



UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN

NATIONAL AIDS CONTROL PROGRAMME



MONITORING AND EVALUATION (M&E) PLAN

Health Sector HIV & AIDS Strategic Plan 2017–2022
(HSHSP IV)

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TR-18-302

FOREWORD

The Tanzania HIV Impact Survey (THIS), 2016–2017 (THIS, 2017), showed adult HIV prevalence of 4.7 percent compared to 5.1 percent in 2012. However, even with this decline, the study found that nine out of the 26 regions in the country had HIV prevalence above the national average. Moreover, the study showed a higher HIV prevalence in urban (7.5%) than in rural areas (4.5%) and among women (6.2%) than men (3.1%). Against this background, the Fourth Health Sector HIV and AIDS Strategic Plan, 2017 –2022 (HSHSP IV) has been developed with the aim of fast-tracking combination prevention strategies to reduce HIV incidence and eliminate the AIDS epidemic as a public health threat by 2030. The goals of HSHSP IV are to be met through the implementation of the “maximum coverage technical efficiencies” scenario, which matches the country’s epidemiology and current funding landscape. The scenario entails the maximisation of efforts and coverage of HIV prevention and treatment services, with a focus on key and vulnerable populations.

This Health Sector HIV and AIDS Monitoring & Evaluation Plan 2017–2022 (HSHSP IV M&E Plan) has been developed to guide stakeholders on how to monitor and evaluate implementation of the HSHSP IV and determine whether its goals and objectives are being met. The guidance includes definition of indicators for the measurement of expected results (impact, outcomes and outputs), sources of data, frequency of data collection, baseline level, and targets for each indicator and institutions that are responsible for collecting and reporting the data.

The HSHSP IV has 75 indicators in total. The number of indicators by the five strategic areas defined in the strategic plan is as follows: (1) HIV testing services – 4 indicators; (2) HIV prevention services – 15 indicators; (3) treatment, care, and support for PLHIV – 21 indicators; (4) health system strengthening – 26 indicators; and (5) crosscutting interventions – 9 indicators. Seven indicators are identified as core HSHSP IV indicators. The M&E plan underscores the importance of using standard national data collection and reporting tools.

An M&E plan that is not implemented is meaningless. Effective implementation of this M&E plan will provide strategic information for planning and decision-making purposes, including any necessary course correction measures required for the attainment of the “triple 90” global goals, through which 90 percent of people living with HIV will know their status; 90 percent of all people diagnosed with HIV will be enrolled in antiretroviral therapy (ART); and 90 percent of all people receiving ART will attain sustainable viral suppression by the year 2020. All stakeholders, including the National AIDS Control Programme officials and other government officials responsible for planning and implementation of HIV prevention programs, regional and council health management teams, healthcare providers, and national and international nongovernmental organizations supporting HIV interventions are called upon to contribute to the data collection, analysis, dissemination, and use efforts as defined in this plan.

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- Tanzania Commission for AIDS (TACAIDS)
- United States Centers for Disease Control, Tanzania (CDC)
- United States Department of Defense (DOD)
- Henry M. Jackson Foundation Medical Research International (HJFMRI)/U.S. Military HIV Research Program (MHRP)
- HIV & AIDS implementing partners, including but not limited to Tanzania Health Promotion Support (THPS), ICAP Tanzania, Jhpiego, and Management and Development for Health

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Any feedback from experiences in implementing this M&E plan should be channelled to the NACP.

Dr. Leonard Subi

Director for Preventive Services

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ABBREVIATIONS

ADR	adverse drug reaction
AE	adverse event
AGYW	adolescent girls and young women
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral medicine
CBHS	community-based health services
CHMT	council health management team
CTC	care, treatment, and support
DBS	dried blood spot
DNA-PCR	deoxyribonucleic acid polymerase chain reaction test
DQA	data quality assessments
EID	early infant diagnosis
eMTCT	elimination of mother-to-child transmission of HIV
FBO	faith-based organisation
FSW	female sex workers
GARP	UNAIDS Global AIDS Response Reporting
GBV	gender-based violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBC	home-based care
HC	health centres
HIS	health information system
HIV	human immunodeficiency virus
HMIS	Health Management Information System
HMT	Health Management Teams
HRHIS	Human Resource for Health Information System
HS	health sector
HSHSP III	Third Health Sector HIV and AIDS Strategic Plan, 2013–2017
HSHSP IV	Fourth Health Sector HIV and AIDS Strategic Plan, 2018–2022
HSSP IV	Fourth Health Sector Strategic Plan, 2015–2020

HTC	HIV testing and counselling
HTS	HIV testing services
HVL	HIV viral load
IBBSS	integrated biological and behavioural surveillance survey
IP	implementing partner
IPC	infection prevention and control
IPT	Isoniazid Preventive Therapy
ISO	International Organization for Standardization
JAPR	Joint Annual Programme Review
KP	key population
KVP	key and vulnerable population
LEEP	Loop Electrosurgical Excision Procedure
LIS	Laboratory Information System
LTFU	loss to follow-up
M&E	monitoring and evaluation
MER	monitoring, evaluation, and reporting
MESI	M&E Strengthening Initiative
MOHC DGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSM	men who have sex with men
MTCT	mother-to-child transmission of HIV
NACP	National AIDS Control Programme
NBS	National Bureau of Statistics
NBTS	National Blood Transfusion Services
NCD	noncommunicable disease
NGI	PEPFAR's Next Generation Indicators
NGOs	nongovernmental organisations
NHLQATC	National HIV Laboratory Quality Assurance and Training Centre
NMSF III	Tanzania Third National Multi-Sectoral Strategic Framework for HIV and AIDS 2013/2014–2017/2018
OI	opportunistic infections
OPD	outpatient department
OVC	orphans and vulnerable children
PEPFAR	United States President's Emergency Plan for AIDS Relief

PLHIV	people living with HIV
PO-RALG	President's Office-Regional Administration and Local Government
PMTCT	prevention of mother-to-child transmission of HIV
PO-PSM	President's Office-Public Services Management
PPM	planned preventive maintenance
PrEP	pre-exposure prophylaxis
PWID	people who inject drugs
PWUD	people who use drugs
QI	quality improvement
RCH	reproductive and child health
RHMT	regional health management team
RMO	Regional Medical Officer
RTI	reproductive tract infection
SA	strategic area
SLIPTA	Stepwise Laboratory Improvement Process towards Accreditation
SLMTA	Strengthening of Laboratory Management towards Accreditation
SO	strategic outcome
SOP	standard operating procedures
SPD	Sentinel Panel of Districts
STI	sexually transmitted infections
TACAIDS	Tanzania Commission for AIDS
TB	Tuberculosis
TBD	to be decided
TDHS	Tanzania Demographic and Health Survey
TFDA	Tanzania Food and Drug Authority
THIS	Tanzania HIV Impact Survey
THMIS	Tanzania HIV/AIDS and Malaria Indicator Survey
TrainSMART	training system monitoring and reporting tool
TSPA	Tanzania Service Provision Assessment
TTI	transfusion-transmitted infection
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development

VIA	visual inspection with acetic acid
VMMC	voluntary male medical circumcision
WHO	World Health Organization
WHO/AFRO	World Health Organization/Regional Office for Africa

1. BACKGROUND

This chapter presents an overview of the HIV and AIDS situation in Tanzania and the Tanzania Fourth Health Sector HIV/AIDS Strategic Plan, 2017–2022 (HSHSP IV), which provides the context for the monitoring and evaluation (M&E) plan. The HSHSP IV seeks to lead Tanzania towards the attainment of the “triple 90” global goals, through which 90 percent of people living with HIV will know their status; 90 percent of all people diagnosed with HIV will be enrolled in antiretroviral therapy (ART); and 90 percent of all people receiving ART will attain sustainable viral suppression by the year 2020.

1.1. HIV and AIDS in Tanzania

1.1.1. HIV Prevalence

HIV prevalence has steadily declined over the past decade, from 7 percent in 2003 to 4.7 percent in 2016.¹ HIV prevalence in Tanzania is characterized by significant heterogeneity across age, gender, socioeconomic status, and geographic location, which implies differentials in the risk of transmission. The current HIV prevalence ranges from less than 1 percent in Lindi to 11.4 percent in the Njombe Region.

The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that in 2015 there were 1,400,000 people living with HIV (PLHIV) in Tanzania. Of this number, 120,000 were children below age 15 and 750,000 were women ages 15 or over. The Tanzania HIV Impact Survey (THIS), 2016–2017 (THIS, 2017) shows that HIV prevalence in women ages 15–49 is twice that in men of the same age. The prevalence of HIV is less than 2 percent amongst those ages of 15–19 years for both males and females; it then increases with age for both sexes. The age disparities in new HIV infections suggest an increase in numbers of new infections amongst younger populations. The general age structure of the population demonstrates that 63 percent of the population is age 24 and younger. This fact highlights the need to improve prevention and treatment amongst younger populations to ensure the health and productivity of the future adult population.

UNAIDS and partners developed the AIDS Impact Module using Spectrum software to assist countries in monitoring their HIV epidemics. This software uses HIV surveillance, survey, and programme data, combined with demographic data, to generate historical trends and short-term projections of key indicators. These indicators, including the number of people living with HIV, the number of new infections, the number of pregnant women infected with HIV, mortality due to AIDS, and treatment coverage, are useful in assessing epidemic trends and the overall impact of the AIDS response, and in planning for future healthcare services and pharmaceutical needs.

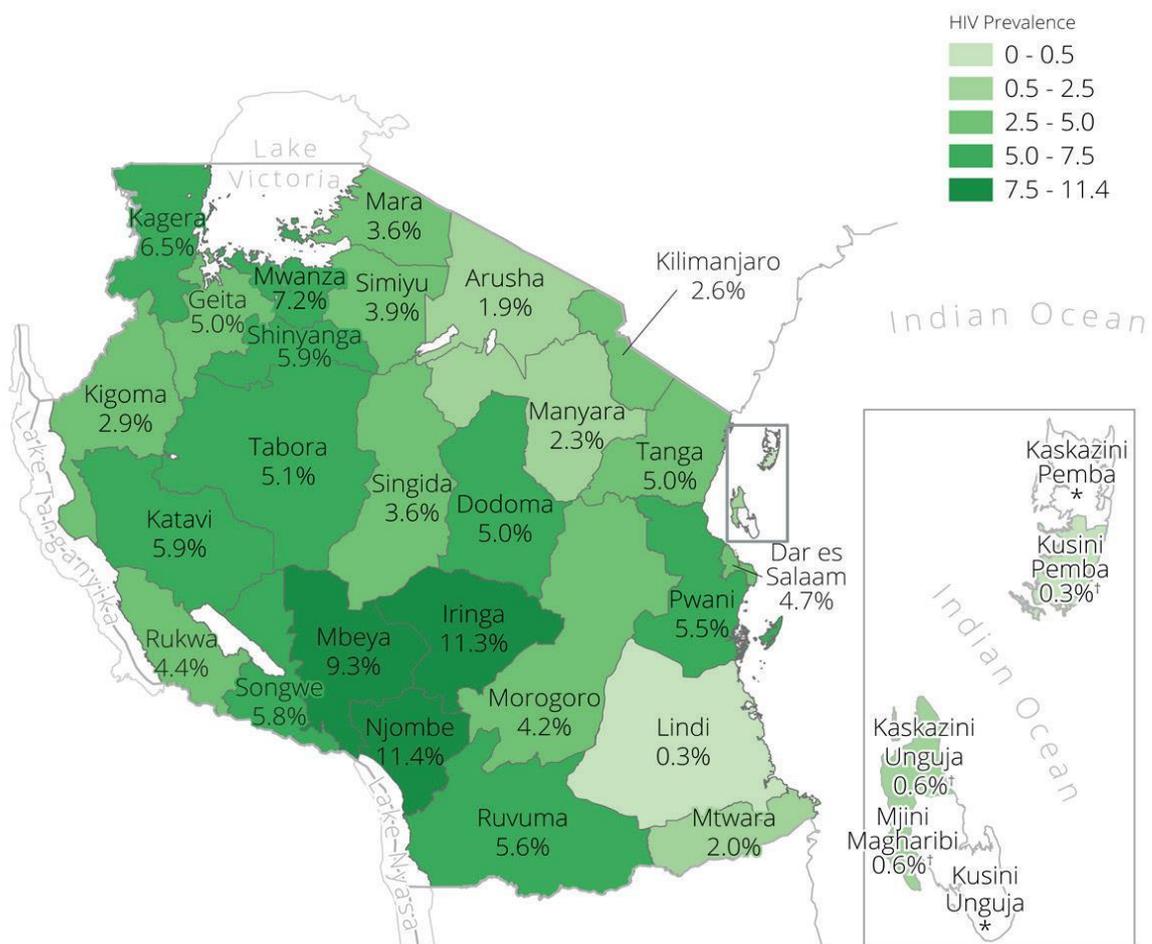
The 2015 AIDS Impact Module estimates indicate that the mother-to-child transmission (MTCT) of HIV rate had decreased to 7.6 percent at the end of breastfeeding. Available data suggest that HIV infection rates begin to rise much earlier in girls than boys, and these differences persist until much later in adulthood. Given the epidemiologic evidence of their early and heightened vulnerability, addressing sexual health services and age-tailored HIV prevention for adolescent girls is a priority.

¹National Bureau of Statistics. (2017). Tanzania HIV Impact Survey (THIS), 2016–2017.

1.1.2. Geographic Heterogeneity of the HIV Epidemic

Mainland Tanzania is demarcated into 26 administrative regions, of which 9 show HIV prevalence above the national average, according to the THIS 2016–2017 study. In general, HIV prevalence is higher in urban (7.5%) than in rural areas (4.5%). The Njombe Region has the highest HIV prevalence estimate (11.4%), followed by Iringa (11.3%) and Mbeya (9.3%). The Lindi Region has the lowest HIV prevalence, at less than 1 percent. There is also evidence from programme data of marked heterogeneity amongst the constituent districts of the regions. Specifically, some high prevalence districts and hotspots have been identified within regions that formerly had relatively low HIV prevalence. Figure 1 depicts regional HIV prevalence estimates based on the THIS 2016–2017 study.

Figure 1. HIV prevalence amongst adults by region, THIS 2016–2017



1.1.3. Sources of New Infections and Risk Factors

The 2014 Modes of HIV Transmission (MOT) study in Tanzania mainland showed that the majority of new infections in Tanzania occur in the context of stable heterosexual relationships (38.8%) and casual heterosexual sex (28.9%). The other sources of infection are clients of sex workers (8.7%),

partners of people engaged in casual sex (7.6%), men who have sex with men (MSM) (6.8%), partners of sex worker clients (3.3%), people who inject drugs (PWID) (2.1%), and sex workers (1.3%). To significantly reduce HIV incidence, interventions are being targeted towards the major sources of new infections—heterosexual relationships, casual heterosexual sex, clients of sex workers, and MSM.

Tanzania has not yet conducted a nationally representative integrated biological and behavioural surveillance survey (IBBSS) to estimate the prevalence of HIV and the size of key and vulnerable populations (KVPs). However, there is a national consensus report that provides national estimates and prevalence for female sex workers (FSWs), MSM, and PWID.² To more accurately gauge the proportionate burden of different KVP groups, there is a need to conduct national mapping and population size estimations for KVPs.

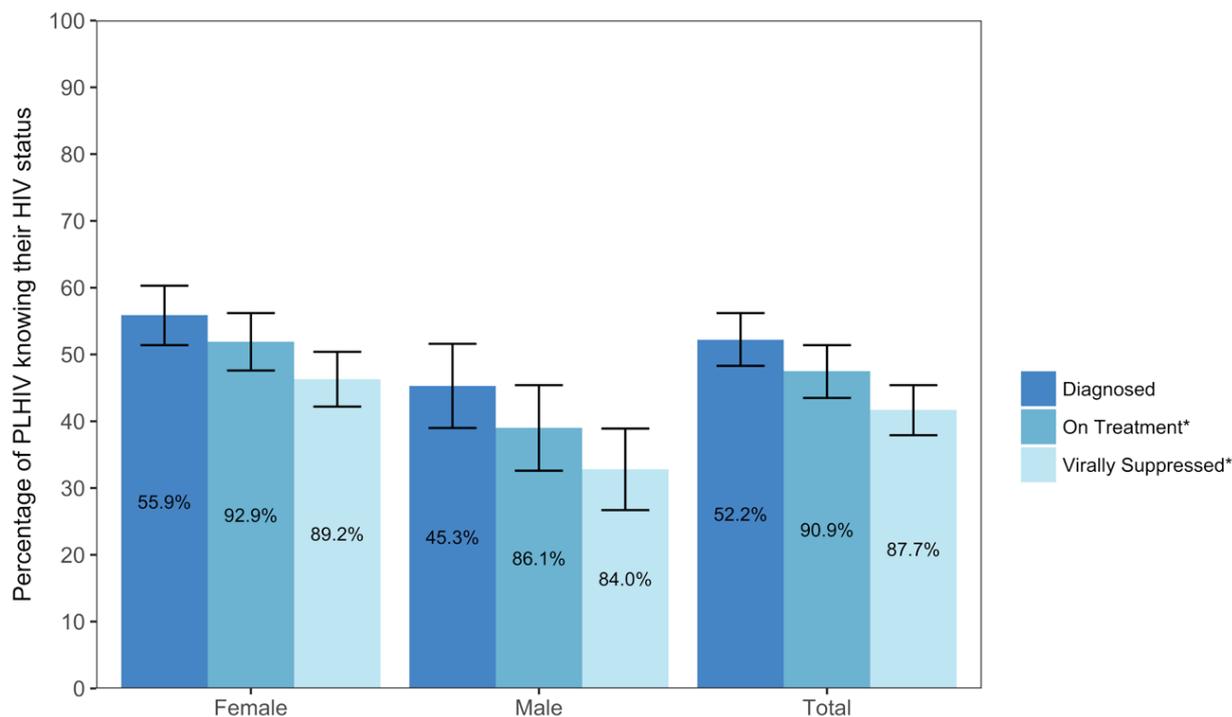
1.1.4. The Fast Track 90-90-90 Amongst People Living with HIV

Achievement of the fast track 90-90-90 goals amongst PLHIV is an ambitious target aimed at helping to end the AIDS epidemic. It is anticipated that by 2020, 90 percent of all PLHIV will know their HIV status; 90 percent of all people diagnosed with HIV will receive sustained ART; and 90 percent of all people receiving ART will attain sustainable viral suppression.

In Tanzania, 52.2 percent of PLHIV ages 15 to 64 years (55.9 and 45.3 percent amongst females and males, respectively) know their HIV status. Amongst PLHIV ages 15 to 64 who know their HIV status, 90.9 percent (92.9 and 86.1 percent amongst females and males, respectively) self-report their current use of ART. Amongst PLHIV ages 15 to 64 who self-report current use of ART, 87.7 percent (89.2 and 84.0 percent amongst females and males, respectively) are virally suppressed, based on the THIS 2016–2017 study (see Figure 2).

² National AIDS Control Programme (NACP). (2014, July). *Consensus estimates on key population size and HIV prevalence in Tanzania*.

Figure 2. Performance against the 90-90-90 goals amongst people living with HIV in Tanzania, THIS 2016–2017



Viral load suppression among HIV-positive individuals in Tanzania is highest amongst older adults, with 64 and 62 percent of females and males ages 55 to 64, respectively, virally suppressed. The corresponding estimates are 59 percent and 36 percent amongst females and males ages 15–54, respectively. Gender disparity in viral load suppression is greater amongst younger adults, with 51 percent of females ages 25 to 34 virally suppressed, compared to 26 percent of men in the same age group. Amongst HIV-positive adults ages 15 and older, viral load suppression varies geographically across Tanzania, ranging from 67 percent in Kagera and Kilimanjaro to 40 percent in Shinyanga and 29 percent in Arusha (THIS, 2016–2017).

1.2. The Health Sector Strategic Plan, July 2015–June 2020 (HSSP IV)

The current National HIV response is guided by the Fourth Health Sector Strategic Plan, 2015–2020 (HSSP IV) and the Fourth Health Sector HIV and AIDS Strategic Plan, 2017–2022 (HSHSP IV). The health and social welfare sector follows the overall Tanzania Development Vision 2025, which seeks to transform Tanzania into a middle-income country status, characterised by a high-quality livelihood, amongst other attributes, by 2025. Derived from this overall vision, the vision of the health and social welfare sector is “to have a healthy society with improved social wellbeing that will contribute effectively to individual and national development.”

1.2.1. Mission

The mission of the health and social welfare sector is “the provision of basic health and social welfare services that are of good quality, equitable, accessible, affordable, sustainable, and gender sensitive.”

1.2.2. Overall and Specific Objectives

The overall objective of HSSP IV is to reach all households with essential health and social welfare services, meeting as much as possible expectations of the population and objective quality standards, and applying evidence and efficient channels of service delivery.

The specific objectives of HSSP IV are as follows:

1. Achieve objectively measurable quality improvement (QI) of primary healthcare services, delivering a package of essential services in communities and health facilities
2. Improve equitable access to services in the country by focusing on geographic areas with higher disease burdens and on vulnerable groups in the populations with higher risk
3. Achieve active community partnership through intensified interactions with the population for improvement of health and social well-being
4. Achieve a higher rate of return on investment by applying modern management methods and innovative partnerships

To improve the social determinants affecting health and welfare, the health and social welfare sector will achieve close collaboration with other sectors and advocate for inclusion of health promoting and health protecting measures in other sectors' policies and strategies. The health sector will mobilise nongovernmental and private partners to promote health and well-being through their strategies.

1.3. The Fourth Health Sector HIV and AIDS Strategic Plan, 2017–2022 (HSHSP IV)

The HSHSP IV is geared to fast tracking combination prevention strategies to reduce HIV incidence and eliminate the AIDS epidemic as a public health threat by 2030. In implementing HSHSP IV, Tanzania has chosen the “maximum coverage technical efficiencies” scenario, which matches the country’s epidemiology and current funding landscape. The scenario entails the maximisation of efforts and coverage of HIV prevention and treatment services, with a focus on KVPs. This strategy is expected to accelerate progress towards attaining the global sustainable development goals (SDGs)—specifically, SDG 3, which aims to end the epidemics of AIDS, tuberculosis (TB), malaria, and neglected tropical diseases, and combat hepatitis, water-borne diseases, and other communicable diseases by 2030. The HSSP IV provides guidance for the mission and goals of all health sector interventions, including the national health sector HIV response.

1.3.1. Vision

The vision of HSHSP IV is an HIV-free society in which new infections are halted and people living with HIV or affected by HIV and AIDS receive quality services and support.

1.3.2. Mission

The mission of HSHSP IV is to provide a results-oriented framework to lead and guide the decentralised health sector HIV response in the intensification, optimisation, and scaling up of quality evidence-based interventions for HIV prevention, care, treatment, and support services for PLHIV to facilitate the attainment of the “triple 90” targets in Tanzania.

1.3.3. Goal

The goal of the HSHSP IV is to increase the coverage of HIV and AIDS services in the general population and subpopulations to ensure the following by 2020:

- Universal access is available to combination prevention services designed to reduce new HIV infections, HIV-related mortality, and stigma and discrimination
- 90 percent of people living with HIV will know their status
- 90 percent of all people diagnosed with HIV are enrolled, followed up on, and in receipt of timely and efficacious ART
- 90 percent of all people receiving ART will attain sustainable viral suppression
- The capacity of the health system is strengthened to support quality HIV and AIDS interventions, and foster integration within the health sector

1.4. Health Sector HIV and AIDS Priority Interventions

The HSHSP IV interventions are grouped into five strategic areas: (1) HIV testing services (HTS); (2) HIV prevention services; (3) treatment, care, and support for PLHIV; (4) health system strengthening (HSS); and (5) crosscutting interventions. In the previous strategic plans, HIV testing and counselling was part of HIV prevention. However, with the new focus on a “Treat All” approach, HTS is regarded as an entry point for treatment, care, and support services for PLHIV and thus considered as a strategic area on its own. This section highlights each strategic area, describing the current situation and priority strategies. Each strategic area has corresponding strategic objectives and indicators, summarized in Appendix 1.

1.4.1. HIV Testing Services

HTS are provided through a mix of modalities, including client-initiated HIV testing and counselling (CITC) and provider-initiated testing and counselling (PITC) provided within health facilities and community settings. In 2016, 7.4 million individuals were tested for HIV, an increase from the 2.5 million recorded in 2014. The annual target for 2016 was nearly 5.5 million tests. According to a 2012 study, the proportion of people who had been tested for HIV and received test results in Mainland Tanzania was 62 and 47 percent amongst women and men, respectively (THMIS, 2012). By end of 2016, about 63 percent of PLHIV (the minimum number who knew their status) in Tanzania were already enrolled in ART care. Some of the gaps and challenges observed in implementing HTS activities include (1) recurrent stockouts of HIV rapid test kits; (2) an inadequate health workforce for maximum coverage of HIV testing according to set standards; (3) low uptake of HTS amongst adolescents, children, and men; and (4) poor data collection systems. Amongst the strategies in the HSHSP IV to improve HTS are (1) intensification of existing and identification of new alternative service delivery models, such as the scale-up of HTS in regions with high HIV prevalence and incidence and low knowledge of HIV status; (2) scale-up of targeted HIV testing, including index client HIV testing (at facility and community levels), community home-based HTS, and mobile HTS that targets hotspots, prisons, orphanages, and selected workplaces; and (3) improved monitoring of HTS.

1.4.2. HIV Prevention Services

HIV prevention services under the HSHSP IV are focused on averting new HIV infections. In implementing the HSHSP IV, Tanzania recognizes the need to balance both HIV prevention and treatment efforts, because although treatment is considered part of prevention as a result of its overarching impact in reducing viral load and thus transmission, effective prevention interventions are at least equally if not more important. HSHSP IV seeks to intensify prevention interventions with particular focus on condom programming; male circumcision; and programmes for KVPs, including adolescent girls and young women (AGYW).

1.4.3. Decentralised and Integrated HIV and AIDS Care, Treatment, and Support Services

Access to ART and other care, treatment, and support (CTC) services (comprehensive HIV care) has improved the health and well-being of PLHIV by reducing both mortality and morbidity associated with HIV. The number of PLHIV accessing CTC services has continued to increase, and the majority will be on ART going forward. With the adoption of a “Treat All” approach, facilities and health systems will be faced with increased numbers of PLHIV seeking care, and with different needs. The HSHSP IV emphasises strengthening the linkage of HIV testing services to care for all HIV-positive individuals. This goal is to be addressed through early treatment initiation and adherence to treatment amongst children, adolescents, and young women and adults.

1.4.4. Building Resilient and Sustainable Systems for Health to Support the National Response

Over the years, Tanzania has made progress towards universal access to HIV and AIDS services provided through community- and health facility-based interventions. In health facilities, these services are provided through CTC services and reproductive and child health (RCH) clinics (Option B+ for pregnant women). The number of health facilities providing ART services has increased from 1,176 out of 6,342 (18%) in 2012 to 6,155 out of 7,494 (82%) by December 2016. Strong and resilient community and health systems are needed to support a sustainable national response to HIV and AIDS. In strengthening health systems, HIV-related infrastructure, service delivery, logistics systems, and human resource capacities need to be built into the national programme and not dealt with in isolation. The HSHSP IV will continue to support the improvement and strengthening of the health system infrastructure within the World Health organization (WHO) health system framework, which recognizes the influence of human resources for health (HRH), health information systems (HIS), medicines and technologies, health financing, and leadership and governance on the ability to deliver quality health services.

1.4.5. Cross-Sector HIV and AIDS Interventions and Other Innovative Investments

Reduction of stigma and discrimination are core elements in the national HIV/AIDS response. The scale-up of care and treatment services has enabled individuals to return to normal lives and contribute to family and national income while partly addressing stigma associated with chronic illness and disability amongst PLHIV. However, there is still a need for more strategic approaches in addressing HIV stigma and discrimination to improve access to health services because there is a close link between stigma and poor adherence to and retention in ART care. The HSHSP IV highlights the importance of addressing legal, social, and policy environmental

factors that contribute to stigma and discrimination, and impede efforts aimed at gender-based violence (GBV) prevention.

1.5. Purpose of the M&E Plan

To determine the extent to which HSHSP IV results are being achieved, there is need for systematic collection of data on the various strategies being applied and services provided. The purpose of this M&E plan is to provide guidance for tracking health sector HIV/AIDS programmes and outcomes as per the HSHSP IV. This M&E plan guides stakeholders on how to monitor and evaluate implementation of the HSHSP IV, and determine whether its goals and objectives are being met. The guidance includes definition of indicators for the measurement of expected results (impact, outcomes, and outputs), sources of data, frequency of data collection, baseline level and targets for each indicator, and institutions responsible for collecting and reporting the data.

1.6. Process for the Development of the M&E Plan

The M&E plan was developed through a consultative process. Its development was coordinated by the National AIDS Control Programme (NACP), with technical support from MEASURE Evaluation Tanzania. The specific processes involved were as follows:

Step 1: MEASURE Evaluation, jointly with NACP, conducted a desk review of key documents that included HSHSP IV and global HIV M&E reference documents, such as PEPFAR 3.0, United Nations General Assembly Special Session (UNGASS) on HIV/AIDS indicators, UNAIDS Global AIDS monitoring indicators, Global Fund (GF) M&E guidelines, and WHO strategic information guidelines for HIV in the health sector. This desk review assisted in the identification of appropriate indicators for monitoring and evaluating HSHSP IV's performance, which were written up in the first draft of the M&E plan.

Step 2: A five-day workshop was conducted with NACP and other stakeholders to review the draft indicators for the M&E plan. This review workshop entailed the following tasks:

- a. Review of the HSHSP IV and identification of indicators (impact, outcome, output, process, and targets) provided in the document, and gaps in indicators for any of the identified programme strategies/areas
- b. Review of definitions for all the indicators, ensuring their alignment with definitions in key national and global M&E reference documents
- c. Review of all data sources and availability of appropriate data collection tools
- d. Setting of baseline levels and targets for each indicator

Step 3: MEASURE Evaluation Tanzania worked with a small taskforce comprising staff from NACP and other implementing partners (IPs) to incorporate inputs from the review workshop into advanced drafts and the final version of the M&E plan.

1.7. Target Audience

The target audience for this M&E plan includes the following:

- National AIDS programme officers
- Government officials responsible for planning and implementation of HIV prevention programmes

- Regional health management teams (RHMTs), council health management teams (CHMTs), and health facilities implementing the HIV/AIDS interventions
- Development partners
- Other key stakeholders from nongovernmental organisations (NGOs) and academic institutions
- Healthcare providers
- Other organisations responsible for planning and implementation of HIV prevention and treatment services

1.8. Organisation of the M&E Plan

This M&E plan is organised into eight chapters, beginning with this introductory chapter. Chapter 2 presents the goal and objectives of the M&E plan, M&E framework, health sector M&E system, and HSHSP IV outcome targets. Chapter 3 outlines the national health sector HIV/AIDS M&E framework, including performance indicators to be measured by multiple stakeholders. Chapter 4 discusses health sector M&E capacity. Chapter 5 describes the M&E data collection strategy, including coordination of data collection, data flow, reporting, and management. Chapter 6 outlines stakeholder roles and responsibilities in the implementation of the M&E plan, and Chapter 7 discusses strategies for promoting data use and dissemination. Chapter 8 concludes with strategies for monitoring and evaluating the implementation of the M&E plan.

2. GOAL AND OBJECTIVES OF THE M&E PLAN

2.1. Introduction

The NACP is mandated to coordinate the national health sector response to the HIV/AIDS epidemic within the national multisectoral HIV coordination structure led by the Tanzania Commission for AIDS (TACAIDS). Ensuring a functional M&E system is in keeping with the internationally accepted “Three Ones” principles to better coordinate the national HIV/AIDS response. The “Three Ones” principles are as follows:

1. One agreed national coordinating authority to steer the multisectoral response
2. One agreed-upon national strategic framework
3. One agreed-upon national M&E framework

In line with these principles, this M&E plan advocates for a harmonised M&E framework, system, and reporting process.

2.2. Goal

The goal of the health sector HIV/AIDS M&E plan is to facilitate the collection of essential data of high quality and promote an environment of data sharing and use for improved outcomes within the health sector’s HIV/AIDS response.

2.3. Objectives

The specific objectives of the M&E plan are as follows:

- Provide guidance on gathering and reporting data essential for monitoring and evaluating the implementation of the HSHSP IV
- Strengthen the national HIV/AIDS health sector M&E system
- Improve the availability and use of routine HIV/AIDS data in decision-making processes
- Strengthen partnerships and coordination for M&E at national and subnational levels

3. THE HEALTH SECTOR HIV AND AIDS M&E FRAMEWORK

This chapter describes the M&E results pathway and presents the HSHSP IV results framework and a summary of impact and outcome performance indicators for the HSHSP IV.

3.1. M&E Results Pathway

M&E is concerned with the efficiency, effectiveness, and impact of interventions. **Efficiency** focuses on the application of resources (people, money, skills, and time) to achieve programme goals and objectives. **Effectiveness** is concerned with the extent to which programme activities bring about desired changes in the lives of the people and communities targeted. **Impact** relates to the long-term programme results from a concerted response to a problem.

Monitoring is the routine or regular assessment of ongoing activities and progress being made in a programme or project. Evaluation, in contrast, is the episodic assessment of overall achievements and the extent to which they can be attributed to specific interventions. Monitoring looks at what is being done, whereas evaluation examines what has been achieved (UNAIDS, 2002). Evaluation draws from data generated by the monitoring system and links this information to the primary beneficiaries to determine the impact of programmes. Monitoring should be integrated within the programme management system.

An M&E framework is designed to help provide data or evidence that programme activities are meeting the objectives of efficiency and effectiveness, and contributing to impact. The common M&E framework considers developmental change as a chain of interrelated components consisting of inputs, processes, outputs, outcomes, and impacts.

Inputs are the people, training, equipment, and resources put into a programme to achieve the delivery of services.

Processes are the activities or services delivered, including HIV/AIDS prevention, care, and support services, to either improve the well-being of beneficiaries or change their behaviours.

Outputs are immediate results of the processes—for example, the number of trained staff or stock levels of essential drugs and commodities.

Outcomes are changes in behaviour or skills, especially safer HIV prevention practices and increased ability to cope with HIV/AIDS.

Impact relates to the long-term programme results—for example, reduced new HIV infections or the improved well-being of people living with HIV.

Inputs are transformed into outputs through activities undertaken or services delivered. The transformation of inputs into outputs entails a process which requires attention to quality, unit costs, access, and coverage of services. M&E focusing on inputs, the process of their transformation, and outputs is also referred to as “process monitoring,” in contrast to outcomes/effectiveness and impact evaluation. Effectiveness or outcomes and impact evaluations often require targeted studies conducted at the start of a programme and repeated after a considerable period of programme implementation, usually with a control or comparison group. An outcomes evaluation or assessment seeks to determine whether, and by how much, programme activities are achieving their intended effects in the target population. Impact evaluation seeks to determine the magnitude of change that can reliably be attributed to a programme intervention. Figure 3 depicts the M&E results pathway.

Table 1. HSHSP IV results framework

<p style="text-align: center;">Goal</p> <p>Increase coverage of HIV and AIDS services in the general population and subpopulations to ensure the following by 2020:</p> <ol style="list-style-type: none"> 1. There will be universal access to combination prevention services designed to reduce new HIV infections, HIV-related mortality, and stigma and discrimination 2. 90% of people living with HIV will know their status 3. 90% of all people diagnosed with HIV will be enrolled, followed up, and receive timely and efficacious highly active antiretroviral therapy 4. 90% of all people receiving ART will attain sustainable viral suppression 5. The capacity of the health system is strengthened to support quality HIV/AIDS interventions and foster integration within the health sector 				
Strategic Area (SA) 1: HIV testing services	SA 2: Prevention of new HIV infections	SA 3: Facility-based care and support for PLHIV	SA 4: Building resilient and sustainable systems for health to support the national response	SA 5: Cross-sector HIV/AIDS interventions and other innovative investments
Strategic Outcome (SO) 1.1: 90% of people living with HIV are aware of their status by 2022	SO 2.1: 85% of women and men engaged in multiple sexual partnerships report use of a condom at last sexual intercourse	SO 3.1: By 2022, 95% of all adults (>15) diagnosed with HIV will be on ART	SO 4.1: RHMTs, CHMTs, and health facilities have active QI teams that oversee the implementation, documentation, and reporting of quantitative data on the quality of HIV/AIDS services	SO 5.1: Proportion of PLHIV who report experiencing stigma and discrimination from healthcare providers reduced from 40% to zero by 2022
SO 1.2: All people (100%) who are identified to be HIV positive during community and facility HTS are linked to HTS services by 2022	SO 2.2: Increased access and use of HIV services by KVP	SO 3.2: All children under 15 years initiated and 90% retained on ART by 2022	SO 4.2: Uninterrupted supply of medicines and commodities for sexually transmitted infections (STIs)/reproductive tract infections (RTIs), HIV, and AIDS at all levels by 2022	SO 5.2: The adoption of safer sexual practices
	SO 2.3: 90% male circumcision rate attained by all regions by 2022	SO 3.3: Reduction of MTCT of HIV from an estimated 8% at the end of breastfeeding in 2015 to 4% by 2022	SO 4.3: Commodity management and logistical information will be generated and used at different levels of the health delivery system to improve decision making	SO 5.3: Increased uptake of comprehensive HIV/AIDS prevention, treatment, care, and support services
	SO 2.4: The incidence of STIs in the general population and syphilis amongst	SO 3.4: By 2022, the burden of other HIV co-infections and co-morbidities	SO 4.4: Improved tracking of adverse drug effects	SO 5.4: Increased access to comprehensive workplace interventions

	pregnant women reduced by 50% by 2022	amongst PLHIV reduced by 50 percent of the 2016 level		focusing on HIV, TB, and Hepatitis B virus (HBV) prevention, care, and support services by employees
	SO 2.5: All (100%) donated blood units will be screened for transfusion-transmitted infections (TTIs) (HIV, HBV, Hepatitis C [HCV], and syphilis) as per the WHO quality assurance procedure by 2022	SO 3.5: By 2022, 95 percent of all PLHIV who are on ART achieve viral suppression	SO 4.5: Quality laboratory services provided for HIV/AIDS clients at all levels	SO 5.5: Reduction of new HIV infection amongst adolescents and young women by 50% by 2022
	SO 2.6: By 2022, 60 percent of female clients 30–50 years screened for cervical cancer using visual inspection with acetic acid (VIA) and cryotherapy	SO 3.6: Improved identification, retention, adherence, and psychosocial support to PLHIV through community-based HIV and AIDS services	SO 4.6: Uninterrupted HIV services as a result of timely planned preventive maintenance (PPM) of laboratory and other healthcare equipment	SO 5.6: 95 percent of adolescents living with HIV will be on ART by 2022
		SO 3.7: Improved identification, retention, adherence, and psychosocial support to PLHIV	SO 4.7: A well-regulated, monitored, and evaluated programme with up-to-date research outcomes relevant to HIV/AIDS that addresses improved data quality and informs programme performance	SO 5.7: Improved male involvement in HIV prevention, care, treatment, and support for their own health and the health of their partners and families
			SO 4.8: Strengthened community participation for quality community-based health services	SO 5.8: Reduced HIV-associated sexual violence and GBV
				SO 5.9: Mitigate effects of GBV on survivors, especially women and young people

				SO 5.10: Demonstration studies to determine the operational and implementation strategies required to roll out pre-exposure prophylaxis (PrEP) and HIV self-testing interventions amongst different populations in Tanzania conducted
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3.3. HSHSP Performance Indicators

The development of a results-based M&E plan entails six essential actions:

1. Formulating outcomes and goals
2. Selecting outcome indicators to monitor
3. Gathering baseline information for each indicator
4. Setting specific targets to reach and the timeline for their realisation
5. Regularly collecting data to assess whether the targets set are being reached
6. Analysing, reporting, and using results for ongoing decision making (Kusek and Rist, 2004)

The formulation of outcomes and goals, and selection of outcome indicators were achieved partly during the HSHSP IV development process and were refined in this M&E plan. Gathering baseline data and setting targets are part of the M&E plan development process. Regularly collecting data to assess whether targets are being met requires clear procedures for data collection, management, analysis, and use in both routine data collection systems and periodic surveys. This M&E plan addresses all of these dimensions.

3.4. HSHSP IV M&E Indicator Matrix

An indicator is a quantitative or qualitative variable that provides a valid and reliable way to measure achievement, assess performance, or reflect changes connected to an intervention. An indicator should reveal whether progress has been made towards expected or planned results in quantity, quality, and timeliness. Unlike performance objectives, an indicator does not specify a level of achievement.

The HSHSP IV identifies seven priority indicators. In addition, there are indicators for measuring performance against each of the strategic outcomes. The identification of indicators for the HSHSP IV has been done carefully to ensure alignment with global M&E reference documents. The indicator prioritisation process was guided by the six criteria identified by the UNAIDS Monitoring and Evaluation Reference Group, as highlighted below in Table 2.

Table 2. Indicator standards

Indicator standards: Operational guidelines for selecting indicators for the HIV response
<p><i>Standard 1: The indicator is needed and useful</i></p> <p>An indicator must provide data that are required and will be used by stakeholders in planning and decision making.</p>
<p><i>Standard 2: The indicator has technical merit</i></p> <p>An indicator must have substantive merit by measuring something of significance and importance within a particular field and be sufficiently sensitive to detect changes in performance. In addition, an indicator must have a monitoring merit or reliability. The indicator must be able to produce the same or very similar results, even if measured by different instruments, procedures, or observers.</p>
<p><i>Standard 3: The indicator is fully defined</i></p> <p>The purpose and rationale of an indicator must be clear, as well as the methods for its measurement, including any disaggregation. The numerators and denominators of the indicator must be specified as appropriate, and the frequency of data collection defined. Equally important is the clarity of the interpretation of the indicator.</p>
<p><i>Standard 4: It is feasible to collect and analyse data for this indicator</i></p> <p>The systems and mechanisms for collecting, interpreting, and using data for the indicator, such as surveys, need to be in place. It is also important to consider the financial and human resources required for collecting data for the indicator.</p>
<p><i>Standard 5: The indicator has been field tested or used in practice</i></p> <p>An indicator should have been field tested and reviewed for data availability.</p>
<p><i>Standard 6: The indicator set is coherent and balanced overall</i></p> <p>A good set of indicators should give an overall picture of the adequacy or otherwise of the response being measured. Indicator sets should cover all key elements of the response being assessed, ensuring an appropriate mix of indicators to assess inputs, outputs, outcomes, and impacts.</p>

The HSHSP IV has 75 indicators in total. The number of indicators by SA is as follows: SA 1 (4); SA 2 (15); SA 3 (21); SA 4 (26); and SA 5 (9). The following seven indicators in Table 3 below are identified as core HSHSP IV indicators.

Table 3. Core HSHSP IV indicators

Indicator reference number (refer to Appendix 2)	Indicator	Indicator level
1.3	Percentage of young people ages 15–24 years living with HIV	Impact
2.2	Percentage of members of KVPs who reported using a condom during their last high-risk sexual encounter	Outcome
3.1	Number of AIDS-related deaths per 100,000 population	Impact
3.5	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	Outcome
3.7	Number and percentage of people living with HIV and on ART who are virologically suppressed (amongst all those currently on treatment who received a viral load measurement regardless of when they started ART)	Outcome
3.8	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	Impact
3.15	Percentage of HIV-infected pregnant women receiving antiretroviral medicines (ARVs) to reduce the risk of MTCT of HIV	Outcome

A summary of all the indicators is provided in Appendix 1. A comprehensive indicator matrix with indicator definitions is included in Appendix 2. The indicator matrix is intended to facilitate the tracking of progress towards the impact, outcomes, and realisation of outputs. The matrix provides the following information:

- Strategic area and corresponding interventions
- Indicators for measuring impacts, outcomes, and outputs
- Definition for each indicator regarding the required numerator and denominator
- Factors of interest for disaggregating data on each indicator (for example, sex, age, region, etc.)
- The source of the indicator, including both national (such as HSHSP IV, HSHSP III, etc.) and global (e.g., PEPFAR MER 2.0, WHO, etc.)
- The data sources; this information defines existing initiatives for collection of data that respond to each indicator, including routine data sources, such as the health management information system (HMIS) and special or periodic studies (e.g., Demographic and Health Surveys, AIDS Indicator Surveys, etc.)
- Frequency of data collection
- Baseline level of each indicator (where available) and targeted level of the indicator by 2022 (where defined)
- Stakeholders who are responsible for collecting or ensuring access to data for measuring each indicator

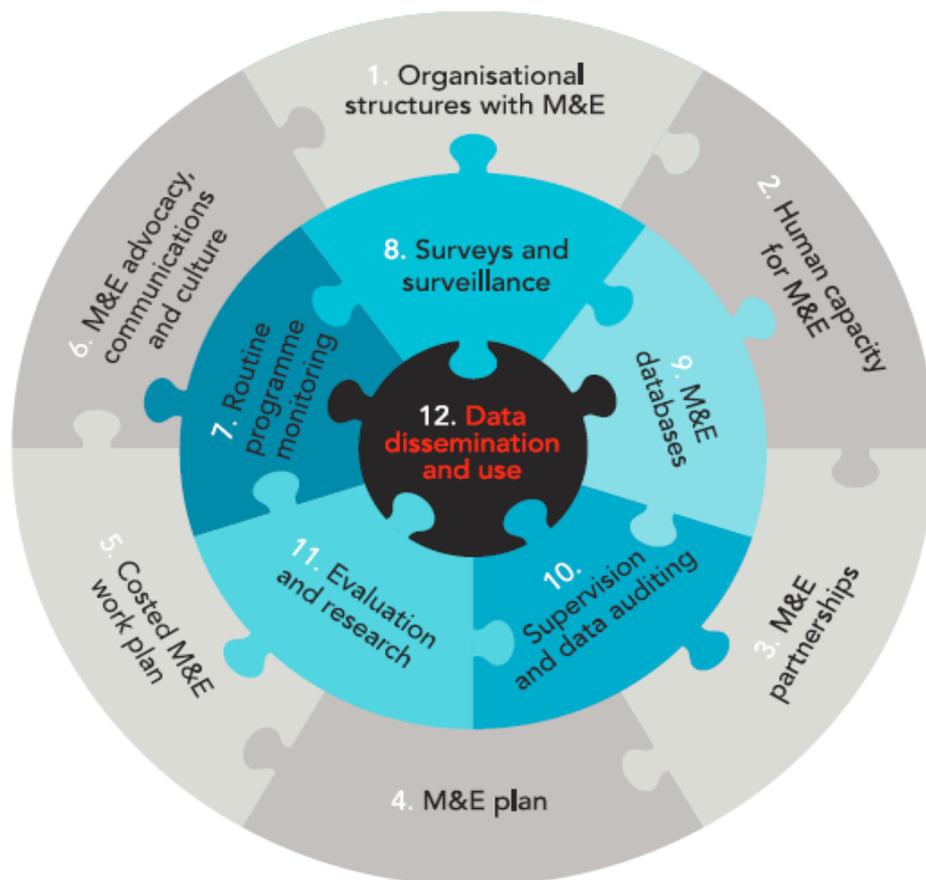
4. THE HEALTH SECTOR M&E SYSTEM CAPACITY

4.1. Introduction

The UNAIDS (2008) *Organising Framework for a Functional National HIV Monitoring and Evaluation System* identifies 12 components of an operational M&E system. The M&E plan is but one of the essential components of a good M&E system. The 12 components of a functional M&E system are the following: (1) organisational structure; (2) human capacity; (3) partnerships and coordination; (4) M&E plan; (5) a costed M&E workplan; (6) advocacy, communications, and culture; (7) routine programme monitoring; (8) surveys and surveillance; (9) databases; (10) supportive supervision and auditing; (11) evaluation and research; and (12) data dissemination and use.

The 12 components can be organised operationally into three categories. The first category, comprising components 1–6, relates to people, partnerships, and planning that support data production and use, which constitute the enabling environment for M&E to function. The second category is concerned with systems for collecting, capturing, and verifying data, and transforming data into useful information (components 7–11), whereas the last component addresses the central purpose of M&E, which is analysis of data to create information that in turn is disseminated to inform and empower decision making at all levels. Figure 4 presents the 12 components framework.

Figure 4. Organizing framework for a functional national HIV M&E system—12 components



Source: Adapted from UNAIDS (2008), Organizing Framework for a Functional National HIV Monitoring and Evaluation System. Geneva: UNAIDS. Page 6.

The middle and center rings in the framework above are interlinked and relate specifically to the purpose of an M&E plan, which is to support tracking of programme implementation and facilitate decision making. The enabling environment, although critical, is not limited to the M&E function and requires interventions at multiple levels and amongst several institutions. The implementation of this M&E plan requires attention to all 12 components, even though some of them are prioritised as described below.

4.2. Health Sector M&E System Strengthening Activities

In 2015, NACP assessed its M&E system using the 12 components framework. This assessment provided specific recommendations on activities for strengthening the NACP M&E system. This section presents recommended activities for selected components that will be implemented during the term of the HSHSP IV. These activities have been updated to reflect current needs. Activities related to data collection, management, and dissemination and use are discussed in a later chapter.

1. Organisational structure for M&E

- Fill all M&E posts within NACP’s national and subnational structures
- Advocate with the President’s Office-Public Services Management (PO-PSM) and President’s Office-Regional Administration and Local Government (PO-RALG) to finalise a scheme of service for council-level M&E officers to improve health sector HIV/AIDS services data collection, quality, and use

- Strengthen the capacity of council and regional HMIS focal persons on HIV data systems, including in District Health Information System-Version 2 (DHIS 2) data analysis, visualisation, and presentation
 - Strengthen collaboration with implementing partners in the implementation of M&E activities for the health sector HIV response
 - Promote and strengthen regional M&E technical working groups (TWGs) as a forum for reviewing performance against the HSHSP IV indicators and addressing data quality and use challenges
2. *Human capacity*
 - Assess knowledge and skills amongst regional and council-level HIV/AIDS M&E focal persons, and develop a capacity-building plan as appropriate
 - Promote the use of the training system monitoring and reporting tool (TrainSMART) in tracking all HIV M&E training activities
 - Review the curriculum for medical records and determine any scope for adding health sector HIV and M&E contents
 3. *Partnerships*
 - Strengthen the NACP national health sector HIV M&E subcommittee as a platform for engaging with stakeholders
 - Develop a regular (quarterly) newsletter as a tool for stakeholder engagement
 - Participate actively in the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) M&E Strengthening Initiative (MESI) and TWG
 4. *Routine programme monitoring*
 - Develop data collection tools and data management guidelines for condom distribution; information education, and communication (IEC); and key populations (KP) programmes
 - Establish and strengthen monitoring and reporting of financial resources and investments for both the government and implementing partners for the health sector HIV response
 5. *Surveys and surveillance*
 - Conduct demonstration studies to determine the operational and implementation strategies required to roll out pre-exposure prophylaxis (PrEP) and HIV self-testing interventions amongst different populations in Tanzania
 - Conduct IBBSS every two years as per protocol
 - Conduct workplace intervention surveys
 6. *National and subnational databases*
 - Complete the integration of HIV care and treatment data reporting into the DHIS 2
 - Harmonise import and export functionalities of all existing HIV databases (CTC2, home-based care [HBC], HIV testing and counselling [HTC], STI, prevention of mother-to-child transmission [PMTCT])
 - Develop a database for the KP programme
 7. *Evaluation and research*
 - Develop an inventory of HIV/AIDS research and evaluation
 - Develop a health sector HIV research and evaluation agenda
 - Develop and disseminate policy briefs on major completed research studies

The national health sector M&E system-strengthening plan based on the activities identified above is provided in Appendix 3.

5. HEALTH SECTOR M&E DATA COLLECTION STRATEGY

5.1. Introduction

A functional monitoring and evaluation system requires standard monitoring indicators and standards for collecting, analysing, and reporting data. This chapter includes information on how data for tracking the implementation of HSHSP IV will be collected, reported, and shared to facilitate decision making.

Two broad types of data sources will be used: routine data sources (for monitoring data) and nonroutine data sources (for evaluation data). Monitoring data will be collected on inputs and outputs, using standard programme-based data collection tools. Evaluation data, on the other hand, will be collected on outcomes and impacts, primarily through population-based biological, behavioural, and social surveys and surveillance.

5.2. Routine Data Sources

Routine data sources will facilitate tracking of activities as they are implemented. Routine monitoring data will be collected at health facilities by healthcare providers with the support of implementing partners, using standardized tools. Table 4 summarizes different standard tools for collecting monitoring data, and the responsibility for and frequency of their reporting.

Table 4. Standard tools for monitoring and responsibility for and frequency of their reporting

	Data collection standard tools	Stakeholder to complete	Reporting frequency
1	HIV testing and counselling tools	Healthcare providers	Monthly
2	HIV care and treatment tools	Healthcare providers	Quarterly
3	HIV home-based care tools	HBC providers and coordinators	Monthly
4	Sexually transmitted infections tools	Healthcare providers	Monthly
5	Prevention of mother-to-child transmission of HIV tools	Healthcare providers	Quarterly/monthly
7	Voluntary male medical circumcision (VMMC)	Healthcare providers	Monthly reports
8	Key populations	Healthcare providers	Monthly reports

Examples of routine data sources are as follows:

Care and treatment reports: The care and treatment programme unit within NACP produces monthly programme data that will be used to respond to some of the indicators in the M&E plan. The data will include cohort analysis of clients on ART. These data will enable reporting on clients that are on treatment 12 months after its initiating. Even though the reports are prepared on a routine basis, NACP will conduct the analysis quarterly and periodically provide results required for purposes of the M&E plan. The analysis will also assess adherence to and provide proxy data on drug resistance.

Health Management Information System (HMIS) reports: The HMIS is the main source of health facility (public and private) service delivery data under the health sector. It generates routine integrated reports for the health sector and provides the bulk of data for monitoring the HSHSP IV.

The DHIS 2 is now the primary national health service data electronic reporting platform. Data collected on health facility- and community-based services are compiled at the facility level and entered into the DHIS 2 on a monthly basis. The DHIS 2 allows the aggregation of national and subnational level data. It will be the primary source of data for the HSHSP IV M&E plan. All data submitted through this system will be verified and approved by NACP before publication.

National Blood Transfusion Services (NBTS) Reports: These reports are produced by the NBTS annually.

Programmatic reports: These reports include, for example, the PMTCT, ART, and National TB and Leprosy Programme reports, produced on a quarterly basis by the respective programmes, which provide additional data not captured under the HMIS/DHIS 2.

5.3. Nonroutine Data Sources (Evaluation Data)

NACP will collect evaluation data in collaboration with other stakeholders. The major data collection initiatives for measuring the impact of the health sector HIV response include THIS and TDHS.

Tanzania HIV Impact Surveys (THIS): The THIS survey collects data related to HIV knowledge and behaviour, and HIV prevalence amongst women and men ages 15–49. The latest THIS survey, conducted in Tanzania in 2016–2017, provides data on HIV viral load and incidence. The surveys are conducted under the leadership of the National Bureau of Statistics (NBS). The previous survey, including malaria indicators, was conducted in 2012. It is anticipated that a follow-up THIS study will be conducted by the end of the HSHSP IV.

Tanzania Demographic and Health Survey (TDHS): The TDHS is conducted every five years as part of a worldwide Demographic Health Surveys (DHS) programme funded by the U.S. Agency for International Development (USAID). The DHS programme assists countries in the collection of data to monitor and evaluate population, health, and nutrition programmes. The last DHS was conducted in 2015–2016. A follow-on survey is anticipated within the timeframe of the HSHSP IV.

Tanzania Service Provision Assessment (TSPA): The TSPA survey is a health facility assessment that provides a comprehensive overview of the status of health service delivery. It collects information on the overall availability of different facility-based health services. Two rounds of TSPA have been conducted in Tanzania—the first one in 2006 and the second in 2014–2015. Like the THIS and TDHS, the TSPA is conducted through the leadership of the NBS. It is expected that the next round of the TSPA will occur within the term of the HSHSP IV.

Epidemic modelling: NACP will also continue to use the Estimation and Projection Package and Spectrum AIDS Impact Model developed by WHO and UNAIDS to monitor changes in HIV outcomes. Spectrum modelling is based on routinely collected data, such as adult and child treatment coverage, PMTCT, and sentinel surveillance data.

ANC-PMTCT data utility surveys: These surveys are conducted biannually at ANC sentinel surveillance sites.

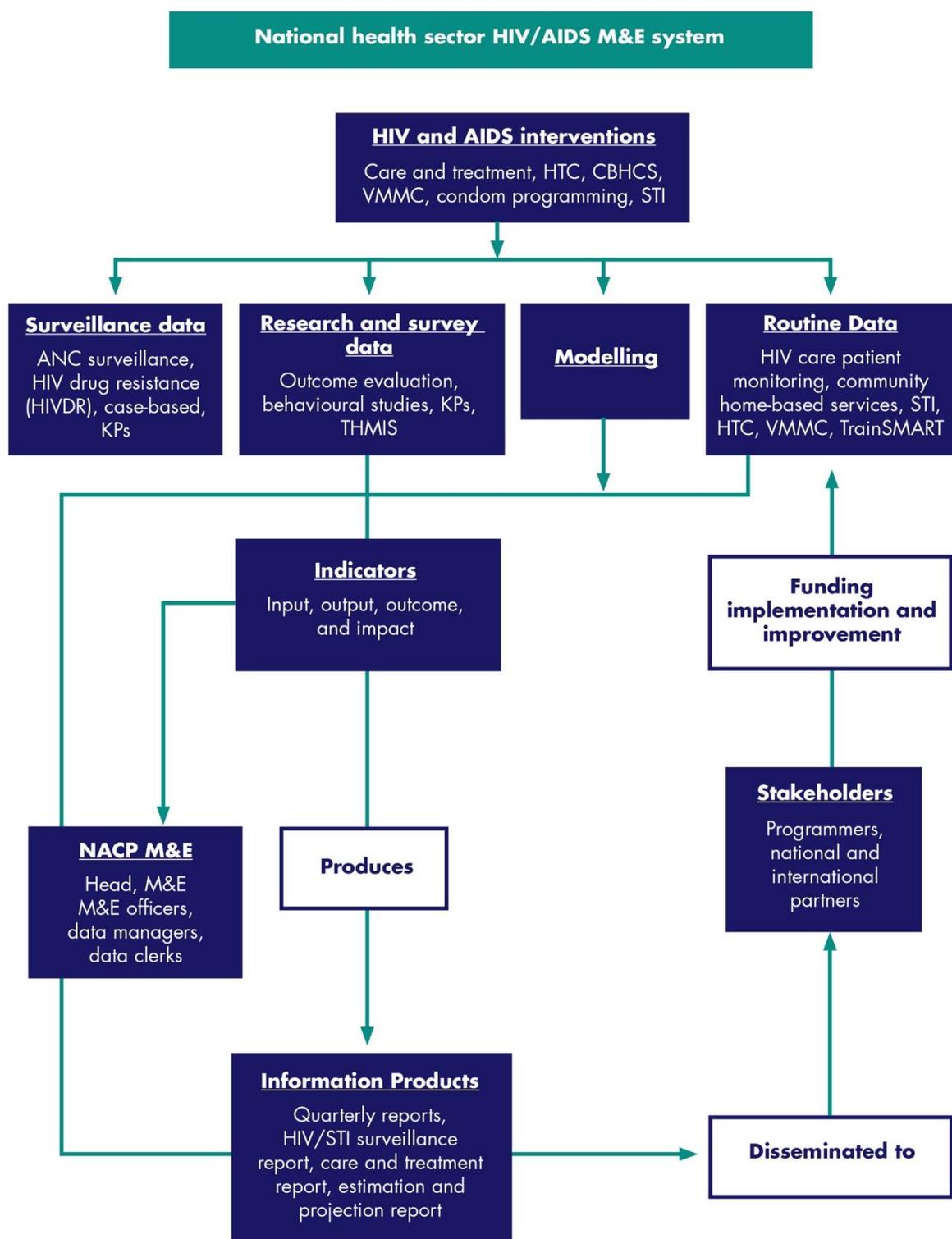
Key populations surveys: These surveys will be conducted for identified KPs as relevant to the Tanzanian context. There has been a general paucity of studies on KPs in Tanzania, but it is expected that new studies will occur during the life of the HSHSP IV.

Special studies: Other special studies will be commissioned as deemed necessary to respond to specific indicators not adequately addressed by the other surveys. The HSHSP IV specifically

recommends demonstration studies to determine the operational and implementation strategies required to roll out PrEP and HIV self-testing interventions amongst different populations in Tanzania.

Figure 5 highlights the interface between monitoring and evaluation data within the health sector M&E system.

Figure 5. Health sector HIV and AIDS M&E system

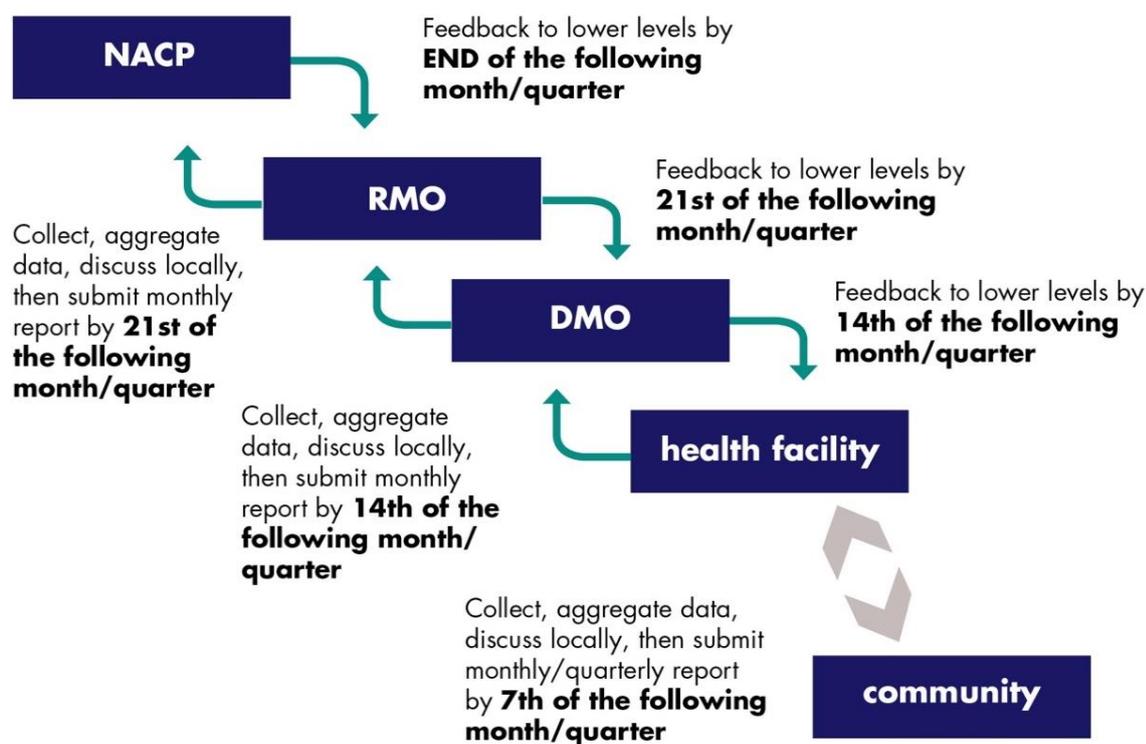


5.4. Reporting and Data Flow

The primary source of routine data for the health sector HIV response is the health facility. There are additional services provided at the community level, such as HBC and community outreaches. Patient- and client-level data collected at the health facility and community levels are used to generate monthly and quarterly summary reports, which are submitted to the District Medical Officer's (DMO's) office. The district then aggregates the summary reports from the various health facilities through the DHIS 2. The aggregated data entered at the district level are accessible to stakeholders at all levels, from the regions to the national level, through the DHIS 2.

In 2017, the MOHCDGEC started rolling out direct entry of data into the DHIS 2 by health facilities, starting with hospitals and ultimately covering all health facilities, to improve both data quality and use at the point of collection. The quality of data from one level to another will be ensured through NACP's existing data management guidelines. Figure 6 illustrates the reporting, data flow, and feedback process, as well as timelines.

Figure 6. Reporting timeline, data flow, and feedback mechanism



Source: Adapted from the National AIDS Control Programme, 2012. National Guideline for the Management of HIV and AIDS Data Quality. Dar es Salaam: Ministry of Health and Social Welfare

5.5. Data Management

Data management includes procedures and standards for handling data, ensuring data quality, and storing data during programme implementation. The data management process includes data sourcing, collection, collation and aggregation, analysis, reporting and use. Procedures identified in the NACP's *National Guideline for the Management of HIV and AIDS Data Quality* (2012) and the MOHCDGEC's *National Guidelines for Health Data Quality Assessment* (2016) will be followed throughout the data management process.

5.5.1. Data Recording and Checking

Both paper-based and electronic systems will be used at the facility level to collect patient- and client-level data during service delivery. A data entry supervisor will perform data checks daily, report any errors, and promptly make corrections with the support of the facility in-charge. The facility in-charge will compile monthly reports and share them with the facility management team before submission to the District AIDS Control Coordinator and DMO. At the district level, reports aggregated from all health facilities will be reviewed by the CHMT before entry into the DHIS 2. Aggregated data will be entered into the DHIS 2 monthly and reports produced quarterly.

5.5.2. Data Retention

A data retention protocol allows programme implementers to store data for a certain period as back-up in case of any loss, for data quality audit purposes, accountability to the government or donors, or use in further analysis. The existing MOHCDGEC data recording and retention policy for government data will be used to document, maintain, and retain HIV/AIDS data at all levels.

5.5.3. Data Storage and Confidentiality

Each data reporting level will ensure appropriate storage, maintenance, and security for archiving their electronic and paper-based records. Confidentiality of patient-level data will be ensured through a password-protected electronic archival and back-up system for electronic data, and storage in a locked area for paper-based data.

5.6. Data Quality Assurance

Crucial to the successful performance of the M&E system is the quality of the data it generates. In line with the *National Guideline for the Management of HIV and AIDS Data Quality* (2012) and the *National Guidelines for Health Data Quality Assessment* (2016), data quality assurance will be performed periodically to verify reported data, identify strengths or gaps in the systems supporting data collection, build M&E capacity, and address challenges found at each level for overall improvement of data quality. NACP will ensure at least one annual data quality assessment, covering national, regional, district, facility, and community levels. The data quality assessment will cover all components of data management and include at least one indicator per programme.

At the regional level, each RHMT will be required to perform a minimum of two data quality assessments (DQAs) per year in every district, involving at least one facility per district. Each assessment at the district level will include a minimum of one indicator per intervention area.

At the district level, DQAs will be integrated into quarterly supervision visits. It is recommended that a DQA be performed at least twice per year for every facility and include at least one indicator per intervention delivered at that facility.

6. STAKEHOLDER ROLES AND RESPONSIBILITIES

Implementation of the health sector HIV and AIDS M&E plan is under the management and supervision of the Directorate of Preventive Services in the MOHCDGEC through the NACP. However, the involvement of other stakeholders from both the public and private sectors is critical to successful implementation of the M&E plan.

M&E functions will be implemented at three main levels: national, regional, and council/district. The NACP will be directly responsible for implementation of the plan at the national level. The RHMT and CHMT will be responsible for implementation at the regional and council/district levels, respectively. The roles and responsibilities of different stakeholders in the implementation of the M&E plan are specified below.

6.1. Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) provides overall technical leadership guidance, advice, and M&E on the implementation of HSHSP IV

- Facilitates effective development, recruitment, and deployment of skilled health workers at health facilities in collaboration with the PO-RALG, PO-PSM, and Ministry of Finance
- Ensures availability of a harmonised and integrated HMIS
- Ensures adherence to guidelines, standards, and regulations
- Promotes and oversees operational research on health sector HIV prevention, care and treatment, and support services
- Ensures timely submission of reports, as well as proper storage and documentation of records
- Provides relevant feedback and dissemination of data and strategic information to all stakeholders involved in HIV/AIDS interventions
- Ensures integration of data quality activities into routine supervision at all levels
- Conducts a data quality assessment at least once a year to assess the status of the data collected and reported at different levels
- Ensures that regional and district levels conduct DQAs at least twice per year

6.2. National AIDS Control Programme (NACP)

- Coordinates and oversees the implementation and monitoring and evaluation of health sector HIV prevention, care, treatment, and support services
- Designs and develops an M&E framework, and ensures the availability of recording and reporting tools for the HSHSP IV
- Facilitates the integration of an HIV information system within the national M&E strengthening initiative and strengthens and promotes effective and efficient data collection, analysis, and use of HIV/AIDS information at all levels
- Organises and coordinates health sector HIV prevention, care, treatment, and supports operational research in collaboration with research institutions

- Leads the implementation of operational research on health sector HIV prevention, care, treatment, and support services

6.3. Research and Academic Institutions

- Plan and conduct research studies and disseminate findings to key stakeholders in the country as part of improving the health sector HIV prevention, care, treatment, and support services
- Jointly coordinate synthesis of new knowledge from research and support the MOHCDGEC/NACP in translating research findings into policy and practice
- Support the MOHCDGEC/NACP scale-up of proven interventions and best practices through the development of appropriate tools and methodologies
- Establish, maintain, use, or make available research and surveillance platforms for the evaluation of national HIV/AIDS interventions to the MOHCDGEC/NACP

6.4. President's Office-Regional Administration and Local Government (PO-RALG)

- Facilitates effective recruitment and deployment of skilled health workers at health facilities in collaboration with the MOHCDGEC and PO-PSM; collaborates with various stakeholders for planning and implementation of health sector HIV prevention, care, treatment, and support services
- Designs and develops planning guidelines to facilitate the implementation of health sector HIV prevention, care, treatment, and support services, such as the Medium-Term Expenditure Framework

6.5. Regional Health Management Teams (RHMTs)

- Provide technical support to CHMTs to incorporate and implement health sector interventions for HIV prevention, care, and treatment in their annual comprehensive council health plans (CCHPs)
- Coordinate, supervise, monitor, and evaluate health sector HIV prevention, care, treatment, and support services provided by both governmental and nongovernmental institutions in the region
- Ensure availability and adherence to national guidelines and standards for health sector HIV prevention, care, treatment, and support services
- Support CHMTs to collect, compile, analyse, interpret, and disseminate data on health sector HIV/AIDS services
- Receive, compile, analyse, use, and disseminate health sector HIV prevention, care, treatment, and support services data from the councils and send them to the national level
- Ensure coordinated implementation of and compliance with national M&E guidelines, standard operating procedures (SOPs), and protocols
- Provide technical assistance to districts in implementing data quality initiatives

- Collect reports from all districts in all programme areas and verify reported numbers before aggregating them to produce a regional report
- Provide feedback to districts according to the guidelines
- Aggregate district-level data (paper or electronic) into regional reports on a monthly or quarterly basis, depending on the agreed-upon timeline
- Ensure timely submission of reports to the MOHCDGEC and NACP
- Ensure linkage between implementing partners, districts, health facilities, and other stakeholders
- Plan and implement capacity-building activities at the district and facility levels to ensure sustainable training of healthcare providers on data quality activities
- Integrate data quality assessments into quarterly supervision visits to districts and facilities
- Conduct at least two data quality assessments per year, covering the regional, district, facility, and community levels
- Support districts to conduct DQAs in accordance with national guidelines

6.6. Council Health Management Teams (CHMTs)

- Plan and incorporate HSHSP IV activities into the CCHP
- Strengthen the HMIS by compiling, disseminating, and using health sector HIV prevention, care, treatment, and support data for service improvement
- Ensure that reports are received from all facilities in all programme areas and verify reported numbers before aggregating them to produce a district report
- Stamp all reports to show when they were received and ensure that the data are entered into the appropriate database
- Aggregate facility-level data (paper or electronic) to produce district reports (monthly/quarterly) according to the agreed-upon timeline; the reports must be signed by the designated CHMT member
- Provide relevant feedback to health facilities on the findings of DQAs and ways to improve in weak areas
- Ensure that training and mentorship for service providers are routinely conducted
- Ensure that facilities have cabinets for storage of data collection and reporting tools, including patient files
- Develop an annual data quality plan for the district
- Enforce the implementation of data quality activities in the health facilities
- Ensure that healthcare providers involved in data collection and reporting are trained on data quality
- Integrate data quality assessments into routine supportive supervision
- Ensure that DQAs are conducted at least twice per year for each facility

6.7. Health Facilities (Hospitals, Health Centres and Dispensaries)

- Ensure the collection, analysis, use, and dissemination of data for improved service delivery
- Ensure the availability of data collection and reporting tools
- Ensure the completeness of all variables in the data collection and reporting tools
- Verify the accuracy and reliability of the recorded and reported data
- Ensure the availability of all SOPs and guidelines on how to fill out data collection, as well as reporting tools, and that they are used accordingly
- Produce facility (monthly and quarterly) reports and ensure their timely submission to the district
- Ensure that analysis and summarisation of data and reports are done properly
- Ensure the availability of cabinets for storage of files, reports, and all data related to HIV/AIDS, as well as a proper filing system that uses appropriate registration numbers to simplify storage and retrieval of documents
- Ensure that staff involved in data recording and reporting are trained on the data quality guidelines
- Implement data quality activities in all sections of the health facility where data are being collected and reported

6.8. Communities

- Collect data on community-based HIV services, such as HBC
- Maintain records of all services provided, using standard reporting tools
- Submit activity reports regularly (monthly and quarterly) to the nearest health facility as guided

6.9. Implementing Partners

- Support the MOHCDGEC in formulating national guidelines and SOPs related to M&E activities
- Collaborate with the MOHCDGEC in ensuring the sustainable availability of recording and reporting tools
- Collaborate with the MOHCDGEC in conducting supportive supervision visits to the RHMTs and CHMTs
- Provide support to the regions and councils covered to conduct DQAs and improve systems for data collection and reporting
- Collaborate with regional and district teams in training, supportive supervision, and mentoring of healthcare workers on data quality activities
- Support the CHMTs to ensure proper verification and completeness of the data recorded at the facility level
- Support the CHMTs/RHMTs in submitting all reports in a timely manner

- Assist in capacity building for data analysis, use, and dissemination at the regional, district, facility, and community levels

7. DATA DISSEMINATION AND USE

Data collected through this M&E plan will need to be analysed and packaged appropriately for different audiences to facilitate their use in planning, resources allocation, programme decision making, and assessment of progress against targets set for the health sector HIV and AIDS response. This chapter describes some key barriers to data use and activities to be undertaken to facilitate data analysis, dissemination, and use at different levels.

7.1. Barriers to Data Use

There are several barriers to data use, including a lack of motivation to review and use data because of excessive workload and a lack of feedback on performance; lack of staff commitment also is a key barrier, especially at the service delivery point. There is a perception amongst healthcare workers that data use initiatives create an additional burden rather than help improve job performance. However, recognition of data use as an important task and dissemination of success stories on data use by national, regional, and district health management authorities can help alleviate such motivational barriers.

Limited capacity to analyse, interpret, and communicate data, not only at the health facility level, but even at the national, regional, and district levels, is also practical barrier to data use. Continuous capacity building on the use of the DHIS 2's capabilities for data analysis, augmented with skills in data synthesis and packaging for different audiences, is needed to improve data use.

Finally, data use may be hindered by infrastructural factors, such as a shortage of data reporting tools, parallel data collection systems that are not always accessible, lack of Internet connectivity, and data storage systems that do not ensure consistent data quality. The integration of data collection and reporting processes would help improve the infrastructure for data use.

7.2. Data Analysis

Since 2015, the reporting of HIV/AIDS programmes has been integrated into the DHIS 2. This integration is expected to improve access to data and promote data analysis from the health facility to district, regional, and national levels. Health facilities that can now input data directly into the DHIS 2 will conduct monthly and quarterly analysis of their data under the guidance of the CHMTs. The CHMTs will organise quarterly data analysis and validation meetings, during which they will look at overall reporting rates, report submission timeliness, data quality, and performance against key indicators. The RHMTs will organise similar meetings to review the performance of all districts within the region. At the national level, NACP will organise annual data analysis workshops that draw together subnational health management teams and implementing partners to analyse data and develop reports on the status of the health sector HIV/AIDS response.

The data analysis activities will be organised to coincide with key decision-making moments at different levels. Key decision-making moments include the following:

- HIV/AIDS M&E quarterly meetings (national level)
- NACP strategic review meetings (national level)
- NACP quarterly M&E subcommittee meetings (national level)
- NACP biannual data review meetings
- RHMTs', CHMTs', and implementing partners' quarterly meetings (regional/council level)
- Weekly performance review meetings (health facility level)

- Quarterly multisectoral AIDS committee meetings (council level)

The information products from the data analysis will include the following:

Health facility level

Monthly and quarterly reports

District level

Quarterly reports

National level

- Quarterly programme monitoring reports
- Annual HIV/AIDS reports
- Quarterly bulletins
- International reports: biennial UNGASS Report, PEPFAR annual reports, UNAIDS Global AIDS Response Reporting (GARP) report, Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) annual reports
- Domestic reports: HIV/AIDS and STI surveillance reports, ANC report, care and treatment report, annual national HIV drug resistance report, PMTCT annual report, and Spectrum estimation and projection report

7.3. Data Dissemination and Use

NACP will organise M&E results dissemination meetings at the national, regional, and district levels with implementing partners, communities, and health facilities on a quarterly and biannual basis.

The dissemination of the M&E results will serve the following purposes:

- Provide feedback to various implementers on the efforts being made and achievements
- Share and use the data and information for better targeting and planning of HIV/AIDS interventions at the district level
- Provide feedback on efforts and resource use in the health sector HIV/AIDS response, and articulate lessons learned, gaps, and challenges faced at the subnational and national levels
- Enhance networking and harmonisation of data use efforts

The types of feedback approaches to promote data use will include the following:

- Making performance comparisons amongst regions, districts, and facilities
- Making recommendations on how to improve performance
- Disseminating exemplary best practices
- Recognizing good performance
- Focusing on resources or helping to find resources
- Directing feedback to those with authority to make decisions
- Linking routine to nonroutine data for a comprehensive view of performance
- Identifying, strengthening, and promoting data use champions at all levels

Table 5 summarises the dissemination plan for different information products arising from the M&E plan.

Table 5. Dissemination plan for informational products from the HSHSP IV M&E plan

Product	Frequency/ timeline	Responsible	Contents	Audience	Dissemination format
Programme monitoring report	Quarterly	NACP	Progress on programme monitoring indicators	Programme manager	Summary, reports
				Politicians and government officials	Policy briefs, brochures
				Implementing partners	Fact sheets, visual presentations, dissemination workshops
				Regions and districts	Fact sheets, visual presentations, dissemination workshops
HIV and AIDS report	Annual	NACP	Progress on programme monitoring indicators	Programme manager	Summary, reports
				Politicians and government officials	Policy briefs, brochures
				Implementing partners	Fact sheets, visual presentations, dissemination workshops
				Regions and districts	Fact sheets, visual presentations, dissemination workshops
Bulletin	Quarterly	NACP	Service provision data update	Public	NACP website
UNGASS report	Biennial	NACP		Donors/funders	Full reports
PEPFAR reports	Annual	NACP		Donors/funders	Full reports
GFATM reports	Annual	NACP		Donors/funders	Full reports
HIV/AIDS and STI surveillance reports		NACP	Survey results	Donors/funders	Full reports, NACP website
				Politicians and government officials	policy briefs, brochures, NACP website

Product	Frequency/ timeline	Responsible	Contents	Audience	Dissemination format
				Regions and districts	Fact sheets, visual presentations,
ANC report		NACP	Survey results	Donors/funders	Full reports, NACP website
				Politicians and government officials	policy briefs, brochures, NACP website
				Regions and districts	Fact sheets, visual presentations, NACP website
Care and treatment report	Annual	NACP		Government and implementing partners	Full reports, NACP website
National HIV drug resistance report	Annual	NACP		Government and implementing partners	Full reports, NACP website
PMTCT report	Annual	NACP		Government and implementing partners	Full reports, NACP website
SPECTRUM estimation and projection report		NACP		Government and implementing partners	Full reports, NACP website
District-level reports	Quarterly	CHMT	Service provision data update	District implementing partners, health workers	Fact sheets, visual presentation
Health facility-level reports	Monthly and quarterly	Healthcare providers	Service provision data update	Health facility staff, community	Fact sheets, visual presentation

7.4. Capacity Building

In addition to tailored feedback and analysis, continuous capacity building will be conducted to enable key decision makers from the health facility to national levels to independently synthesise, analyse, and interpret data for programming. The large number of staff in need of capacity building, as well as staff turnover, requires a continuous capacity-building approach. Two key capacity-building approaches will be pursued to improve data analysis and use during implementation of the HSHSP IV. The first approach will be an expansion of the DHIS 2 training curriculum to include data analysis, visualisation, and presentation; the second will be the expansion of the number of supportive supervision visits provided by programme and M&E staff at all levels of the health system.

Examples of staff to be targeted for the capacity-building activities include the following:

- NACP data managers
- Regional/council health secretaries
- Regional/council HMIS focal persons
- Regional/council medical recorders
- Regional/council health management teams

8. MONITORING AND EVALUATION OF HEALTH SECTOR HIV PLAN IMPLEMENTATION

The HSHSP IV M&E plan identifies indicators (Appendix 1) against which programme performance will be assessed. These indicators will be tracked regularly to ensure that programme targets are met and the implementation of the strategic plan is on course.

8.1. Annual M&E Operational Plans

To ensure effective implementation of the M&E plan, NACP will develop **annual M&E operational plans** with active stakeholder involvement, based on M&E system strengthening and other data quality and data use interventions. The operational plans will be more detailed to provide the expected number of participants in different activities, timelines, and associated costs. The implementation status of the operational plans will be reviewed at the end of every year at the Joint Annual Programme Review (JAPR) meetings, along with data collected on the different indicators identified in the M&E plan. The JAPR will bring together the NACP, MOHCDGEC, PO-RALG, RHMTs/CHMTs, implementing partners, and other stakeholders.

In addition to the JAPR, the health sector HIV M&E subcommittee and the MOHCDGEC's MESI and TWG meetings will provide a critical forum for reviewing progress of the implementation of the HSHSP IV and promptly instituting any necessary corrective measures.

8.2. Mid- and End-Term Evaluation

Two evaluations will also be conducted to determine the success of the HSHSP IV. NACP will organise a joint mid-term review (MTR) before the end of the third year of the HSHSP IV. This assessment will focus on progress made in implementing the plan and the appropriateness of the overall strategic direction. The evaluation will be designed to inform the remaining period of the plan and recommend adjustments where needed.

The NACP will facilitate an independent external evaluation in the final year of the HSHSP IV (end-term evaluation), focusing on achievements (impacts and outcomes) of the HSHSP IV. The end-term evaluation will also provide contextual information for the subsequent planning period.

Both evaluations will be conducted with significant involvement of stakeholders. The costs for the evaluations will be included in the health sector budget. When appropriate, the MTR and the end-of-term evaluation will be combined with the JAPR for that year.

8.3. Assumptions for the Successful Implementation of the HSHSP IV M&E Plan

The successful implementation of this M&E plan hinges on the assumption that the NACP will rally all key stakeholders to implement the strategic activities identified in the HSHSP IV. Stakeholders will commit to an annual work planning process whereby programme performance targets will be set and responsibility for their attainment defined, including financial contributions. Another assumption is that implementing partners will harmonise their support for M&E-related activities based on NACP's annual M&E operational plan. A budgetary provision of 7–10 percent of the total cost of implementing the strategic activities in the HSHSP IV will be set aside for M&E-related activities.

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APPENDIX 1. SUMMARY OF HSSSP IV INDICATORS, BY LEVEL, IN THE M&E RESULTS PATHWAY (IMPACT, OUTCOME, AND OUTPUT)

Indicator reference number	Indicator	Level
STRATEGIC AREA 1: HIV TESTING SERVICES		
Strategic outcome 1: 90% of people living with HIV are aware of their status by 2022		
1.1	Proportion of women and men ages 15+ years who have ever tested for HIV and know their results	Outcome
1.2	Proportion of individuals who test for HIV as couples	Output
1.3*	Percentage of young people ages 15–24 years who are living with HIV	Impact
Intervention area 1.1: Linkage to HIV prevention, care, treatment, and support services		
Strategic outcome 2: All people (100%) identified as HIV positive during community and facility HTS are linked to HIV care, treatment, and support services by 2022		
1.4	Proportion of individuals (all ages, including children) diagnosed with HIV and linked to appropriate services	Outcome
STRATEGIC AREA 2: PREVENTION OF NEW HIV INFECTIONS		
Intervention area 2.1: Comprehensive condom programming		
Strategic outcome 1: 85% of women and men engaged in multiple sexual partnerships report use of a condom at last sexual intercourse		
2.1	Percentage of women and men ages 15+ who had higher-risk sex in the last 12 months who reported using a condom the last time they had sexual intercourse	Outcome
2.2*	Percentage of members of KVPs who reported using a condom during their last high-risk sexual encounter	Outcome
Intervention area 2.2: Programming for key and vulnerable populations (KVPs)		
Strategic outcome 2: Increased access and use of HIV services by KVP		
2.3	Proportion of health facilities providing KVP-friendly services	Output
2.4	Number of KVP receiving HIV services	Output
2.5	Percentage of members of KVPs who have been tested for HIV in the last 12 months and know their results	Outcome
2.6	Percentage of KVP who are HIV infected	Outcome
Intervention area 2.3: Voluntary male medical circumcision (VMMC)		
Strategic outcome 3: 90% male circumcision rate attained by all regions by 2022		
2.7	Proportion of males receiving VMMC services at healthcare facilities in the last 12 months	Output
2.8	Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery within the reporting period	Outcome
Intervention area 2.4: STI management		
Strategic outcome 4: Incidence of STIs in the general population and syphilis amongst pregnant women reduced by 50% respectively by 2022		
2.9	Prevalence of syphilis amongst pregnant women	Outcome

Indicator reference number	Indicator	Level
2.10	Percentage of antenatal care attendees screened for syphilis at first antenatal care visit	Output
2.11	Percentage of ANC care attendees screened for syphilis	Output
Intervention area 2.5: Blood safety		
Strategic outcome 5: All (100%) donated blood units will be screened for TTIs (HIV, HBV, HCV, and syphilis) as per the WHO quality assurance procedure by 2022		
2.12	Percentage of donated blood units screened for HIV per WHO quality assurance procedures	Outcome
Intervention area 2.6: Reproductive health cancers		
Strategic outcome 6: By 2022, 60% of female clients ages 30–50 screened for cervical cancer using VIA and cryotherapy		
2.13	Percentage of HIV-positive women ages 15–49 screened for cervical cancer using the VIA method	Output
2.14	Proportion of health facilities providing cervical cancer screening (VIA)	Output
2.15	Proportion of health facilities using cryotherapy/loop electrosurgical excision procedure (LEEP) for early treatment of precancerous cervical lesions	Output
Strategic area 3: Facility-based care and support for PLHIV		
Intervention area 3.1: ART services for adults		
Strategic outcome 1: By 2022, 95% of all adults (>15) diagnosed with HIV will be on ART		
3.1*	Number of AIDS-related deaths per 100,000 population	Impact
3.2	Number of PLHIV newly initiated on treatment in the past 12 months	Output
3.3	Number of PLHIV currently on ART	Output
3.4	Percentage of persons on second-line regimen during reporting period	Outcome
3.5*	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	Outcome
3.6	Percentage PLHIV on ART monitored using viral load as a standard of care	Output
3.7*	Number and percentage of people living with HIV and on ART who are virologically suppressed (amongst all those currently on treatment who received a viral load measurement regardless of when they started ART)	Outcome
Intervention area 3.2: Paediatric ART services		
Strategic outcome 2: All children under 15 years initiated and 90% retained on ART by 2022		
3.8*	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	Impact
3.9	Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	Outcome
3.10	Percentage of HIV-exposed infants tested with DNA-polymerase chain reaction (PCR) within 2 months of age	Output
3.11	Percentage of dried blood spot (DBS) samples rejected at DNA-PCR testing laboratories	Output

Indicator reference number	Indicator	Level
3.12	Percentage of DBS tests that have turnaround time for DBS reduced to less than 4 weeks from when the sample is collected to results back to client/caregiver	Output
Intervention area 3.3: ART for pregnant and lactating women		
Strategic outcome 3: Reduction of mother-to-child transmission of HIV from an estimated 8% in 2015 to 4% at the end of breastfeeding by 2022		
3.13	Proportion of pregnant women tested for HIV and who know their status	Outcome
3.14	Proportion of male partners of pregnant mothers tested for HIV and who know their HIV status	Outcome
3.15*	Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of MTCT of HIV	Outcome
3.16	Proportion of women alive and on ART during PMTCT care	Outcome
Intervention area 3.4: HIV co-infections and co-morbidities		
Strategic outcome 4: By 2022, the burden of other HIV co-infections and co-morbidities amongst PLHIV reduced by 50 percent of the 2016 level		
3.17	Number of HIV-positive patients who received TB treatment	Output
3.18	Percentage of HIV-positive patients starting isoniazid preventive therapy (IPT) during the reporting period	Outcome
Intervention area 3.5: Achieving viral suppression		
Strategic outcome 5: By 2022, 95% of all PLHIV who are on ART achieve viral suppression		
	Refer to indicators 3.6 and 3.7	
Intervention area 3.6: Community-based HIV/AIDS care		
Strategic outcome 6: Improved identification, retention, adherence, and psychosocial support to PLHIV through community-based HIV and AIDS services		
Strategic outcome 7: Improved identification, retention, adherence, and psychosocial support to PLHIV		
3.19	Percentage of PLHIV on care and treatment enrolled in community-based health services (CBHS)	Outcome
3.20	Percentage of missed appointment/lost to follow-up (LTFU) clients followed up and linked back to health facility services by community-based HIV and AIDS service providers	Outcome
3.21	Percentage of care and treatment facilities with a designated CBHS provider/supervisor	Output
STRATEGIC AREA 4: BUILDING RESILIENT AND SUSTAINABLE SYSTEMS FOR HEALTH TO SUPPORT THE NATIONAL RESPONSE		
Intervention area 4.1: Quality improvement of HIV and AIDS services		
Strategic outcome 1: RHMTs, CHMTs, and health facilities have active QI teams that oversee the implementation, documentation, and reporting of quantitative data on the quality of HIV and AIDS services		
4.1	Percentage of health facilities (hospitals) with active quality improvement (QI) teams, i.e., completing at least 1 QI cycle per intervention per quarter)	Output
4.2	Percentage of RHMTs and CHMTs with active QI teams	Output
4.3	Proportion of health facilities providing quality HIV testing and counselling services according to national standards	Output

Indicator reference number	Indicator	Level
4.4	Percentage of health facilities providing HIV services assessed for data quality in the last 12 months	Output
Intervention area 4.2: Medicine and technologies		
Strategic outcome 2: Uninterrupted supply of medicines and commodities for STI/RTI, HIV, and AIDS at all levels by 2022		
4.5	Percentage of health facilities that have experienced a stockout of selected tracer items in the HIV programme in the last 3 months (HSHSP III, p. 81)	Output
4.6	Proportion of Government of Tanzania (GOT) expenditure from its own funds on procurement of ARVs, HIV rapid test kits, and diagnostics	Output
4.7	Proportion of hospitals and health centres implementing an electronic logistics data management system	Output
4.8	Proportion of health facilities with at least one clinical staff trained on rational use of HIV medicines and pharmacovigilance	Output
Intervention area 4.3: Health facility commodity management and rational use of medicine		
Strategic outcome 3: Commodity management and logistical information will be generated and used at different levels of the health delivery system to improve decision making		
4.9	Percentage of HIV care and treatment facilities prescribing and dispensing ARV/opportunistic infections (OIs) medicines according to national guidelines	Output
4.10	Percentage of ordering facilities submitting ARV/OIs and laboratory logistics reports within a specified time limit	Output
Strategic outcome 4: Improved tracking of adverse drug effects		
4.11	Number of care and treatment facilities documenting adverse drug reactions (ADR)s and reporting them to the Tanzania Food and Drug Authority (TFDA)	Output
4.12	Proportion of health facilities using pharmacovigilance reports at a facility level	Output
Intervention area 4.4: Laboratory services		
Strategic outcome 5: Quality laboratory services provided for HIV/AIDS clients at all levels		
4.13	Percentage of care and treatment hospital and health centre laboratories enrolled in the Strengthening of Laboratory Management towards Accreditation (SLMTA) process according to the WHO/Regional Office for Africa (AFRO) Stepwise Laboratory Improvement Process towards Accreditation (SLIPTA) quality assurance standards	Output
4.14	Percentage of hospital and health centre laboratories enrolled in the SLMTA process that achieved star rank according to the WHO/AFRO (SLIPTA) quality assurance standards	Output
4.15	Percentage of health facilities offering ART (CTC and PMCTC) that provide viral load and early infant diagnosis (EID) testing services through conventional and point-of-care testing	Output
4.16	Percentage of EID and HIV viral load (HVL) tests conducted at care and treatment laboratories against the annual targets	Output
4.17	Percentage of care and treatment laboratories that submit Laboratory Information System (LIS) reports (HVL, EID, CD4,	Output

Indicator reference number	Indicator	Level
	syphilis, cryptococcus, chemistry, and haematology) on a timely basis	
Intervention area 4.5: Healthcare equipment maintenance (laboratory equipment)		
Strategic outcome 6: Uninterrupted HIV services as a result of timely PPM of laboratory and other healthcare equipment		
4.18	Percentage of laboratory equipment covered by PPM system	Output
4.19	Percentage of equipment at care and treatment facilities/ laboratories reported as broken down in a given period	Output
4.20	Percentage of average time the laboratory equipment at care and treatment facilities/laboratories are functioning per quarter against the minimal requirement	Output
Intervention area 4.6: HIV strategic information		
Strategic outcome 7: A well-regulated, monitored, and evaluated programme with up-to-date research outcomes relevant for HIV and AIDS that addresses improved data quality and informs programme performance		
4.21	Proportion of RHMTs/CHMTs with a government employee designated to perform M&E functions	Output
4.22	Percentage of facilities providing HIV services with timely submission of reports into the DHIS 2	Output
4.23	Percentage of health facilities providing ART services with electronic data management systems (CTC database)	Output
Intervention area 4.8: Community-based health system		
Strategic outcome 8: Strengthened community participation for quality community-based health services (CBHS)		
4.24	Percentage of PLHIV on care and treatment enrolled in CBHS	Outcome
4.25	Percentage of missed appointment/loss to follow-up (LTFU) clients followed up and linked back to health facility services by community-based HIV and AIDS services providers	Outcome
4.26	Percentage of care and treatment facilities with a designated CBHS provider/supervisor	Output
STRATEGIC AREA 5: CROSS-SECTOR HIV AND AIDS INTERVENTIONS AND OTHER INNOVATIVE INVESTMENTS		
Intervention area 5.1: Stigma, discrimination, and gender-based violence (GBV)		
Strategic outcome 1: Proportion of PLHIV who reported experiencing stigma and discrimination from healthcare providers reduced from 40% to zero by 2022		
5.1	Percentage of women and men ages 15+ expressing specific accepting attitudes towards people with HIV and AIDS	Outcome
5.2	Percentage of PLHIV who experienced or perceived stigma when accessing health services	Outcome
Intervention area 5.2: Targeted social and behaviour change communication (SBCC)		
Strategic outcome 2: Adoption of safer sexual practices		
Strategic outcome 3: Increased uptake of comprehensive HIV and AIDS prevention, treatment, care, and support services		
5.3	Percentage of women and men ages 15–24 who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Outcome
5.4	Percentage of young women and men ages 15–24 who have had sexual intercourse before the age of 15	Outcome

Indicator reference number	Indicator	Level
Intervention area 5.3: Health sector workplace interventions		
Strategic outcome 4: Increased access to comprehensive workplace interventions focusing on HIV, TB, and HBV prevention, care, and support services by employees		
5.5	Number of health sector institutions implementing workplace HIV interventions	Output
Intervention area 5.4: Adolescents and young people		
Strategic outcome 5: Reduction of new HIV infections amongst adolescents and young women by 50% by 2022		
Strategic outcome 6: 95 percent of adolescents living with HIV will be on ART by 2022		
5.6	Percentage of adolescents and youth who receive HTS and receive their test results	Output
Intervention area 5.5: Male involvement		
Strategic outcome 7: Improved male involvement in HIV prevention, care, treatment, and support for their own health and the health of their partners and families		
	Refer to indicator 1.2: Proportion of individuals who test for HIV as couples	
	Refer indicator 3.14: Proportion of male partners of pregnant mothers tested for HIV and who know their HIV status	
Intervention area 5.6: Gender-based violence		
Strategic outcome 8: Reduce HIV associated sexual and gender-based violence		
Strategic outcome 9: Mitigate effects of GBV on survivors, especially women and young people		
5.7	Proportion of men and women ages 15–49 who experienced physical or sexual violence in the past 12 months	Outcome
5.8	Proportion of sexually abused clients receiving HIV post-exposure prophylaxis	Outcome
5.9	Proportion of sexually and physically abused clients tested for HIV	Output

Note: Core HSHSP IV indicators are marked with an asterisk (1.3, 2.2, 3.1, 3.5, 3.7, 3.8, and 3.15).

APPENDIX 2. COMPREHENSIVE HSHSP IV INDICATORS MATRIX

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
STRATEGIC AREA 1: HIV TESTING SERVICES									
Strategic outcome 1: 90% of people living with HIV are aware of their status by 2022									
1.1	Proportion of women and men ages 15+ years who have ever been tested for HIV and know their results	Numerator: Number of women and men ages 15+ years who have ever been tested for HIV and know their results Denominator: Number of women/men ages 15+	Age, sex, residence, marital status, wealth quantile, education	UNGASS, GARP	THIS 2016/17	Every 5 yrs	Women= 70.8% Men= 59.2% (THIS 2016-17)	Women=90% Men=90%	TACAIDS, NBS/MOHCD, GEC, PO-RALG
1.2	Proportion of individuals who test for HIV as couples	Numerator: Number of individuals who received testing and counselling services for HIV, and received their results as couples Denominator: Total number of individuals who received testing and counselling services during the same period	Age, sex	PEPFAR Next Generation Indicator (NGI) P11.1.D	NACP Annual Surveillance Report	Annually	4% (2016) general population	7%	NACP
1.3	Percentage of young people ages 15-24 living with HIV	Numerator: Number of young people ages 15-24 tested whose HIV test results are positive Denominator: Number of young people ages 15-24 tested for HIV	Age: 15-19; 20-24 Region Sex	HSHSP IV 2017-2022	Tanzania HIV/AIDS and Malaria Indicator Survey (TAMIS)	4-5 yrs	12% (2016)	To be decided (TBD)	TACAIDS, NBS

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 1.1: Linkage to HIV prevention, care, treatment, and support services									
Strategic outcome 2: All (100%) people identified as HIV positive during community and facility HTS are linked to HIV care, treatment, and support services by 2022									
1.4	Proportion of individuals (all ages, including children) diagnosed with HIV and linked to appropriate services	Numerator: Number of individuals (adults and children) who were tested for HIV, given results, and linked to appropriate services Denominator: Number of individuals (adults and children) who tested positive for HIV	All ages, sex Geographic location	HSHSP IV	NACP, IHIS	5 yrs and annually	91% (IHIS 2016/17), 98% programme data 2017	100%	NACP, NBS
STRATEGIC AREA 2: Prevention of new HIV infections									
Intervention area 2.1: Comprehensive condom programming									
Strategic outcome 1: 85 percent of women and men engaged in multiple sexual partnerships report use of a condom at last sexual intercourse									
2.1	Percentage of women and men ages 15+ who had higher-risk sex in the last 12 months who reported using a condom the last time they had sexual intercourse	Numerator: Number of women and men ages 15+ who had higher-risk sex (non-marital, non-cohabiting partner) in the last 12 months who reported using a condom the last time they had sexual intercourse Denominator: Number of all respondents ages 15-49 who reported having had more than one sexual partner in the last 12 months	Age, sex	GARP; GF M&E toolkit	IHIS (adolescent/youth secondary analysis)	Every 4-5 yrs	Males: 35% Females: 27% (IHIS 2016/17)	Males: 40% 2021 Females: 32% 2021	TACADS/ NACP, IPs, TAMISEMI- AFYA
2.2	Percentage of members of KVPs	Numerator: Number of members of KVPs who	Sex, Age	UNGASS	IBBSSS	Every 2-3 yrs	FSWs =	FSWs = 95% MSM = 50%	TACADS/ NCP,

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	who reported using a condom during their last high-risk sexual encounter	reported using a condom during their last high-risk sexual encounter Denominator: Number of KPs having sex in the past 12 months	KVP type: sex worker; PWD; people who use drugs (PWD), MSM, AGYW	GARP 2013 NACP			83.8%, (2016) MSM=43.1% (2016) PWD=4% (2016) PWD=22% (N=300,000) AGYW	PWD=30%	IPs, TAMISEMI- AFYA
Intervention area 2.2 Programming for key and vulnerable populations (KVP)									
Strategic outcome 2: Increased access and use of HIV services by KVP									
23	Proportion of health facilities providing KVP-friendly services	Numerator: Number of health facilities providing KVP-friendly services Denominator: Number of health facilities designated to provide KVP-friendly services	by facility type, geographic area	HSHSP IV 2017–2022	Health facility survey (SPA)	Every 2 yrs	NONE	TBD	TACADS/ NACP, IPs, TAMISEMI- AFYA
24	Number of KVP receiving HIV services	Number of KVP receiving HIV services	KVP type: (SW, PWD, PWUD, AGYW, MSM); type of service (HTS, ART)	HSHSP IV 2017–2022	Health facility survey (SPA)	Every two yrs	SWs, 25,305 PWD, 3,614 PWUD, 95 AGYW, 16,096 MSM, 3,294	TBD	TACADS/ NACP
25	Percentage of members of KVPs who have tested for HIV in the last 12	Numerator: Number of KVP who have been tested for HIV during the last 12 months and know their results	By KVP age range, type: SWs, PWD, PWUD, AGYW, MSM	UNGASS; GARP, HSHSP IV 2017–2022	IBBSSS	Periodic, every 2 yrs	FSWs, 76.4% (2017) MSM, 78.3% (2017)	100%	MOHCDGEC/ NACP, IPs, TAMISEMI- AFYA

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	months and know their results	Denominator: Number of KVP respondents					PWD: 71.5% (2017)		
26	Percentage of KVP who are HIV-positive	Numerator: Number of KVP who are HIV-positive Denominator: Number of KVP who tested for HIV	Age, Sex KVP type: sex worker, PWD, PWUD, AGYW, MSM	GARP 2013; GFM&E toolkit	NACP consensus report 2014	3-5 yrs	SWs: 31.4% (2016) MSM: 42% (2016) PWD: 51% (2016)	IBD	MCHDGECC /NACP, IPs, TAMISEMI- AFYA
Intervention area 23: Voluntary male medical circumcision (VMMC)									
Strategic outcome 3: Ninety percent (90%) male circumcision rate attained by all regions by 2022									
27	Proportion of males receiving VMMC services at healthcare facilities in the last 12 months	Numerator: Number of males receiving VMMC services at healthcare facilities in the last 12 months Denominator: Total males targeted for VMMC	Age	HS-SP IV 2017-2022, PEPFAR, monitoring, evaluation, and reporting (MER) 2.0	DHIS 2	Monthly, quarterly, annually	2%	90%	NACP, IPs, TAMISEMI- AFYA, DPs
28	Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery within the reporting period	Number of clients circumcised that experience one or more moderate or severe AE(s) during the reporting period	By AE: (moderate or severe)	PEPFAR MER 2.0,	DHIS 2	Monthly, quarterly, annually	0.6%	<0.5	NACP, IPs, TAMISEMI

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 2.4: STI management									
Strategic outcome 4: Incidence of STIs in the general population and syphilis amongst pregnant women reduced by 50% respectively by 2022									
2.9	Prevalence of syphilis amongst pregnant women	Numerator: Number of ANC attendees tested positive for syphilis Denominator: Number of ANC attendees tested for syphilis	Age	GARP; HSHSP IV	Sentinel surveillance	Every 2 yrs	18%	1%	MOH/DGEC /NACP, IPs, TAMISEMI- AFYA
2.10	Percentage of ANC attendees screened for syphilis at first ANC visit	Numerator: Number of ANC attendees screened for syphilis at first ANC visit Denominator: Number of ANC attendees at first ANC visit	Age	GARP; HSHSP IV	Sentinel surveillance	Every 2 yrs	50%	100%	MOH/DGEC /NACP, IPs, TAMISEMI- AFYA
2.11	Percentage of ANC attendees screened for syphilis	Numerator: Number of ANC attendees treated for syphilis Denominator: Number of ANC attendees with a positive syphilis serology	Age	GARP; HSHSP IV	Routine data	Monthly, quarterly	70%	100%	MOH/DGEC /NACP, TAMISEMI- AFYA
Intervention area 2.5: Blood safety									
Strategic outcome 5: All (100%) donated blood units will be screened for TTIs (HIV, HBV, HCV, and syphilis) as per the WHO quality assurance procedure by 2022									
2.12	Percentage of donated blood units screened for HIV per WHO quality assurance procedures	Numerator: Number of units of donated blood screened for HIV per WHO quality assurance procedures Denominator: Number of all blood units donated	None	NMSF HSHSP IV	NBIS	Quarterly, annually	6%	100%	MOH/DGEC /NBIS

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 2.6: Reproductive health cancers									
Strategic outcome 6: By 2022, 60 percent of female clients ages 30–50 screened for cervical cancer using VIA and cryotherapy									
2.13	Percentage of HIV-positive women ages 15–49 screened for cervical cancer using VIA method	Numerator: Number of HIV-positive women ages 15–49 screened for cervical cancer using VIA method Denominator: Number of HIV-positive women ages 15–49 currently on care	Age, geographic location	WHO	DHIS2	Quarterly, annually	22%	50%	MCHDGECC, IPs, TAMISEMI-AFYA
2.14	Proportion of health facilities providing cervical cancer screening (VIA)	Numerator: Number of health facilities using VIA for cervical cancer screening Denominator: Number of health facilities that provide HIV care and treatment services	Facility type (hospital, health centre, dispensary), ownership (public, private, faith-based organisation (FBO)) Geographic location	WHO	DHIS2	Quarterly, annually	435/6259 (6%)	80%	MCHDGECC, IPs, TAMISEMI-AFYA
2.15	Proportion of health facilities using cryotherapy/LEEP for early treatment of precancerous cervical lesions	Numerator: Number of health facilities using cryotherapy/LEEP for early treatment of precancerous cervical lesions Denominator: Number of designated health facilities that provide HIV care and treatment services	Facility type (hospital, health centre, dispensary), ownership (public, private, FBO), geographic location	WHO SI guideline 2015	Programme report	Annually	TBD	80%	MCHDGECC, IPs, TAMISEMI-AFYA

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Strategic area 3: Facility-based care and support for PLHIV									
Intervention area 3.1: ART services for adults									
Strategic outcome 1: By 2022, 95 percent of all adults (>15) diagnosed with HIV will be on ART									
3.1	Number of AIDS-related deaths per 100,000 population	Number of AIDS-related deaths per 100,000 population	Female vs. male age range: 15–19, 20–24, and 25+ years, region	HSHSP IV 2017–2022			49.1	23.1	TACADS/NBS
3.2	Number of PLHIV newly initiated on treatment in the past 12 months	Number of adults and children newly initiated on ART in the past 12 months	Sex, age, pregnancy status, breastfeeding	HSHSP IV	DHIS 2	Quarterly, annually	244,680	186,492	MOH/DGEC /NACP, IPs, DPs
3.3	Number of PLHIV currently on ART	Number of PLHIV currently on ART	Sex, age, pregnancy status, breastfeeding	HSHSP IV	DHIS 2	Quarterly, annually	964,812	1,273,820	MOH/DGEC /NACP, IPs, DPs
3.4	Percentage of persons who are on second-line regimen during reporting period	Numerator: Number of persons who are on second-line regimen during reporting period Denominator: Total number of persons currently on ART during reporting period	Age, sex	HSHSP IV	DHIS 2	Quarterly, annually	2.9%	10%	MOH/DGEC /NACP, IPs, DPs

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
3.5	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART	Numerator: Number of adult and children who are still alive and on ART at 12 months after initiating treatment Denominator: Total number of adults who initiated ART who were expected to achieve 12-month outcomes within the reporting period, including those who have died since starting ART, those who have stopped ART, and those recorded as LTFU at month 12	Female vs. male age range: 15–19, 20–24, and 25+ years Region	HS-SP IV 2017–2022	Care and treatment report cohort analysis	Annually	Adults: 82% Children: 86% (2017)	90% for both (adults & children)	MOH/DGEC /NACP, IPs, DPs
3.6	Percentage of PLHIV on ART monitored using VL as a standard of care	Numerator: Number of clients on ART monitored using VL as a standard of care Denominator: Total number of clients currently on ART	Age, sex	HS-SP IV 2017–2022	CIC2 data base, HIS 2	Quarterly, annually	75% (2017)	95%	MOH/DGEC /NACP, IPs, DPs
3.7	Number and percentage of people living with HIV and on ART who are virologically suppressed (amongst all those currently on treatment who received a VL measurement regardless of when they started ART)	Numerator: Number of people living with HIV and on ART who have a suppressed VL (<1,000 copies/ml) Population-level denominator: Number of people living with HIV who are currently receiving ART	Age (<5, 5–9, 10–14, 15–19, 20–24, 25–49, 50+), sex, geographic location	WHO SI guideline, 2015, p. 153	ART register, patient records, population-based surveys; e.g., THIS	Semi-annually and annually	85% (2017)	100%	MOH/DGEC /NACP, IPs, DPs

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 3.2: Paediatric ART services									
Strategic outcome 2: All children under age 15 (100%) initiated and 90% retained on ART by 2022									
3.8	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	Numerator: Estimated number of children who will be newly infected with HIV due to MICT amongst children born to HIV-positive women Denominator: Estimated number of HIV-positive women who delivered in the previous 12 months	None	HSHSP IV 2017-2022	Spectrum modelling	Annually	1.9% (2016)	1.3%	MOH/DGEC
3.9	Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	Numerator: Number of HIV-exposed infants tested with DNA-PCR within 2 months of birth Denominator: Estimated number of all infants born to HIV-infected mothers	None	HSHSP IV 2017-2022	Numerator; programme data denominator; Spectrum estimates	Annually	55.2% (2016)	90% (2022)	MOH/DGEC /PMICT
3.10	Percentage of HIV-exposed infants tested with DNA-PCR within 2 months of birth	Numerator: Number of HIV-exposed infants who are tested with DNA-PCR within 2 months of birth Denominator: Number of all infants born to HIV-infected mothers	Infants who received DNA-PCR test in first 2 months after birth and 2-12 months; infants tested should be counted only once	NMSF	PMICT programme data	Annually	55.2% (2016)	90% (2022)	None

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
3.11	Percentage of DBS samples rejected at DNA-PCR testing laboratories	Numerator: Number of DBS samples rejected at DNA-PCR testing laboratories Denominator: Number of all DBS samples received at DNA-PCR testing laboratories	None	HS-SP III	Lab data	Annually	3% National HIV Laboratory Quality Assurance and Training Centre (NHLQATC)	<1%	MOH/DGEC NHLQATC
3.12	Percentage of DBS tests that have turnaround time for DBS reduced to less than 4 weeks from when the sample is collected to results back to client or caregiver	Numerator: Number of DBS tests that have turnaround time for DBS reduced to less than 4 weeks from when the sample is collected to results back to client or caregiver Denominator: Number of all DBS tests	None	HS-SP III	Facilities with CTC2 database; enhanced monitoring	Annually	60 days	28 days	MOH/DGEC PMICT
Intervention area 3.3: ART for pregnant and lactating women									
Strategic outcome 3: Reduction of MICT of HIV from an estimated 8% in 2015 to 4% at the end of breastfeeding by 2022									
3.13	Proportion of pregnant women tested for HIV and know their status	Numerator: Number of pregnant women tested for HIV and given results Denominator: Estimated number of pregnant women in a year	Age (16-19, 20-24, ≥25)	eMICH	Routine PMICT data (MHS)	Annually	91%	98%	MOH/DGEC PMICT

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
3.14	Proportion of male partners of pregnant mothers tested for HIV and know their HIV status	Numerator: Number of male partners of pregnant women tested for HIV and given results Denominator: Estimated number of Pregnant women per year	None	eMICT II	Routine PMICT data (MHS)	Annually	5/2%	80%	MOH/DGEC PMICT
3.15	Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of MTCT of HIV	Numerator: Number of HIV-positive pregnant women who received ARVs during the past 12 months to reduce risk of MTCT Denominator: Estimated number of HIV-positive pregnant women identified in the last 12 months, based on ANC surveillance	By regimen type: (1) Single-dose nevirapine only (2) Prophylactic regimens using a combination of 2 ARVs (3) Prophylactic regimens using a combination of 3 ARVs (4) ART for HIV-positive pregnant women eligible for treatment	HS-SP IV 2017-2022	PMICT database	Annually	TBD	95%	MOH/DGEC /NACP, RCH clinics
3.16	Proportion of women alive and on ART during PMICT care	Numerator: Number of mothers alive and on ART while in PMICT care Denominator: All mothers tested as HIV positive in a specified time	12 months, 24 months	eMICT II	Routine PMICT cohort data	Annually	Not available	95% at 12 months, >90% at 24 months	MOH/DGEC PMICT

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 3.4 : HIV co-infections and co-morbidities									
Strategic outcome 4: By 2022, burden of other HIV co-infections and co-morbidities amongst PLHIV reduced by 50 percent of the 2016 level									
3.17	Number of HIV-positive patients who received TB treatment	Number of HIV-positive patients who received TB treatment	Age, sex	HS-SP IV 2017-2022	DHIS 2	Annually	14,343 (2017)	63,691	NACP, National Tuberculosis and Leprosy Programme (NITP), IPs, TAMISEMI-AFYA
3.18	Percentage of HIV-positive patients starting IPT during the reporting period	Numerator: Number of HIV-positive patients starting IPT Denominator: Number of adults and children enrolled in HIV care during the reporting period	Age Sex	HS-SP IV 2017-2022	DHIS 2, CIC2 database	Quarterly, annually	7.4%	100%	NACP; NITP, IPs, TAMISEMI-AFYA
Intervention area 3.5: Achieving viral suppression									
Strategic outcome 5: By 2022, 95 percent of all PLHIV who are on ART achieve viral suppression									
	Refer to indicators 3.6 and 3.7								
Intervention area 3.6: Community-based HIV/AIDS care									
Strategic outcome 6: Improved identification, retention, adherence, and psychosocial support to PLHIV through community-based HIV and AIDS services									
Strategic outcome 7: Improved identification, retention, adherence, and psychosocial support to PLHIV									
3.19	Percentage of PLHIV receiving care and treatment enrolled in CBHS	Numerator: Number of PLHIV receiving care and treatment enrolled in CBHS	Sex, age	HS-SP III	DHS	Monthly	51.2% (507,479/990,699)	90%	LGA, NACP, MOH-DGEC

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
		Denominator: Total number of PLHIV receiving care and treatment services							Development partners
3.20	Percentage of missed appointment/LTFU clients followed up and linked back to health facility services by CBHS	Numerator: Number of missed appointments/LTFU clients linked back to health facility services by CBHS providers Denominator: Number of missed appointments and LTFU clients reported in the reporting period	Type of clinic; i.e., RCH, CTC	HS-HSP III	FMS	Monthly	None	90%	LGA, NACP, IPs, development partners
3.21	Percentage of care and treatment facilities with a designated CBHS provider or supervisor	Numerator: Number of care and treatment facilities with a designated CBHS provider/supervisor Denominator: Total number of care and treatment facilities	By facility level	HS-HSP III	DHS/NACP CBHS report	Annually	48%	90%	MCH/DGEC
STRATEGIC AREA 4: Building resilient and sustainable systems for health to support the national response									
Intervention area 4.1: Quality improvement of HIV and AIDS services									
Strategic outcome 1: RMTs, CHMTs, and health facilities have active quality improvement teams that oversee the implementation, documentation, and reporting of quantitative data on the quality of HIV and AIDS services									
4.1	Percentage of health facilities (hospitals) with active QI teams, i.e., completing at least 1	Numerator: Number of health facilities providing HIV services with an active QI team	Facility type (dispensary, health centre,	HS-HSP III	HIV routine programme data	Quarterly	No	50%	NACP

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	QI cycle per intervention per quarter	Denominator: Number of health facilities providing HIV services	hospital) and by residence						
4.2	Percentage of R-HMIs and CHMIs with active QI teams	Numerator: Number of R-HMIs/CHMIs with active QI team Denominator: Number of R-HMIs/CHMIs	None	HS-HSP III	Routine Programme data	Annually	0	90%	NACP
4.3	Proportion of health facilities providing quality HIV testing and counselling services according to national standards	Numerator: Number of facilities providing quality HIV testing and counselling services according to national standards Denominator: Total number of facilities providing HIV testing and counselling services	Disaggregated by facility type (dispensary, health centre, hospital), facility ownership (public or private), and residence (rural vs urban)	HS-HSP III	TSPA	Biennially	81% TSPA 2014-2015	100%	NACP
4.4	Percentage of health facilities providing HIV services assessed for data quality in the last 12 months	Numerator: Number of health facilities providing HIV services assessed for data quality in the last 12 months Denominator: Total number of health facilities providing HIV services	By intervention type (care and treatment, etc.) and facility level	HS-HSP III	NACP DQA report/DHS	Annually	Core and treatment: 26 (100%) Pediatric: 14 (100%) Other interventions: 26 (100%)	100%	MCH/DGEC

Intervention area 4.2: Medicine and technologies

Strategic outcome 2: Uninterrupted supply of medicines and commodities for STI/RTI, HIV, and AIDS at all levels by 2022

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
4.5	Percentage of health facilities that have experienced stockouts of selected tracer items in HIV programme in the last 3 months (HSHSP III, p. 81)	Numerator: Number of health facilities that have experienced stockouts of at least one tracer item in the last 12 months Denominator: Number of health facilities providing care and treatment	Disaggregated by facility type (dispensary, health centre, hospital), facility ownership (public, private, FBO), geographic location	GFM&E Toolkit; NMSF	HMS	Quarterly	5%	3%	MOH/DGEC
4.6	Proportion of Government of Tanzania expenditure from own funds on procurement of ARVs, HIV rapid test kits, and diagnostics	Numerator: Amount of funds allocated for procurement of ARVs, HIV rapid kits, and diagnostics Denominator: Total expenditure for HIV commodities	None	Newmodel GF (2018–2020)	PER (Public Expenditure Review), NASA (National AIDS Spending Assessment)	Biennially	12 billion	14.4 billion	TACADS
4.7	Proportion of hospitals and health centres implementing electronic logistics data management system	Numerator: Number of hospital and health centres implementing logistics data management system Denominator: Number of hospitals and health centres implementing HIV care and treatment services	By facility type (hospital, health centre), geographic location	Programme indicator	LMS (Logistics Management Information System)	Quarterly	48% of facilities (400/826)	75%	MOH/DGEC

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
4.8	Proportion of health facilities with at least one clinical staff trained on rational use of HIV medicines and pharmacovigilance	Numerator: Number of health facilities with at least one clinical staff trained on rational use of HIV medicines and pharmacovigilance Denominator: Number of health facilities implementing HIV care and treatment services	By facility type (dispensary, health centre, hospital), facility ownership (public, private, FBO), geographic location	FSHSP III	TrainsMART	Quarterly	9% (180/192)	80%	MCH/DGEC
Intervention area 4.3: Health facility commodity management and rational use of medicine									
Strategic outcome 3: Commodity management and logistic information will be generated and used at different levels of the health delivery system to improve decision making									
4.9	Percentage of HIV care and treatment facilities prescribing and dispensing ARV/Os according to national guidelines	Numerator: Number of HIV care and treatment facilities prescribing and dispensing ARV/Os according to national guidelines Denominator: Total number of health facilities implementing HIV care and treatment	By facility type	FSHSP IV 2017–2022	Rational use of medicine assessment report	Annually	TBD	ARV/Os: 80%	MCH/DGEC
4.10	Percentage of ordering facilities submitting ARV/Os and laboratory logistics reports within a specified time limit	Numerator: Number of facilities submitting ARV/Os and laboratory logistics within a specified time limit Denominator: Number of facilities implementing HIV care and treatment services	By commodity system type (ARV/Os, and laboratory)	FSHSP IV	eLMS	Nb ARV and Os reported quarterly; plans are underway to start reporting after every 2 months	ARV: 95% Lab: 90%	ARV: 100% Lab: 90%	MCH

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Strategic outcome 4: Improved tracking of adverse drug effects									
4.11	Number of care and treatment facilities documenting ADRs and reporting TFDA	Numerator: Number of care and treatment facilities documenting ADRs and reporting them to TFDA Denominator: Number of care and treatment facilities.	By facility type	HSHSP IV	TFDA	Quarterly	Not currently available	60%	MOH/DGEC
4.12	Proportion of health facilities using pharmacovigilance reports at a facility level	Numerator: Number of health facilities using pharmacovigilance reports Denominator: Total number of health facilities implementing HIV care and treatment	By facility level	HSHSP IV	Rational use of medicine assessment report	Annually	TBD	70%	MOH/DGEC, GHSC-TA, USAID
Intervention area 4.4: Laboratory services									
Strategic outcome 5: Quality laboratory services provided for HIV/AIDS clients at all levels									
4.13	Percentage of care and treatment hospital and health centre laboratories enrolled in SLMTA process according to the WHO/Afro (SLIPTA) quality assurance standards	Numerator: Number of laboratories which meet quality assurance standards for enrolment in SLMTA Denominator: Number of care and treatment hospitals (N=241) and health centres (N=585)	By facility type (dispensary, health centre, hospital), facility ownership (public, private, PBO), geographic location	WHO'S Guidelines 2015	Country SLMTA Report	Annually	National, zonal, and specialised hospitals: 7 Region: 24 District: 25	Hospitals: 80% Health centres: 10%	MOH/DGEC, WHO, CDC, USAID, DOD, and IPs

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
							Private, military, and FBO: 22 Health centres: 3		
4.14	Percentage of hospital and health centre laboratories enrolled in SLMTA process which achieved star rank according to the WHO/AFRO (SLIPTA) quality assurance standards	Numerator: Number of laboratories which meet quality assurance standards and achieve at least one-star rank Denominator: Number of care and treatment hospitals and health laboratories enrolled in the SLMTA programme	By facility type (dispensary, health centre, hospital), facility ownership (public, private, FBO), geographic location	WHO	Country SLMTA report	Annually	National, zonal, and specialised hospitals, 5 Regional, district, FBO, private, and military hospitals, 25 Health centres, 0	Hospitals: 80% Health centres: 10%	MOH/DGEC, WHO, CDC, USAID, DOD, and IPs
4.15	Percentage of health facilities offering ART (CTC and PMCT) that provide VL and EID testing services through conventional and POC testing	Numerator: Number of health facilities offering ART that provide both VL and EID services Denominator: Number of health facilities offering ART services (CTC and PMCT): Hospitals N = 241; health centres, N = 585; dispensaries, N = 1,100	By facility type (hospital, health centre, dispensary), facility ownership (public, private, FBO), geographic location, type of test (EID or HML)	HS-HSP IV	LIS (Lab Information System) and PMCT annual report	Quarterly	Hospitals: 90% Health centres: 70% Dispensaries: 50%	Hospitals: 99% Health centres: 95% by 2022 Dispensaries: 80% by 2022	MOH/DGEC, CHAI, WHO, CDC, USAID, DOD, and IPs

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
4.16	Percentage of EID and HML tests conducted at care and treatment laboratories against the annual targets	Numerator: Number of EID and HML tests conducted at care and treatment laboratories Denominator: Targeted number of EID and HML tests per year	By facility type (hospital, health centre, dispensary) facility, ownership (public, private, FBO), geographic location (EID and HML)	HS-HSP IV	Open Laboratory Data Repository	Quarterly	HML: 80% EID: 33%	HML: 95% by 2022 EID: 90% by 2022	MOH/DGEC, CHAI, and IPs
4.17	Percentage of care and treatment laboratories that submit timely LIS reports (HML, EID, CD4, syphilis, cryptococcus, chemistry, and haematology)	Numerator: Number of care and treatment hospital and health centre laboratories timely submit LIS reports Denominator: Total number of care and treatment hospital and health centre laboratories	Disaggregated by level: national/specialised/zonal/regional; district, FBO, military, private hospital; health centre; geographic location	HS-HSP IV	Open LDR (NHLQATC)	Quarterly	National/specialised/zonal and regional: 80% District/FBO/military, and private: 0% Health centres: 0%	National/specialised/zonal and regional: 99% District/FBO/military and private: 50% Health centres: 20%	MOH/DGEC and PO-RALG
Intervention area 4.5: Healthcare equipment maintenance (laboratory equipment)									
Strategic outcome 6: Uninterrupted HIV services as a result of timely PPM of laboratory and other healthcare equipment									
4.18	Percentage of laboratory equipment covered by PPM system	Numerator: Numbers of laboratory equipment on PPM contract Denominator: Total numbers of laboratory equipment identified for PPM	Disaggregate by test panel (HML, EID, CD4, chemistry and haematology) and testing platform	HS-HSP IV	Open Laboratory Data repository (Open LDR)	Biannually	HML/EID: 90% CD: 40% chemistry: 35% haematology: 35%	HML/EID: 98% CD4: 90% Chemistry: 70% Haematology: 70%	MOH/DGEC, CDC, USAID, DOD, and IPs

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
4.19	Percentage of equipment at care and treatment facilities or laboratories reported as broken down in a given period	Numerator: Numbers of equipment at care and treatment facilities laboratories reported as broken down in a given period Denominator: Numbers of equipment at care and treatment hospital and health centre laboratories	Disaggregate by type of test and level of facility HIV/ED; CD4; Haematology; chemistry	HS-HSP IV	Open LDR	Monthly	HIV/ED; CD4; haematology; chemistry; (Pavel/ Bohati)	HIV/ED CD4 Haematology Chemistry	MOHCDGEC CDC, USAID, DOD, and IPs
4.20	Percentage of average time the laboratory equipment at care and treatment facilities functioning per quarter against minimal requirements	Numerator: Average time the laboratory equipment at care and treatment facilities are functioning Denominator: Standard functioning time of equipment at care and treatment hospital and health centre laboratories	Disaggregate by type of test and level of facility HIV/ED; CD4; haematology; chemistry	HS-HSP IV	Open LDR	Quarterly	HIV/ED; CD4; haematology; chemistry	HIV/ED; CD4; haematology; chemistry	MOHCDGEC CDC, USAID, DOD, and IPs
Intervention area 4.6: HIV strategic information									
Strategic outcome 7: A well-regulated, monitored, and evaluated programme with up-to-date research outcomes relevant for HIV and AIDS, and that addresses improved data quality and informs programme performance									
4.21	Proportion of RHMTs/CHMTs with a government employee designated to perform M&E functions	Numerator: Number of RHMTs/CHMTs with a government employee designated to perform M&E functions Denominator: Total number of RHMTs/CHMTs	By regions and districts	HS-HSP IV	PORALG workforce database	Annually	None	50% (2022)	PORALG/ MOHCDGEC

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
4.22	Percentage of facilities providing HIV services with timely submission of reports into the DHIS 2	Numerator: Number of facilities providing HIV services with timely submission of reports into the DHIS: Denominator: Total number of facilities providing HIV services	By HIV interventions (HIS, ART, PMTCT, CBHS, VMMC, STI)	FSHSP IV; GF Health Systems Strengthening (HSS) M&E Plan	DHIS	Quarterly/monthly	CIC/ART: 87%	100% (2022)	MOH/DGEC
4.23	Percentage of health facilities providing ART services with electronic data management systems (CIC database)	Numerator: Percentage of health facilities providing ART services with electronic data management systems (CIC database) Denominator: Number of health facilities providing ART (Including Option B+)	By level of facility	FSHSP IV	DHIS	Annually	1,700/6,259 (27%)	95%	MOH/DGEC
Intervention area 4.8: Community-based health system (CBHS)									
Strategic outcome 8: Strengthened community participation for quality CBHS									
4.24	Percentage of PLHIV on care and treatment enrolled in CBHS	Numerator: Number of PLHIV on care and treatment enrolled in CBHS Denominator: Total number of PLHIV on care and treatment services	Sex, age	FSHSP IV	DHIS	Monthly	51.2% (507,479/990,699)	90%	LGA, NACP, MOH/DGEC, development partners
4.25	Percentage of missed appointment/LTFU clients followed up and linked back to health facility	Numerator: Number of missed appointments/LTFU clients linked back to health facility services by CBHS providers	Type of clinic (RCH, CT)	FSHSP IV	HMIS	Monthly	None	90%	LGA, NACP, IPs, development partners

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	services by CBHS providers	Denominator: Number of missed appointments and LTFU clients reported in the reporting period							
4.26	Percentage of care and treatment facilities with a designated CBHS provider or supervisor	Numerator: Number of care and treatment facilities with a designated CBHS provider or supervisor Denominator: Total number of care and treatment facilities	By facility level	HS-SP IV	DHS/NACP CBHS report	Annual	48%	90%	MCH/DGEC
STRATEGIC AREA 5: Cross-sector HIV and AIDS interventions and other innovative investments									
Intervention area 5.1: Stigma, discrimination, and gender-based violence (GBV)									
Strategic outcome 1: Proportion of PLHIV who reported experiencing stigma and discrimination from healthcare providers reduced from 40% to zero by 2022									
5.1	Percentage of women and men ages 15+ expressing specific accepting attitudes towards people with HIV and AIDS	Numerator: Number of women and men ages 15+ expressing specific accepting attitudes towards people with HIV and AIDS Denominator: Number of women and men ages 15+ surveyed	Male and female, age, education, residence	IHIS	IHIS 2016–2017	5 yrs	Men: 40% Women: 25%	100%	MCH, NBS, TACAIDS
5.2	Percentage of PLHIV who experienced or perceived stigma when accessing health services	Numerator: Number of PLHIV who reported experiencing stigma when accessing HIV services Denominator: Total number of PLHIV surveyed	Sex, age, residence	IHIS	IHIS 2016–2017	5 yrs	TBD	0%	TACAIDS, MCH/DGEC, NACP, NACOP/HA

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 5.2: Targeted social and behaviour change communication (SBCC)									
Strategic outcome 2: Adoption of safer sexual practices									
Strategic outcome 3: Increased uptake of comprehensive HIV and AIDS prevention, treatment, care, and support services									
5.3	Percentage of women and men ages 15–24 who correctly identify both ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission	Numerator: Number of respondents ages 15–24 who correctly answered all five questions Denominator: Number of all respondents ages 15–24	Sex, age, residence	GARP; GF M&E toolkit	THIS 2016–2017	5 yrs	Males: 37% Females: 36.7%	Men: 50% (2022) Women: 50% (2022)	NBS, TACAIDS, MOH/DGEC
5.4	Percentage of young women and men ages 15–24 who have had sexual intercourse before the age of 15	Numerator: Number of respondents ages 15–24 who had sexual intercourse before age 15 Denominator: Number of respondents ages 15–24	Age, sex, residence	THIS, UNGASS	THIS 2016–2017	Every 3–5 yrs	Males: 14.7% Females: 9.3%	TBD	NBS, TACAIDS, MOH/DGEC
Intervention area 5.3: Health sector workplace interventions									
Strategic outcome 4: Increased access to comprehensive workplace interventions focusing on HIV, TB, and HBV prevention, care, and support services by employees									
5.5	Number of health sector institutions implementing workplace HIV interventions	Numerator: Number of enterprises implementing an HIV AND AIDS workplace programme, providing at least one of the 4 critical components Denominator: NA	Type of health sector institution, (training institution, ministerial departments and agencies, healthcare facilities, etc.)	PEPFAR/NGI P10.1.D, HSHSP IV	Workplace survey	Annually	None	None	MOH/DGEC, TACAIDS

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
Intervention area 5.4 Adolescents and young people									
Strategic outcome 5: Reduction of new HIV infection amongst adolescents and young women by 50% by 2022									
Strategic outcome 6: 95% of adolescents living with HIV will be on ART by 2022									
5.6	Percentage of adolescents and youth who receive HIV and then their test results	None	Sex: male vs. female; age ranges (15-19; 20-24); marital status; geographic area	(ZHSFSP III) 2017-2022	HIS database	Annually	Not available	50% (2022)	UNICEF, MOH/DGEC
Intervention area 5.5: Male involvement									
Strategic outcome 7: Improved male involvement in HIV prevention, care, treatment, and support for their own health and the health of their partners and families									
	Refer to Indicator 1.2: Proportion of individuals who test for HIV as couples								
	Refer to Indicator 3.14: Proportion of male partners of pregnant mothers tested for HIV and who know their HIV status								
Intervention area 5.6: Gender-based violence									
Strategic outcome 8: Reduce HIV-associated sexual and GBV									
Strategic outcome 9: Mitigate effects of GBV on survivors, especially women and young people									
5.7	Proportion of men and women ages 15-49 who	Numerator: Number of ever married or partnered men and women ages	Age, sex, residence	GARP	DHS 2	Annual	Females: 47,719	TBD	TACADS, MOH/DGEC

No	Indicator	Indicator definition (numerator and denominator)	Disaggregation	Indicator source	Data source	Frequency	Baseline	Target	Stakeholder
	experienced physical or sexual violence in the past 12 months	15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months Denominator: Total number of women ages 15-49 surveyed					Males: 10,986 (2017)		
5.8	Proportion of sexually abused clients receiving HIV PEP	Numerator: Number of sexually abused clients receiving HIV PEP Denominator: Number of all clients reported sexually abused	Age, sex, residence	HSHSP IV	DHIS 2	Monthly	Females: 666/2,325 (28.6%) Males: 169/403 (42%)	100%	TACADS, MOHCDGEC
5.9	Proportion of sexually and physically abused clients tested for HIV	Numerator: Number of sexually abused clients tested for HIV Denominator: Number of all clients reported sexually abused	Age, sex, residence	HSHSP IV	DHIS 2	Monthly	Females: 12,918 (27%) Males: 3,085 (28%)	100%	TACADS, MOHCDGEC

APPENDIX 3. HEALTH SECTOR M&E SYSTEM STRENGTHENING ACTION PLAN

M&E system component	Specific activities	Timeline	Responsibility
1. Organisational structure for M&E	1.1. Fill in all M&E posts within NACP's national and subnational structures	2018	NACP; PO-PSM; PO-RALG
	1.2. Advocate with the PO-PSM and PO-RALG for the finalisation of a scheme of service for council-level M&E officers to improve health sector HIV/AIDS services data collection, quality, and use	2018	NACP
	1.3. Strengthen the capacity of council and regional HMIS focal persons on HIV data systems, including in DHIS 2 data analysis, visualisation, and presentation	Ongoing	NACP
	1.4. Strengthen collaboration with implementing partners in the implementation of M&E activities for the health sector HIV response	Ongoing	NACP
	1.4.1. Conduct annual HIV workplan development workshop with implementing partners	March-May each year	NACP
	1.4.2. Conduct quarterly HIV programme performance review with implementing partners	Quarterly	NACP
	1.5. Promote and strengthen regional M&E TWGs as a forum for reviewing performance against the HS-SP IV indicators and addressing data quality and data use challenges	2018	NACP; R-HMIs; CHMIs
	1.5.1. Develop terms of reference for regional M&E TWGs	July, 2018	NACP
	1.5.2. Establish a secretariat for regional M&E TWGs	Sep. 2018	R-HMIs; CHMI
	1.5.3. Conduct quarterly regional M&E TWG meetings	Oct. 2018, then quarterly	NACP; R-HMIs; CHMIs
2. Human capacity	2.1. Assess knowledge and skills amongst regional and council-level HIV/AIDS M&E focal persons and develop capacity-building plan as appropriate	2018; 2019	NACP
	2.1.1. Conduct M&E skills assessment amongst regional and council-level HIV/AIDS M&E focal persons	Oct. 2018	NACP

	2.1.2.	Develop customised training packages for regional and council level HIV/AIDS M&E focal persons	Dec. 2018	NACP
	2.1.3.	Conduct training for regional and council level HIV/AIDS M&E focal persons	Jan.–July 2019	NACP
	2.2.	Promote the use of the training system monitoring and reporting tool (TrainSMART) in tracking all HIV M&E training activities	2018	NACP; MOHCDGEC
	2.2.1.	Provide access to trainSMART database for all councils within the country	July 2018	NACP; MOHCDGEC
	2.2.2.	Appoint a trainSMART database focal person for each council	Dec. 2018	NACP; MOHCDGEC
	2.2.3.	Conduct orientation training for trainSMART focal persons	2019	NACP; MOHCDGEC
	2.3.	Review the curriculum for medical records and determine scope for adding health sector HIV and M&E contents	2018	NACP
3. Partnerships	3.1.	Strengthen the NACP national health sector HIV M&E subcommittee as a platform for engaging with stakeholders	2018	NACP
	3.1.1.	Review the terms of reference for the NACP national health sector HIV M&E subcommittee	2018	NACP
	3.1.2.	Streamline MOHCDGEC M&E Strengthening Initiative (MESI) and NACP national health sector HIV M&E subcommittee meeting schedules	2018	NACP; MOHCDGEC
	3.2.	Develop a regular (quarterly) newsletter as a tool for stakeholder engagement	Ongoing	NACP
	3.3.	Actively participate in the MOHCDGEC M&E MESI and TWG	Ongoing	NACP
	3.3.1.	Assign an NACP M&E subcommittee member to attend all MOHCDGEC MESI M&E TWG meetings	Ongoing	NACP
4. Routine programme monitoring	4.1.	Develop data collection tools and data management guidelines for condom distribution, IEC, and KPs programmes	2018	NACP
	4.2.	Establish and strengthen monitoring and reporting of financial resources and investments of both the government and implementing partners for the health sector HIV response	2018	NACP; FORALG
5. Surveys and surveillance	5.1.	Conduct demonstration studies to determine the operational and implementation strategies required to roll out PrEP and HIV self-testing interventions amongst different populations in Tanzania	2018–2019	NACP; NBS

	5.1.1. Create a study advisory committee	2018	NACP; NBS
	5.1.2. Develop study protocols	2018	NACP; NBS
	5.1.3. Conduct the demonstration studies in selected sites	2018-2019	NACP; NBS
	5.2. Conduct integrated biological and behavioural surveillance surveys every two years as per protocol	2019; 2021	NACP; NBS
	5.2.1. Create a study advisory committee	2019	NACP; NBS
	5.2.2. Develop a study protocol	2019	NACP; NBS
	5.2.3. Conduct the IBBSS study in selected sites	2019	NACP; NBS
	5.3. Conduct workplace intervention surveys	2019	NACP; NBS
	5.3.1. Develop study protocol	2019	NACP
	5.3.2. Implement workplace intervention surveys	2019	NACP
6. National and subnational databases	6.1. Complete the integration of HIV care and treatment data reporting into the DHIS2	2018	NACP; MOH/JD/GEC
	6.1.1. Harmonise import and export functionalities of all existing HIV databases (CTC2, HBC, HTC, STI, PMICT) with the DHIS2	2018	NACP; MOH/JD/GEC
	6.2. Develop a database for the KPs programme	2018	NACP
7. Evaluation and research	7.1. Develop an inventory of HIV/AIDS research and evaluation	2018	NACP
	7.2. Develop a health sector HIV research and evaluation agenda	2018	NACP
	7.3. Develop and disseminate policy briefs on major research studies completed	Ongoing	NACP

