and Health Data Score:** 6.66

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### 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.

- NASA categories include the following information:
  - (1) funding sources by domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, other
  - (2) expenditures by technical area(s); (3) types/classifications of expenditures; (4) sub-national expenditures.

- Additional information on National Health Accounts activities (previous 2018 results included substantial support from USAID and WHO)

<table>
<thead>
<tr>
<th>Data Source</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>TACAIDS with some external technical assistance from UNAIDS: (see attachments) - 2021 NASA (National AIDS Spending Assessment) Report- 2021 Final - NASA Zanzibar Final report - 20 September 2019</td>
<td>Collection of HIV/AIDS expenditure data occurs using standard tools, including NASA, NHA and planning and implementation is led by the host country government with substantial technical assistance. TACAIDS is responsible for NASA activities and Ministry of Social Planning is responsible for National Health Accounts information.</td>
</tr>
<tr>
<td>National Health Accounts collects HIV/AIDS expenditure data by source, per program area, by type of expenditure and sub-nationally. NHA 2020 Analysis Report- 02.09.2021 TZ Development Partners Group Financial Resource Tracking Information can be found here: <a href="http://www.tzdpg.or.tz/fileadmin/documents/dpg_internal/dpg_working_group">http://www.tzdpg.or.tz/fileadmin/documents/dpg_internal/dpg_working_group</a></td>
<td></td>
</tr>
</tbody>
</table>
### 15.3 Timeliness of Expenditure Data: To what extent are expenditure data collected in a timely way to inform program planning and budgeting decisions?

| Sub-nationally | ☐ A. No HIV/AIDS expenditure data are collected | 15.3 Score: 2.50 | Publicly available information can be found on TACAIDS website: 2018 Public Expenditure review

| | ☐ B. HIV/AIDS expenditure data are collected irregularly, and more than 3 years ago | | Public Expenditure Review, NASA, and NHA activities are used to monitor expenditures in Tanzania. At least one of these activities is implemented every year. Scoring for this question was updated to reflect a better understanding of timing components for available options. At least one collection of expenditure data activity is conducted annually, however, depending on the activity, published data may represent different time frames.

| | ☐ 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 | | |

### 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.

| ☐ A. No system exists for routine collection of HIV/AIDS service delivery data | 16.1 Score: 1.00 | Public Portal Link: https://hmisportal.moh.go.tz/hmisportal/#/pages/home

| | 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 | | HSSP III Review (see attached)

| | ☐ C. One information system, or a harmonized set of complementary information systems, exists and is primarily managed and operated by an external agency/institution | | MTR review for HSSP IV draft report has been prepared (see attached)

| | ☐ 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 | | HSSP IV:


| NACP manages and operates a patient monitoring system, including CTC2 database at facility level and national client level data in CTC3.

| Aggregate data for all services reported into GOT DHIS HMIS System: Public Portal Link: HSSP III Review: MOHSW website: MTR review for HSSP IV draft report has been prepared (IRene to share). HSSP IV: | | |

### Area?
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?

- E. One information system, or a harmonized set of complementary information systems, exists and is managed and operated by the host country government

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.)?

- 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

16.3 Comprehensiveness of Service Delivery Data: To what extent does the routine collection of HIV/AIDS service delivery data (e.g., PMTCT, Adult Care and Support, Adult Treatment) correspond to the HIV progress of PLHIV?

- 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

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16.2 Score: 1.67

2019 Investments Case

The exact percentage of financing covered by GoT is not a straightforward calculation. Many data collection technicians from council level upwards are supported by government, but at facility level, operational costs are also covered by implementing partners (funded through PEPFAR or Global Fund).

16.3 Score: 1.33

HIMIS Portal: https://hmisportal.moh.go.tz/hmisportal

NACP Surveillance Report

The collection of routine mortality data is comparable ICD-10 data. However, cause specific mortality data is connected to the HMIS Directorate. Challenges exist with lab related systems capacity to confirm COD for PLHIV, so data is not readily reliable. ICD-10 code use is not always representative, as a result Government of Tanzania relies on modeling to gather information on AIDS-related mortality. Does the government collect community based data by required disaggregates (site classification)?
16.4 Score: 0.00

Tanzania DHIS2 System
Tanzania CTC3 Database
NACP HTS and KVP reporting is monthly and available within MOH DHIS2/HMIS.

HIV Care and treatment client level data from health facilities is uploaded into the CTC3 database on a weekly basis from Implementing Partners. Data analyses is conducted on a quarterly basis (monthly for certain data points of interest).

16.5 Score: 1.17

Documents:
- HIV Strategic Plan
- Annual HIV Program Report, 2018
- Annual Health Statistical 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 for HIV testing.

Teams also review variations in performance by sub-national unit and utilize created maps from DHIS2 to facilitate geographical analysis.

Continuum of Care Data for Key and Priority Populations: Aggregate data on...

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

16.5 Analysis of Service Delivery Data:
To what extent does the host country government routinely analyze service delivery data to measure program performance?

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

- Standardized CLM indicators are relatively new; UNAIDS is working to develop standard indicators for monitoring of CLM activities.
- Community based reporting is housed under TACAIDS TOMSHA system, which documents community sites’ HIV and AIDS related services.
<table>
<thead>
<tr>
<th>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?</th>
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<tbody>
<tr>
<td></td>
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| 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): |
|---------------------------------------------------------------|
| Cross check for all data sources in FY2019 SID folder, then follow up accordingly. | NACP Data Quality Guidelines (Prosper) |
| M&E Data Quality Review tool (General Health Sector tool covers HIV indicators) (Walter to provide copy) | |
| HIS Policy (E- Gov and HMIS policies publicly available) | |
| HMIS Manual (Prosper) | |
| Auditor report (Data Quality) - M&E | |
| Data Review meetings at national and subnational 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: 6.50
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<tr>
<th>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.</th>
<th>Data Source</th>
<th>Notes/Comments</th>
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<tr>
<td>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?</td>
<td>17.1 Score: 1.00</td>
<td>Publicly available data source not available, so this is based on discussion during the SID workshop. There is a CRVS system that is recording births and deaths. The CRVS system is in place and a method for birth and death registration is available. Currently there is still low coverage for both birth and death registration. For future versions, please break down in more detail and define fully operational. Data from the CRVS system is not available publicly.</td>
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<td>[IF YES] How often is CRVS data updated and made publically available (select only one)?</td>
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<td>☐ A. No, there is not a CRVS system.</td>
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<td>☑ B. Yes, there is a CRVS system that... (check all that apply):</td>
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<td>☐ records births</td>
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<td>☐ is fully operational across the country</td>
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<td>17.2 Unique Identification: Is there a national Unique Identification system that is used to track delivery of HIV/AIDS and other health services?</td>
<td>17.2 Score: 0.00</td>
<td>Based on discussion during the SID workshop. Currently all clients on treatment have a CTC Number that is used to track delivery of HIV/AIDS treatment services. The GoT has developed a National Health Identification 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. GoT has developed the national health client registry, that contains nationally approved identifications standards that uniquely identify health care clients. This</td>
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### 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?

- [x] 17.3 Score: 1.43
  - National Administrative 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.
  - Updated scoring for SID 2021 activity reflect stakeholder interpretation of available options for national administrative data; particularly, we do not have interoperability between HIV/AIDS HIS Systems with Education, Poverty, Employment, or Other (please specify) systems which may have been selected during the 2019 SID Activity.

### 17.4 Census Data

Does the host country government regularly (at least every 10 years) collect and publically disseminate census data?

- [ ] 17.4 Score: 2.00
  - NBS link to Census data:
  - GOT regularly collects census data and makes it available 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

Data for Decision-Making Ecosystem Score: 6.43

National Health Facility Registry: http://moh.go.tz/hfrportal/
May 2021 Service Delivery Report

Postal codes are not available all over the country. But we may have information at facility level; coverage may not be 100% but we should have sufficient coverage.

THIS CONCLUDES THE SET OF QUESTIONS ON DOMAIN D