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PERFORMANCE EVALUATION OF TUNAJALI II AND LIFE COMPREHENSIVE HIV CARE ACTIVITIES IN TANZANIA

September 2016

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Cover Photo: Community health worker team in Mtwara. Photo credit: Terence Beney.

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ACRONYMS

AGPAHI	Ariel Glaser Pediatric AIDS Healthcare Initiative
ANC	Antenatal
ART	Antiretroviral therapy
ARV	Antiretroviral
B2TI	Back to Treatment Initiative
C&T	Care and treatment
CAG	Controller and Auditor General
CBCS	Community-based care services
CCHPs	Comprehensive Council Health Plans
CDC	Centers for Disease Control
CHMT	Council Health Management Team
CHW	Community Health Worker
CoC	Continuum of care
CSO	Civil Society Organization
CSSC	Christian Social Services Commission
CTCs	Care and treatment clinics
DBS	Dry blood spot
DMOs	District Medical Officers
DRCHCO	District Reproductive and Child Health Coordinator
EGPAF	Elizabeth Glaser Pediatric Aids Foundation
EID	Early infant diagnosis
FANC	Focused antenatal care
FAR	Fixed Amount Reimbursement
GBV	Gender-based violence
GDP	Gross domestic product
GTI	Gender Training Institute
HBC	Home-based care
HEID	HIV-exposed early infant diagnosis
HMIS	Health management information system
IP	Implementing Partner
LGAs	Local government authorities

LIFE	Linking Initiatives for the Elimination of Pediatric HIV
M&E	Monitoring and evaluation
MNCH	Maternal and Newborn Child Health
MoHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MUHAS	Muhimbili University of Health and Allied Sciences
NACP	National Aids Control Program
NACS	Nutritional assessment counselling and support
NGO	Nongovernmental Organization
OVC	Orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PHFS	Partners for HIV-free survival
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of mother-to-child transmission
PNC	Postnatal care
RCH	Reproductive and child health
RHMT	Regional health management team
SCM	Supply chain management
SILC	Savings and Internal Lending Communities
TA	Technical assistance
TACAIDS	Tanzania Commission for AIDS
TRCS	Tanzania Red Cross Society
URT	United Republic of Tanzania
USAID	United States Agency for International Development
USG	U.S. Government
VCT	Voluntary counseling and testing
WHO	World Health Organization

EXECUTIVE SUMMARY

INTRODUCTION, PURPOSE, AND OBJECTIVES

USAID Tanzania commissioned a performance evaluation of its two PEPFAR-funded comprehensive HIV care activities, both due to close out in 2016. The TUNAJALI II and Linking Initiatives for the Elimination of Pediatric HIV (LIFE) activities are being implemented by Deloitte and the Elizabeth Glaser Pediatric Aids Foundation (EGPAF) respectively, in a total of 77 (out of 169) districts, in 11 (out of 30) regions across the country. The purpose of the evaluation was to determine the extent to which the goals, objectives, and results of the two activities were achieved; the likelihood of intended results being sustained after the end of the activities; the lessons learned from the implementation of the two programs; and which program components should be included in the design of subsequent activities to maximize performance, results, and sustainability. Findings on cost effectiveness that were practicable in a performance evaluation, and useful considering the evaluation purpose, were also required.

The scope of the evaluation was further delimited by the evaluation questions:

1. To what extent has the use of quality service delivery increased in TUNAJALI II and LIFE supported districts?
2. To what extent has integration of clinical and community maternal and newborn child health (MNCH) services into the prevention of mother-to-child transmission (PMTCT) platform improved access to quality MNCH services?
3. To what extent have capacity-building efforts contributed to improved performance of local government authorities (LGAs) related to governance, accountability, fiscal management, and technical oversight?
4. How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community HIV services to HIV-positive clients, as well as pregnant women and newborns receiving services through the two mechanisms?

COUNTRY BACKGROUND

National HIV prevalence was 5.1 percent in 2012¹ but varies substantially across regions, from as high as 14.9 percent to less than 1 percent. Prevalence is higher among women (6.2 percent) than men (3.8 percent); and young women 23-24 years old are more than twice as likely to be infected than their male peers (6.6 percent vs 2.8 percent). District councils, which are local government structures, are directly responsible for health services delivery at dispensaries, health centers, and district hospitals. Service delivery is hampered by a number of persistent challenges, including a substantial and growing treatment gap, inadequate health financing, poor logistics and supply chain management (SCM), and a very low clinician-to-population ratio.

METHODOLOGY²

The evaluation adopted a mixed methods design that integrated an analysis of secondary context, implementation, monitoring, and cost data with primary data generated during fieldwork. The secondary

¹ 2011-2012 Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS)

² A detailed description of the methodology is presented in Annex II of this report.

data analysis provided the broad foundational evidence for evaluative conclusions. The primary data grounded the interpretation of evidence in an understanding of the implementation context. Secondary clinical services data were largely quantitative and subjected to descriptive statistical analysis; all qualitative data, both primary and secondary, were subjected to thematic content analysis.

Seven districts were visited during the fieldwork. Each visit included observations at two facilities, the district hospital, and either a health center or dispensary. Community meetings were facilitated at the health center or dispensary, and interviews with Council Health Management Team (CHMT) personnel and government officials were held at each site.

A unit cost per key service in each program was calculated and benchmarked against costs for similar services documented in the literature. This resulted in findings determining whether the costs per person for each of the services fell within a reasonable range.

FINDINGS

Activity Descriptions

Both TUNAJALI II and LIFE adopted a district implementation model to improve access to quality services through strengthening the technical capacities of health management teams; investing in infrastructure for treatment services; procuring equipment and supplies for laboratory services; and expanding community-based care and support services. Both activities attempted to intensify the role of LGAs in the oversight of health services through capacity building and a limited grant mechanism. Unlike TUNAJALI II, LIFE was not funded to support care and treatment (C&T) services; it focused on PMTCT, reproductive and child health (RCH), MNCH, and community-based care services (CBCS).

Performance of Support to Clinical Services

TUNAJALI II contributed significantly to increased use of quality service delivery in program districts over the period of program implementation (2012 to 2015), including MNCH services, as demonstrated by

- Increase in number of care and treatment clinics (CTCs) from 174 to 223
- Increase of 107% in number of adults and children newly enrolled and 51% currently enrolled on antiretroviral therapy (ART)
- Increase of 120% in the number of adults and children known to be alive 12 months after initiation of treatment
- Increase in number of facilities offering PMTCT services from 606 to 1,099
- Increase in proportion of pregnant women with known HIV status by 53%
- Proportion of total deliveries in health facilities settled at a high 96%
- Increase in proportion of women receiving uterotonics in labor from 30% to above 90%
- Increase in proportion of newborns receiving postnatal check two days after birth from 65% to 74%.

LIFE contributed significantly to increased use of quality service delivery in program districts over the period of program implementation (2012 to 2015), including MNCH services, as demonstrated by

- Increase in number of facilities offering PMTCT services from 967 to 1,376

- Increase in proportion of women attending antenatal clinic (ANC) tested for HIV from 51% to 91%
- Increase in proportion of women receiving uterotonics in labor from 15% to above 25%
- Increase in number of women giving birth in a health facility by over 30%
- More than doubling of number of infants receiving postnatal health check two days after birth.

Effective practices that appear to be factors in the strong performance of support to clinical services include (1) the training, deployment, and support of an extensive network of community volunteer cadres; (2) support for scaling-up and improving laboratory services; (3) strategies to mitigate supply chain deficiencies; (4) evidence-driven quality improvement activities; and (5) LIFE's capacity development model for integrating MNCH services into the PMTCT platform, which is described in more detail in the main report.

Performance of Capacity Development Interventions

The development of CHMT technical capacity is a significant factor contributing to the successes of support to clinical services.

Improvements in the financial management, public accountability, and governance of LGAs were limited. Externalities – such as the complex dynamics of the public service, the high career mobility of public servants, and the inflexible procurement and disbursement procedures – diluted the expected effects of training and the limited grant-making mechanism to district councils.

The capacity of civil society organization (CSOs) has been enhanced through the program and community-level organizations have benefited substantially from these efforts, both technically and organizationally. While a limited number have managed to source funding from alternative donors, they remain confronted with the reality that PEPFAR support is difficult to match financially.

Cost Effectiveness

Cost effectiveness was assessed by calculating the cost per client of selected services rendered in the TUNAJALI II and LIFE activities and then comparing the calculated cost per client to benchmarks from the literature.

The average ART cost per patient in the TUNAJALI II project was lower than those calculated in other countries, including Botswana, Ethiopia, Nigeria, Uganda, and Vietnam (Menzies et al., 2011).

The provision of PMTCT services is cost-effective in TUNAJALI II- and LIFE-supported regions. The average cost of US\$402 and US\$642 per HIV positive woman for TUNAJALI II and LIFE programs respectively compares well with previous studies on PMTCT costing. A systematic review of the cost of providing PMTCT services revealed a mean cost of US\$792 per patient (Galárraga et al., 2012).

The economic cost of additional funding for MNCH ranged from US\$7 to US\$9 per woman who delivered at a health facility, and the average cost per newborn for postnatal checks within two days of birth ranged from US\$10 to US\$21. In the literature, integrating PMTCT and MNCH services has been shown to reduce PMTCT cost and improve efficiency in averting mother-to-child transmission. This evaluation offers evidence suggesting that integrating MNCH into an existing PMTCT platform allows for cost-efficient introduction of MNCH services into existing activities.

RECOMMENDATIONS

Strategic Level Recommendations

The strategic level recommendations are based on an analysis of country background data that identified the key contextual factors undermining the performance of the two activities under review.

- Consider a national-level mechanism to address mounting deficits in health financing.
- Consider a national-level intervention to support the United Republic of Tanzania (URT) in addressing human resource shortages in the health sector.
- Re-examine the current targeting strategy.
- Review and strengthen current mechanisms for addressing supply change management functionality.
- Consider a national public sector reform mechanism that has transition of health sector service delivery from PEPFAR-funded programs to URT as its ultimate goal.

Operational Level Recommendations

Support to Clinical Services

The recommendations on support to clinical services are directed at strengthening or scaling up the activities observed to be the factors most evidently related to successful program performance. As such, the recommendations are concerned with replicating effective practices.

- Scale up the support to laboratory services.
- Scale up MNCH services. Integration with PMTCT services offers advantages in terms of cost efficiency and reach.
- Review and optimize the recruitment, training, deployment, and management of volunteer cadres.
- Formalize and replicate the LIFE MNCH training model for clinicians.
- Formalize and replicate strategies for mitigating SCM problems.
- Replicate TUNAJALI II's B2TI campaign.
- Scale up data-driven quality improvement initiatives.

Capacity-Building Interventions

The recommendations on capacity-building interventions are directed at strengthening activities intended to intensify the role of LGAs in the oversight and management of health services. As such the recommendations are concerned with addressing deficient practices.

- Develop a strategy to deal with career mobility in local government.
- Partner with an organization with expertise in organizational development.
- Place capacity-building technical specialists on regional program teams.
- Implement a procurement system that promotes capacity building of LGAs.

I. INTRODUCTION, PURPOSE, AND OBJECTIVES

USAID Tanzania commissioned a performance evaluation of its two PEPFAR-funded comprehensive HIV care activities, both due to close out in 2016. The TUNAJALI II and Linking Initiatives for the Elimination of Pediatric HIV (LIFE) activities are being implemented by Deloitte and the Elizabeth Glaser Pediatric Aids Foundation (EGPAF) respectively, in a total of 77 (out of 169) districts, in 11 (out of 30) regions across the country. The evaluation was conducted from March through May of 2016.

A performance evaluation, as defined in USAID evaluation guidance, was required for this assignment. Performance evaluations balance a review of results achieved with an equal interest in the effectiveness of implementation and the influence of context on program efficacy. Identifying factors that enabled or limited effective implementation and documenting the consequent lessons learned is emphasized. While evaluative pronouncements on results are not feasible to the level of rigor demanded in impact evaluations, credible evidence for results is presented where feasible. The review of results is typically limited to achievements at output level (e.g., number of people reached with services), which directly indicates implementation performance.

The scope of work, supplemented by guidance from USAID Tanzania provided during the evaluation in-brief, notes that the purpose of the evaluation is to determine

- The extent to which the goals, objectives, and results of the two activities were achieved;
- The likelihood of the intended results being sustained after the end of the activities;
- The lessons learned from the implementation of the two programs; and
- Which program components should be included in the design of subsequent activities to maximize performance, results, and sustainability.

The scope of the evaluation is further limited to specific aspects of performance, namely the increase in numbers of people accessing care and treatment (C&T), prevention of mother-to-child transmission (PMTCT) and maternal and newborn child health (MNCH) services; the capacity-building activities supporting transition of services to local government authorities (LGAs); and the capacity-building activities supporting the extension of services into communities through local community service organizations (CSOs). Finally, the scope of work requires the evaluation to produce findings on cost effectiveness that are practicable in a performance evaluation and useful considering the evaluation purpose.

With this limited scope it should be noted that the evaluation does not do justice to the full efforts of the two activities. However, it does highlight key lessons to inform the design of future activities and enhance effective implementation in the areas considered.

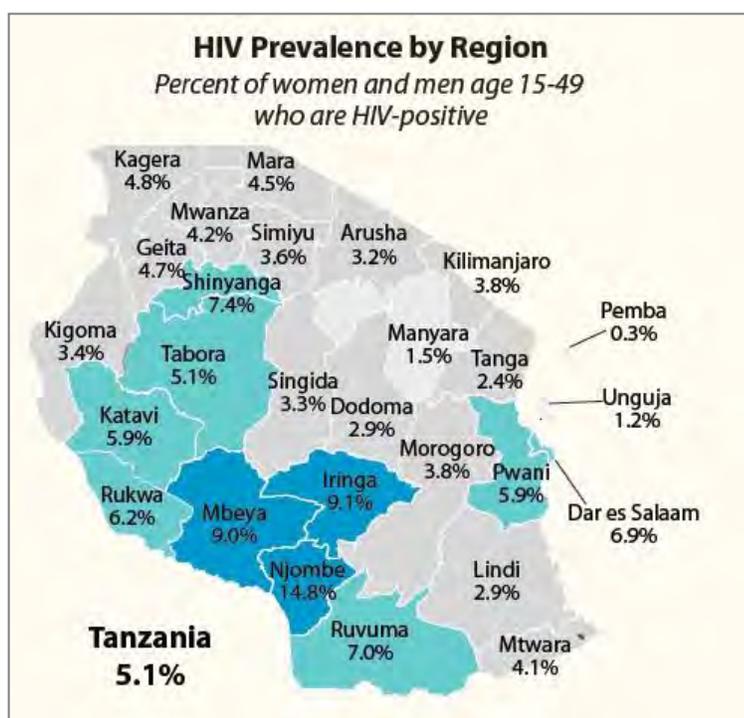
The report begins by presenting background that has bearing on implementation performance, including the country context and PEPFAR's strategic priorities in Tanzania. The evaluation's purpose and objectives are then explained in greater detail and the methodology they dictate is described. Findings are presented according to the evaluation questions, but separately for each activity. The report converges into a general discussion of conclusions and recommendations because the final evaluative pronouncements and lessons learned are broadly applicable to future programming.

II. BACKGROUND

COUNTRY CONTEXT

The population of the United Republic of Tanzania (URT) was estimated at 52 million in 2014; at the current growth rate it is projected to reach 70 million by 2025. Life expectancy at birth is 65 years, and the population is primarily young, with 21.4 percent of women and 25.5 percent of men between 15 and 19 years of age. The gross enrollment rate in primary education exceeded the sub-Saharan average during the first decade of the new millennium but subsequently dropped below it and now stands at 87 percent, according to 2013 measures. Although Tanzania has one of Africa's fastest-growing economies, with national gross domestic product (GDP) per capita expanding at an average of 7 percent since 2000, widespread poverty persists. In 2011 the national poverty headcount ratio at national poverty lines was 28 percent and higher in rural (33 percent) compared to urban (22 percent) areas.³ While the country is positioned for improvement on all development indicators, it is impeded by persistent economic and social challenges, including a generalized AIDS epidemic and a broader health burden.

HIV PREVALENCE AND THE NATIONAL RESPONSE



National HIV prevalence has decreased steadily, from 7 percent in 2004⁴ to 5.1 percent in 2012,⁵ but varies substantially across regions, from as high as 14.9 percent in Njombe, to less than 1 percent on Pemba island. Prevalence is higher among women (6.2 percent) than men (3.8 percent), and this holds true in every age category. Overall, 2 percent of young women and men age 15-24 are HIV positive. However, there is a significant surge in prevalence for young women – by 23-24 years of age they are more than twice as likely to be infected than their male peers (6.6 percent vs 2.8 percent). An estimated 72,000 new infections and 78,000 AIDS-related deaths occur in Tanzania annually.

The health services delivery role of the Ministry of Health, Community Development, Gender, Elderly and

Figure 1. Map of Prevalence by Region

Children (MoHCDCGEC) is limited to training institutions and national specialized hospitals. Otherwise, its mandate is to create an enabling environment for health services by providing overall policy (National Health Policy) and strategic direction (Five-Year Health Strategic Plans), and developing systems and

³ All statistics quoted are from the World Bank Development Indicators data bank.

⁴ 2003-2004 THMIS.

⁵ 2011-2012 THMIS.

guidelines to support LGAs. District councils, which are local government structures, are directly responsible for health services delivery at dispensaries, health centers, and district hospitals. Local and regional governments, and therefore the primary health care services and regional services they deliver, operate under the Prime Minister's Office, Regional Administration and Local Government (PMO-RALG). This institutional arrangement reflects the government's commitment to decentralizing service delivery.

Two key agencies govern the national response to HIV and AIDS, reflecting the dual oversight of the Tanzanian health system. The National Aids Control Program (NACP) oversees programmatic HIV activities in the country and is situated within the MoHCDGEC; the Tanzania Commission for AIDS (TACAIDS), situated within the Prime Minister's office, is responsible for overseeing the multi-sectoral response. Over the years, Tanzania has assembled a comprehensive policy response to the HIV challenge,⁶ complemented by effective programs expanding treatment services to all those in need. For example, the uptake of voluntary counselling and testing (VCT) has been impressive, as has the national scale-up of antiretroviral therapy (ART), and the rapid scale-up of PMTCT services since 2004.⁷ Despite the successes, however, a number of challenges persist.

PERSISTENT CHALLENGES TO AN EFFECTIVE RESPONSE

The Treatment Gap

An estimated 1,400,000 Tanzanians are currently living with HIV/AIDS.⁸ The number of adults and children on care and receiving ART has been increasing steadily since 2008, but a substantial treatment gap remains. By 2013, there were 473,707 adults and 38,848 children on ART, representing 41 percent and 16 percent coverage respectively.⁹ The treatment gap is exacerbated by difficulties in retaining clients in care, with the percentage of adults and children with HIV known to be on treatment 36 months after initiation of ART not reaching much above 70 percent.

In 2015, the MOHCDGEC, through the NACP, issued a circular with new service guidelines for people living with HIV (PLHIV) that are aligned with the World Health Organization (WHO) guidelines of July 2013. Eligibility for antiretroviral (ARV) enrollment was expanded to include adults and adolescents (15 years and older) with CD4 levels under 500. The 2015 guidelines also called for immediate expansion of pediatric eligibility to allow all HIV-positive children and adolescents under 15 to be enrolled on ARV regardless of CD4 count. As a result of these changes, new targets for treatment, aligning with the UNAIDS 90-90-90 targeting guideline, were set in November 2015.¹⁰ Not only is there a pressing need

⁶ For example, HIV-specific planning in the form of the Third National Multi-Sectoral Strategic Framework (2013/14–2017/18) and the Health Sector Strategic Plan III (HSSP 2009-2015); the country's long-term national strategy for growth and reduction of poverty (MKUKUTA I and MKUKUTA II) directly attends to the implications of HIV and AIDS for national progress; the National Policy on HIV/AIDS (2001) addressed prevention, care for people living with HIV (PLHIV), HIV and AIDS testing, financing issues and research; the HIV and AIDS Prevention and Control Act (HAPCA) of 2008 upholds many of the international declarations and treaties Tanzania affirms or is signatory to and specifically legislates against discrimination of PLHIV in the workplace. Numerous policies, acts, and plans have followed, including the National Costed Plan of Action for Most Vulnerable Children (2012) and the Youth Development Policy (2008).

⁷ By December 2010, 99.7 percent of all pregnant women received PMTCT services, and by 2014 a total of 5,361 out of 5,863 reproductive and child health (RCH) facilities (91 percent) were officially providing PMTCT services. In addition, the number of health facilities providing HIV-exposed early infant diagnosis (HEID) increased from 3,808 in 2013 to 4,058 in 2014.

⁸ 2007-2008 THMIS.

⁹ Tanzania Country Profile, UNAIDS, 2014.

¹⁰ Futures Group Policy Brief, 2015.

to extend HIV-related services based on projected targets, but retention rates also denote an imperative to deliver them with consistent quality to ensure an effective national response.

Health Financing and Sustainability

In 2012, national expenditure on health made up 7 percent of total GDP,¹¹ and it is estimated that the Tanzanian government allocates 5 percent of these funds for HIV/AIDS activities.¹² However, the URT has yet to meet the Abuja target of allocating 15 percent of total government spending on health, despite the Health Sector Strategic Plan establishing a target date of 2015 for that level of allocation. The Global Fund and PEPFAR are the backbone of the country's HIV program scale-up, providing almost 90 percent of the HIV/AIDS financing in Tanzania.¹³ With Tanzania's commitment to achieve the global 90-90-90 targets by 2020,¹⁴ the total projected funding gap for ART commodities is US\$640 million for 2016–2020.¹⁵

In the light of Tanzania's drive to decentralize service delivery, understanding health financing at the local level further illuminates the resource challenges. An analysis of comprehensive council health plans (CCHPs) for 2013-2014 shows that local government block grants and the council health basket grant together constitute the largest portion of funds available for services. While these funds originate ostensibly from the central government, they represent, to a large extent, a redistribution of donor funding from the central to the local level. Add to this the contribution from the Global Fund and it is evident that almost 70 percent of health funding at the local level is generated from donors. The largest portion of that, however, is subject to the central government's currently inefficient budgeting and allocation processes, with severe delays in disbursements undermining local planning and efficient delivery. Moreover, contributions from health insurance and the councils' own resources constitute less than 5 percent of current health resources. While there may be some potential to further grow the contribution from these sources, it seems unlikely that a significant share of the 70 percent financing burden being met by donors and the central government can feasibly be shifted to the contributors of the 5 percent.

¹¹ World Health Organization. "WHO African Region: Tanzania." Accessed February 3, 2015. <http://www.who.int/countries/tza/en/>.

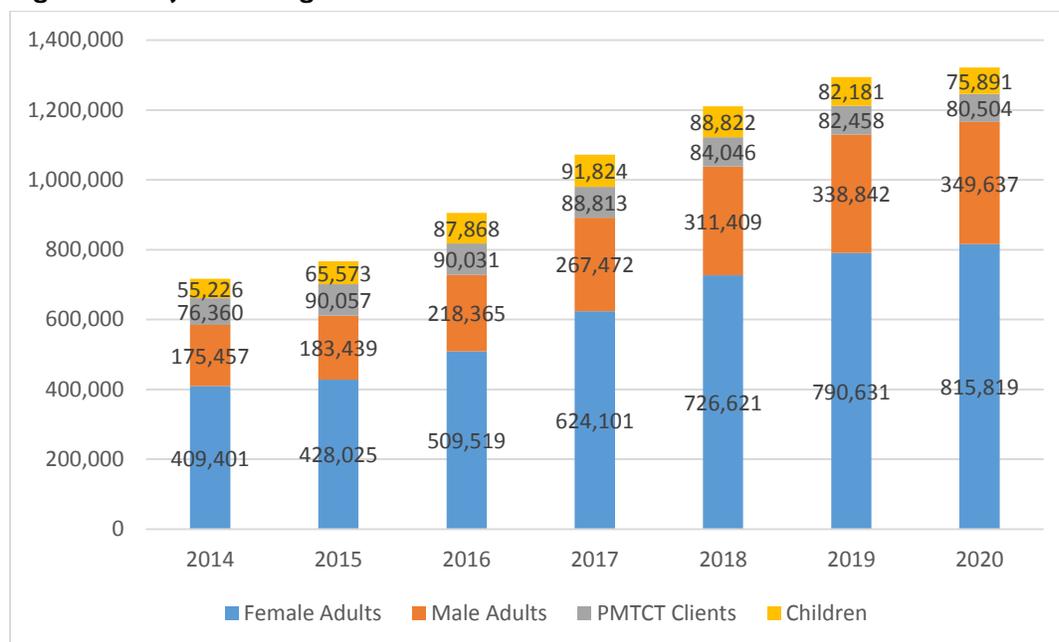
¹² Prime Minister's Office, The United Republic of Tanzania. November 2013. "Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)," 32. Accessed February 2, 2015. http://tac aids.go.tz/index.php?option=com_docman&task=doc_download&gid=81&Itemid=142. wload&gid=81&Itemid=142.

¹³ Innovation for Greater Impact: Exploring Resources for Domestic Health Funding in Africa. http://theglobalfight.org/wp-content/uploads/Innovation-for-Greater-Impact-2-18-15_smallpdf.pdf.

¹⁴ 90% of all PLHIV are diagnosed and know their HIV status, 90% of those diagnosed are initiated and maintained on ART, and 90% of those on ART are virally suppressed.

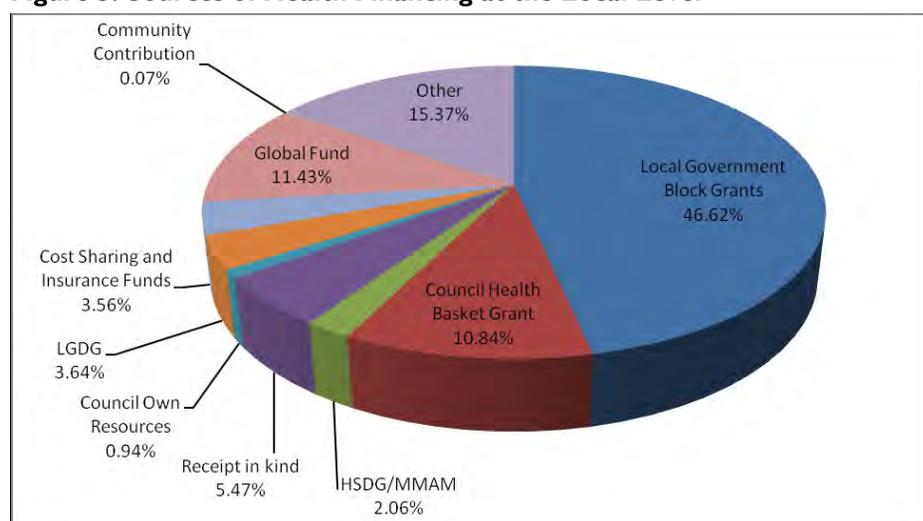
¹⁵ Health Policy Project Brief, December 2015.

Figure 2: Projected Targets for Treatment Based on 90-90-90 Guidelines



Source: Health Policy Project Brief, December 2015.

Figure 3: Sources of Health Financing at the Local Level



Source: CCHP Analysis, 2013-2014.

Additional Challenges

The welcome expansion of services thus far has exposed vulnerabilities in management and service delivery systems. Critical impediments to strengthening health outcomes in Tanzania include the severe shortage of qualified and capable human resources, inadequate infrastructure, and overburdened logistics systems and supply chains. In addition, behavior change issues remain a significant challenge to safe sexual practices, health-seeking behaviors, the elimination of stigma, and shifting of cultural norms that disadvantage women. The latter issue in particular is associated with a high prevalence of sexual and gender-based violence (GBV).

In sum, there is still much to be done to solidify key interventions and systems so that they will have a sustainable impact.

PEPFAR PRIORITIES AND APPROACH

PEPFAR’s strategic priorities for Tanzania are captured in the Global Health Initiative country strategy and the PEPFAR country partnership framework, both of which are responsive to the country context. The latter articulates six goals that direct U.S. Government (USG) and URT collaboration to address the HIV epidemic (Table 1). Goals 4 and 5 focus on two persistent structural hindrances to quality care, namely inconsistent drug and commodity supply and the lack of adequate human resources. While the emphasis is on supporting the delivery of HIV-related health services (Goal 1), the country partnership framework also commits the USG to “build the capacity of state and non-state actors at national and local levels” to oversee service delivery (as reflected in Goal 3), and acknowledges that “progress in this goal area is necessary for the success of all other partnership framework goals.”¹⁶

Table 1: Country Partnership Framework Goals, 2008 to 2013

Country Partnership Framework Goals
<p>1. Service Maintenance and Scale-up:</p> <ul style="list-style-type: none"> • Invest in care, treatment, and support services to reduce morbidity and mortality due to HIV and AIDS and improve the quality of life for PLHIV and those affected by HIV and AIDS. • Care, treatment, and support services include services for orphans and vulnerable children (OVC), community and home-based care, and facility-based care (ART, PMTCT, and TB/HIV). • Support quality improvements.
<p>2. Prevention: The Partnership Framework describes a three-pronged approach:</p> <ul style="list-style-type: none"> • Increase the efficacy of prevention programming. • Bring to scale prioritized prevention interventions. • Enhance the enabling environment through sustained leadership, policy change, and attention to structural factors affecting HIV transmission.
<p>3. Leadership, Management, Accountability, and Governance:</p> <ul style="list-style-type: none"> • Provide well-coordinated, effective, transparent, accountable, and sustainable leadership and management for the HIV and AIDS response. • Build the capacity of state and non-state actors at national and local levels for these oversight functions. • Progress in this goal area is necessary for the success of all other goals.
<p>4. Sustainable and Secure Drug and Commodity Supply: Strengthen a functional, prioritized, transparent, and timely logistics and supplies procurement system, including planned preventive maintenance of essential equipment.</p>
<p>5. Human Resources:</p> <ul style="list-style-type: none"> • Ensure the human resources capacity necessary for the achievement of quality health and social welfare service at all levels. • Expected inputs to achieve this goal include training of new personnel, improved retention, and improved management of existing and future personnel.
<p>6. Evidence-based and Strategic Decision Making:</p> <ul style="list-style-type: none"> • Improve the use of relevant and comprehensive evidence, provided in a timely manner, in HIV-related planning and decision making. • Key approaches include improving management and coordination of relevant data systems, increasing national capacity to implement surveys and studies, improving incidence measures, and adopting best practices.

¹⁶ All quotations from PEPFAR Country Partnership Framework, March 2010.

PEPFAR is also concerned with strengthening capacity, accountability, and resources for transition to country ownership. This requires building capacity “in management and oversight, fiscal accountability and technical expertise for quality service delivery” at all levels of the system and particularly, considering the URT’s firm commitment to decentralization of service delivery, at the local government level. In USAID Tanzania’s planning, transition will be effected through a “focus on building and strengthening the capacity and systems of central [and] local government ... through initially intense technical assistance (TA) from implementing partners (IPs), with a focus on training, recruitment, administration, commodity management, and fiscal accountability.” There is a further commitment in transition planning to ultimately “fund LGAs ... to help support the management and oversight of LGAs to health facilities.” Transition planning also appreciates the need to complement government capacity with augmented capacity in civil society, both to support the delivery of services and to reinforce mechanisms to hold government to account.¹⁷

Both currents of supporting HIV-related health services delivery, while simultaneously strengthening country partners for transition, are reflected across USAID Tanzania’s health portfolio, summarized in Table 2. The descriptions also broadly reflect the activities in the TUNAJALI II and LIFE programs.

Table 2: Summary of USAID's Health Portfolio Activities

National Level
USAID provides direct and indirect financial and technical support to the MoHCDGEC and its entities, either directly or through IPs, to strengthen coordination and management of HIV interventions in the country.
Regional Level
USAID provides TA and capacity building through direct assistance to select regions, as well as indirect assistance through sub-agreements with international and local IPs.
District Level
USAID supports the Council Health Management Team (CHMT) with TA and capacity building to ensure that personnel, finances, diagnostic and medical supplies, drugs, physical infrastructure, transport, and the health management information system (HMIS) are functioning, and to improve the quality of comprehensive council health plans based on the identified health needs of the district.
Health Facility Level (Health Centers and Dispensaries)
USAID supports health facilities by providing indirect TA, grants, and capacity building through international and local partners; providing HIV care and treatment clinics with separate buildings, additional staff, and allowances; and strengthening linkages to home-based care through various cadres of home-based care workers who also receive allowances.
Local Nongovernmental Organizations (NGOs), Civil Society Organizations (CSOs), and the Private Sector
USAID provides direct funding to various international partners to support public and CSO sector service delivery. Many CSOs hold subcontracts with the international clinical partners for clinical service provision, while a few local CSO treatment partners have graduated from subcontractor to prime partner to receive direct funding for service delivery.

¹⁷ All quotations are from PEPFAR/Tanzania Transition Strategy for Facility-Based HIV/AIDS Services.

III. EVALUATION METHODS AND LIMITATIONS

EVALUATION DESIGN

The evaluation adopted a mixed-methods design that integrated an analysis of secondary context, implementation, monitoring, and cost data with primary data generated during fieldwork. The secondary data analysis, utilizing TUNAJALI and LIFE project data, provided the broad foundational evidence for evaluative conclusions. The primary data, generated through fieldwork, grounded the interpretation of evidence in observations and an understanding of the implementation context. It also offered the evaluators an opportunity to triangulate emerging findings from the secondary data analysis.

FIELDWORK DATA COLLECTION AND ANALYSIS

Seven districts were visited during the fieldwork. Each visit included observations at two facilities: the district hospital and either a health center or dispensary. Community meetings were facilitated at the health center or dispensary, and interviews with council health management team (CHMT) personnel and government officials were held at each site.

Due to time constraints it was not feasible to transcribe key informant interviews and focus group discussions. Fieldwork data were captured in a structured format, and the structured fieldwork notes served as primary documents for qualitative analysis. Where consent was given, interviews and focus group discussions were recorded, and the audio files served as reference and verification for structured field notes data. Initial analysis of fieldwork data took place during regular analytical debriefs by the full evaluation team while in the field.

Secondary clinical services data were largely quantitative and subjected to descriptive statistical analysis; all qualitative data, both primary and secondary, were subjected to thematic content analysis. A brief evaluation matrix (Table 3) provides additional detail.

Table 3: Evaluation Matrix

Understanding the Question	Approach to Respond
1. To what extent has the use of quality service delivery increased in TUNAJALI II- and LIFE-supported districts?	
The focus of this evaluation question was on describing the increase in use of services and attempting a credible attribution of the trends to activity efforts.	A statistical analysis of routine program data was conducted, tracking the indicators specified in the scope of work focusing on care and treatment (C&T) and PMTCT. Trend analyses within implementation districts were used to demonstrate program performance.
2. To what extent has integration of clinical and community MNCH services into the PMTCT platform improved access to quality MNCH services?	
The evaluation question was directed at determining the extent to which MNCH services were accessed and considering whether integration with PMTCT contributed to the performance measured.	A statistical analysis of routine program data was conducted, tracking the indicators specified in the scope of work and focusing on RCH and MNCH. Trend analyses within implementation districts were used to demonstrate program performance.
3. To what extent have capacity-building efforts contributed to improved LGA performance related to governance, accountability, fiscal management, and technical oversight?	

Understanding the Question	Approach to Respond
The question directs the evaluation to analyze how capacity development improved fiscal management, governance, and accountability; LGA governance and the health related technical capacity of the CHMTs in particular; and readiness of local government to sustain quality services.	Interview data were collected during fieldwork, supplemented by a thorough document review.
4. How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community services to HIV-positive clients and pregnant women and newborns?	
This question directed the evaluation to consider the comprehensiveness of the continuum of care (CoC), and in particular how building NGO and CSO capacity contributed to ensuring access to comprehensive and quality services.	Interview data were collected in the field, complemented by a thorough document review, as well as consideration of CSO quantitative performance indicators.

COST-EFFECTIVENESS

A unit cost per key service in each program was calculated and benchmarked against costs for similar services documented in the literature. This resulted in findings determining whether the costs per person for each of the services fell within a reasonable range. A retrospective top-down costing approach was used, due to our reliance on financial accounts, and indirect costs were allocated to key services in a step-down fashion, using the number of clients in key service areas as the allocation key.

LIMITATIONS

The following limitations influenced the reliability and validity of the evaluation:

A large volume of routine monitoring data was placed at our disposal by both programs and could not be exhaustively interrogated. The statistical analysis was therefore selective, directed by the specific indicators in the scope of work. The volume of documentary data was equally extensive and again had to be approached selectively.

The fieldwork sample was very small and by no means representative considering the size of the two activities under review. As a consequence, the triangulation of secondary data with data from the field had to be executed with caution. Field observations from such a limited sample simply do not carry sufficient weight to justify modifying findings from the analysis of a comprehensive set of secondary data. The risk to validity of assigning equal weight to secondary and primary data had to be carefully managed.

Evaluating two large mechanisms simultaneously poses peculiar challenges for the evaluators, and care had to be taken to ensure that findings were not confounded across mechanisms. Despite meticulous efforts, the distinction between mechanisms may not be as discriminating as it should.

In the cost-effectiveness analysis, a retrospective top-down costing approach was employed, due to our reliance on financial accounts. Accuracy of estimates from this method relies on the assumption that variation in clinical practice is negligible and data quality is consistent. In addition, economic costs borne by another organization, such as government or a faith-based organization, e.g., cost of salaries, buildings and other administrative activities, were not included in our analysis.

IV. FINDINGS

EVALUATION QUESTIONS

The purpose of the evaluations was operationalized in the following four evaluation questions, which have been renumbered for purposes of this evaluation:

1. To what extent has the use of quality service delivery increased in TUNAJALI II- and LIFE-supported districts?
2. To what extent has integration of clinical and community MNCH services into the PMTCT platform improved access to quality MNCH services?
3. To what extent have capacity building efforts contributed to improved LGA performance related to governance, accountability, fiscal management, and technical oversight?
4. How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community HIV services to HIV-positive clients and pregnant women and newborns?

Questions 1 and 2 have been grouped together, as they reflect on the performance of program activities supporting clinical services. They will each be answered separately for TUNAJALI II and LIFE. Questions 3 and 4 reflect on the performance of capacity-building program activities and have therefore been grouped together. Because both programs performed similarly in terms of capacity building, an integrated answer will be presented for questions 3 and 4.

ACTIVITY DESCRIPTIONS

While TUNAJALI II and LIFE made multiple contributions at all levels of the health system, including national policy formulation and systems strengthening, the evaluation questions direct this assessment to concentrate on district-level interventions.

The condensed descriptions of the two programs underscore their similarities. Both adopted a district implementation model and set out to improve the quality of services primarily through strengthening the technical capacities of health management teams. Both invested in infrastructure for care and treatment services and equipment and supplies for laboratory services. In both cases, increasing access relied heavily on the expansion of community-based care and support services. And, in a contribution to transition, both activities attempted to intensify the role of LGA in oversight of health services through capacity building and a comparable limited grant mechanism.

However, the differences distinguishing the two programs are definitive. Unlike TUNAJALI II, LIFE was not funded to support C&T services. However, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) was resourced through the Centers for Disease Control (CDC) to expand quality HIV care and treatment services in the Arusha, Kilimanjaro, Lindi, and Tabora regions, and claims that this overlap allowed it to strengthen the CoC broadly in these regions. And although both programs prioritized sustainability, an explicit result area in TUNAJALI II lent greater prominence to activities such as the formation of Savings and Internal Lending Communities (SILC) for PLHIV households, supporting facilities to access health insurance funds, and investigating options for revenue generation by local government.

TUNAJALI II

A Brief Overview

Following its implementation of the first TUNAJALI program (2006–2011), Deloitte continued to “support the provision of sustainable, high quality, comprehensive and integrated HIV prevention, care, treatment and support services”¹⁸ through TUNAJALI II in all districts of the Iringa, Njombe, Morogoro, Dodoma, and Singida regions of mainland Tanzania. TUNAJALI II adopted a district-based approach with the overarching goal of “empowering local councils with the capacity to plan, coordinate, gender mainstream and provide sustainable, integrated and quality health and HIV care and support services.”¹⁹ Consequently, the approach focused on

- Strengthening regional health management teams (RHMTs) and CHMTs operating at the district level through training, targeted TA, joint supportive supervision and quality improvement interventions at facilities; and
- Intensifying the involvement of the leadership and management at LGAs in the oversight of health service delivery through a fixed amount reimbursement (FAR) grant mechanism, additionally supported with training and TA.

The clinical services targeted for improvement were adult C&T, including provider-initiated counseling and testing and TB/HIV collaborative management, and PMTCT, including early infant diagnosis (EID), with some attention given to RCH services. RCH efforts became more deliberate in 2014 when additional funding was introduced for improving MNCH services.

In addition to building the technical capacity of health management teams, TUNAJALI II strengthened service delivery through investing in infrastructure for C&T centers and procuring equipment and supplies for laboratory services. Access to facility-based clinical services was augmented by an extensive CBCS network, established through sub-grants to local CSOs and the building of their organizational and technical capacities.

The total award under the cooperative agreement amounted to \$103,000,000.²⁰ Five results areas stipulated in the cooperative agreement framed the choice of program activities, as summarized in Table 4.

Table 4: Summary of TUNAJALI II Results and Related Activities

Result	Activities
Result 1: Improved leadership and management capacity of LGAs for consistently high quality HIV services delivery.	The capacity-building activities and sub-grant mechanism intended to intensify the role of local government leadership and management in the oversight of health service delivery.
Result 2: Improved capacity of CSOs for consistently high-quality HIV and AIDS service delivery.	Strengthening CBCS through sub-grants to local CSOs and development of their organizational and development capacities.
Result 3: Increased revenues and resources available for integrated HIV and AIDS care.	Advocating for additional resources to be allocated to health services by LGAs, improving systems for facilities to access health insurance funds, and working with PLHIV households to

¹⁸ TUNAJALI II Quarterly Report October–December 2015, p. 6.

¹⁹ TUNAJALI II Quarterly Report October–December 2015, p. 6.

²⁰ As of 8/13/2015.

Result	Activities
	reduce economic vulnerabilities and contribute to health insurance.
Result 4: Improved access to high-quality, integrated, and comprehensive HIV C&T services.	Strengthening the technical capacity of health management teams, supportive supervision and quality improvement interventions, investments in infrastructure and laboratory services, and the enhancement of the CoC through expanding CBCS services.
Result 5: Improved woman and girl child–responsive HIV treatment, care, and support.	Crosscutting efforts to expand the engagement of men and boys as clients, and specific efforts to raise community awareness of services to women and girls, including gender-based violence (GBV) services.

Implementation Roles and Responsibilities

Deloitte implemented TUNAJALI II in collaboration with sub-partners, and each had specified roles and responsibilities.

- Deloitte provided overall program management, strategic leadership, and oversight. As the prime IP it was also responsible for grants and finance management, program monitoring and evaluation, institutional capacity building, and systems-strengthening for local authorities and CSOs.
- The Christian Social Services Commission (CSSC) provided technical leadership in the provision of community home-based care services through mentoring, coaching, and training regional and district mentors, and training facility and community-based health care workers.
- Additional technical partners included Muhimbili University of Health and Allied Sciences (MUHAS), which trained regional and district clinical mentors and supported operational research to enhance program effectiveness; the Gender Training Institute (GTI) for gender mainstreaming and advocacy on citizen rights with LGAs; and COUNSENUTH, which provided nutrition training and integration of nutrition assessment, counselling, and support (NACS) into MNCH and PMTCT services.

TUNAJALI II implemented the district approach through regionally based teams consisting of technical officers for C&T, PMTCT, provider-initiated testing and counseling (PITC), MNCH, home-based care (HBC), and laboratory services. Technical officers were overseen by a regional technical coordinator and a regional program manager, and supported by grant and monitoring and evaluation (M&E) officers.

LIFE

A Brief Overview

The Elizabeth Glaser Pediatric AIDS Foundation implemented the LIFE program (Linking Initiatives for the Elimination of Pediatric HIV) in all the districts of the Shinyanga, Tabora, Mtwara, Lindi, Arusha, and Kilimanjaro regions of mainland Tanzania. The “virtual elimination of pediatric HIV” was the guiding principle of implementation, reflecting both the IP’s founding ethic and the focused support to PMTCT, RCH, and later MNCH clinical services.

While not strictly limited to it, LIFE utilized a district approach as its implementation model. The emphasis was on strengthening CHMTs and systems, primarily by providing targeted TA, mentorship, and supportive supervision to CHMTs as they in turn provided TA and supervision to health facilities. HBC and other community outreach activities were widely implemented to augment facility-based delivery of clinical services. In addition, LIFE supported LGAs through a limited grant mechanism in an effort to intensify their role in the delivery of health services.

The total award under the cooperative agreement amounted to \$60,000,000.²¹ Three objectives stipulated in the cooperative agreement framed the choice of program activities,²² as summarized in Table 5.

Table 5: Summary of LIFE Objectives and Related Activities

Objective	Activities
Objective 1: Increase access to integrated, quality, and comprehensive PMTCT,* RCH, and community-based HIV/AIDS services.	Strengthening the technical capacity of health management teams, supportive supervision and quality improvement interventions, investments in infrastructure and laboratory services, and the enhancement of the CoC through expanding CBCS services.
Objective 2: Strengthen linkages and referral networks across service delivery points and facility and community-based services to improve services and ensure a CoC.	Strengthening community-based care and support services (CBCS) through sub-grants to local CSOs, development of their organizational and technical capacities and developing, deploying, and supporting community outreach cadres (HBC workers, Community Health Worker (CHWs) and CGIAR Research Programs.
Objective 3: Ensure sustainability through a strengthened health system and through the transfer of capacity, management, and oversight of activities to the local government and other local institutions.	Using capacity-building activities and sub-grant mechanism to intensify the role of local government leadership and management in oversight of health service delivery.

*EGPAF adheres to the WHO's conception of "comprehensive PMTCT" comprising 4 elements, namely (1) primary prevention of HIV infection among women of childbearing age; (2) preventing unintended pregnancies among women living with HIV; (3) preventing HIV transmission from a woman living with HIV to her infant; and (4) providing appropriate treatment, care, and support to mothers living with HIV

Implementation Arrangements, Roles, and Responsibilities

EGPAF implemented the LIFE program in collaboration with sub-partners, and each partner had specified roles and responsibilities.

- EGPAF provided overall leadership and management to the LIFE Program, as well as directly contributing technical support to improving comprehensive quality PMTCT and RCH services, with strong linkages to other HIV services, such as C&T, along the CoC.
- Pathfinder supported implementation of comprehensive CBCS services that focused on increasing retention along the CoC. The support included strengthened referrals to

²¹ As of 8/13/2015.

²² The wording of the objectives shifted to some extent across the life of the program, as reflected in the quarterly and annual reports. The rationale for these shifts is apparent in the reporting; however, the changes do not have significant bearing on the evaluation as formulated and the authority of the cooperative agreement has therefore been favored.

- other services, such as palliative care, community financing and livelihood initiatives, counseling services, and other community-based RCH services.
- The Tanzania Red Cross Society (TRCS), a local organization and a long-standing partner of Pathfinder, managed the program's HBC services. TRCS mobilized and deployed its large volunteer network to provide HBC services at the community level and supported CHMTs to integrate HBC with other district HIV programs as well as adopt systems and procedures to manage HBC more effectively.
 - The Ariel Glaser Pediatric AIDS Healthcare Initiative (AGPAHI), a local registered organization, provided district-level TA to local government in the Shinyanga Region.

LIFE implemented the district approach through regional teams based in Kilimanjaro, Mtwara, and Tabora. The Kilimanjaro and Mtwara teams oversaw an additional region each, namely Arusha and Lindi respectively, while technical operations for Shinyanga region were carried out by AGPAHI. Technical staff at regional teams included a program officer for clinical services who oversaw C&T, PMTCT, and malaria services; a strategic information officer who was responsible for all M&E issues; a program officer for community engagement; and a program officer for laboratory services.

PERFORMANCE OF SUPPORT TO CLINICAL SERVICES

The evaluation posed two questions concerning the performance of the programs in their strengthening of clinical services:

1. **To what extent has the use of quality service delivery increased in the TUNAJALI II and LIFE-supported districts?**
2. **To what extent has integration of clinical and community MNCH services into the PMTCT platform improved access to quality MNCH services?**

This section presents an analysis of the secondary data demonstrating the results of each program's efforts and attempts to identify effective practices that plausibly contributed to positive performance, introducing primary data from fieldwork. The performance of each program is reviewed separately.

TUNAJALI II

Care and Treatment

The number of CTCs in TUNAJALI II districts increased from 174 in 2012 to 223 in 2015. This is largely attributable to support from the program, which invested in building, renovations, and equipping and furnishing CTCs. Increasing the number of CTCs precipitated a substantial increase in the numbers of people accessing services. The increase in numbers accessing services after the increase of CTCs suggests that communities in the vicinity of new service sites were previously severely underserved.

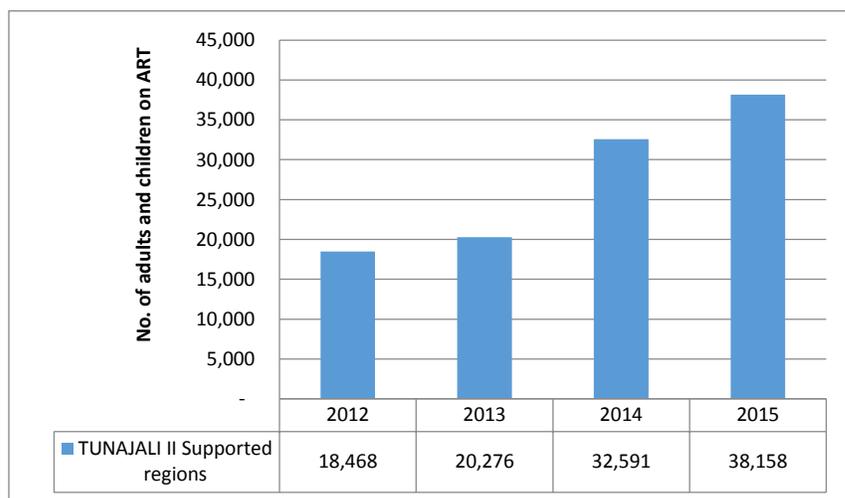
“In fact this CTC we are using now we got it from TUNAJALI, we were only the outreach site before TUNAJALI, so they helped us renovating and equipped everything we are using now although now it is small because of the increase of clients from 150 up to 5000 we are serving now.” – CTC Clinician, Njombe

The findings from secondary data endorse claims from interviewees in the field. The overall number of adults and children newly enrolled on ART has been remarkable, increasing by 107% between 2012 and 2015 cumulatively across TUNAJALI II districts (Figure 4). However, the data also show significant decreases in new enrollments in the Dodoma and Njombe regions from 2014 to 2015, countering their respective trends of steady increases in preceding years. The implementing partner has attributed the drop in Njombe numbers to the 2013 administrative reform in which the Iringa region was split and Njombe established, implying a measurement artefact in the statistics. Collapsing the numbers for the two regions into a single figure does confirm the upward trend in new enrollments. The disaggregated result however remains concerning. Njombe has the highest HIV prevalence in Tanzania and lower new enrollments suggest that the more remote areas of the southeast are still confronted by formidable service challenges. The 2016 monitoring data will be telling, but should the inference on service delivery be confirmed, this observation should be considered when geographic rationalization decisions are proposed in the next country operational plan.

While the rate of new enrollments serves as a helpful indicator of immediate performance, the extent to which care and treatment is gaining traction and improving health outcomes is better reflected in indicators that capture longer-term trends and effects. The number of adults and children currently on ART has increased 51% over the implementation period across TUNAJALI II districts, and from which a cautious inference may be made that new enrollments are being retained (Figure 5). More compelling is the dramatic 120% increase in the number of adults and children known to be alive 12 months after initiation (

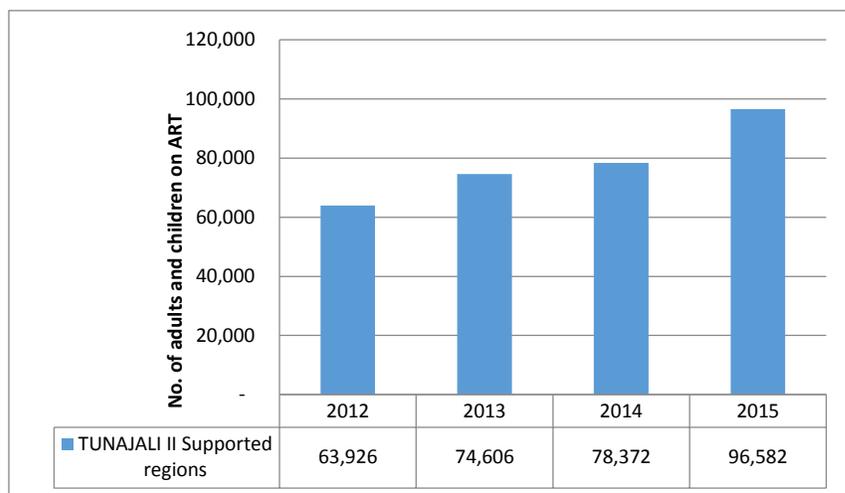
Figure 6), and the fact that it is the regions with the highest prevalence that are contributing most to this overall increase.

Figure 4: Number of Adults and Children with Advanced HIV Infection Newly Enrolled on ART, TUNAJALI II



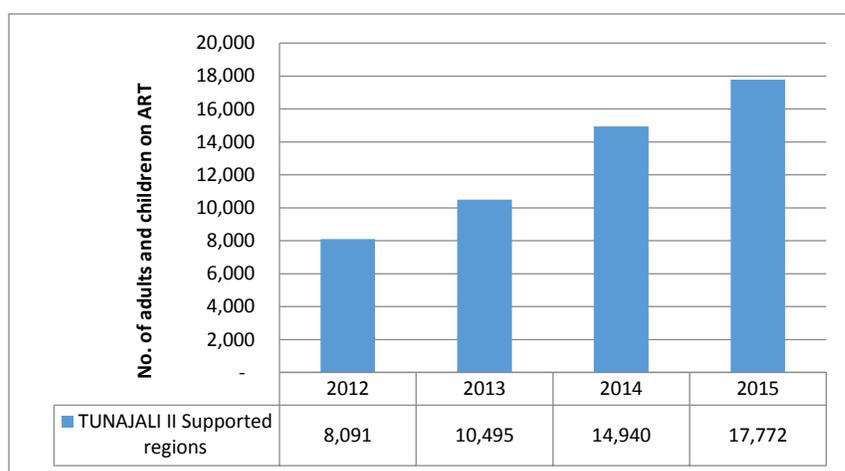
Source: TUNAJALI II monitoring data

Figure 5: Number of Adults and Children with Advanced HIV Infection Currently Receiving ART, TUNAJALI II



Source: TUNAJALI II monitoring data.

Figure 6: Number of Adults and Children Known to be Alive and on Treatment 12 months after Initiation, TUNAJALI II



Source: TUNAJALI II monitoring data.

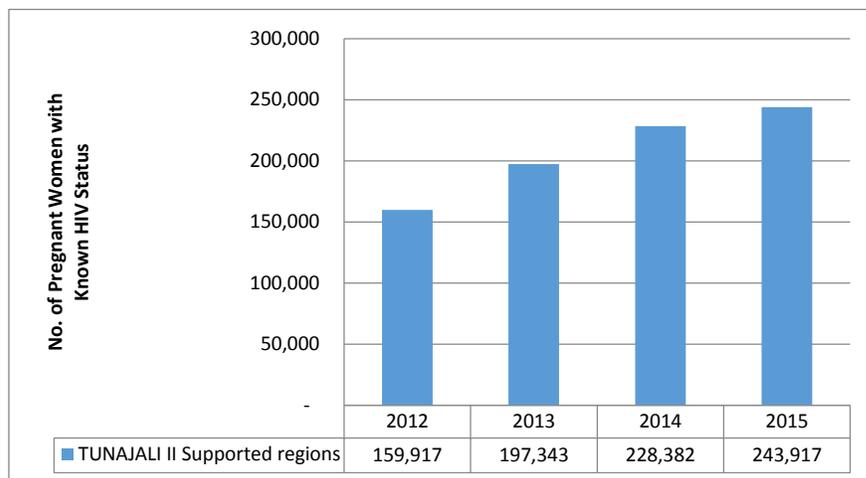
PMTCT, RCH, and MNCH

The number of facilities offering PMTCT services in TUNAJALI II districts has increased markedly, from 606 in 2012 to 1,099 in 2015. Not only has this raised the number of pregnant women accessing PMTCT, but integration of RCH services has been successful in improving access to the full range of services available to mothers and infants, prompting some unanticipated demands on the system.

“With the integration we get more women and children retained into ARTs, which is very important to us but again that has brought about some challenges because some women want to continue receiving ARTs at RCH even after two years.”– RCH Clinician, Morogoro

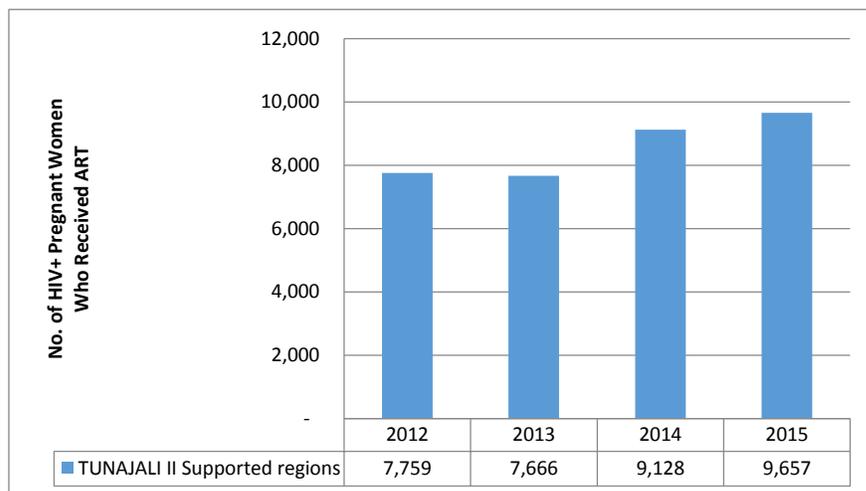
The secondary data demonstrate that the results intended from the escalation of PMTCT services are being achieved. Overall the number of pregnant women with known HIV status has increased by 53% during the implementation period (Figure 7), while the number of HIV+ pregnant women who received ART has also been on a steady upward trend (Figure 8).

Figure 7: Number of Pregnant Women with Known HIV Status, TUNAJALI II



Source: TUNAJALI II monitoring data.

Figure 8: Number of HIV-Positive Pregnant Women who Received ART, TUNAJALI II



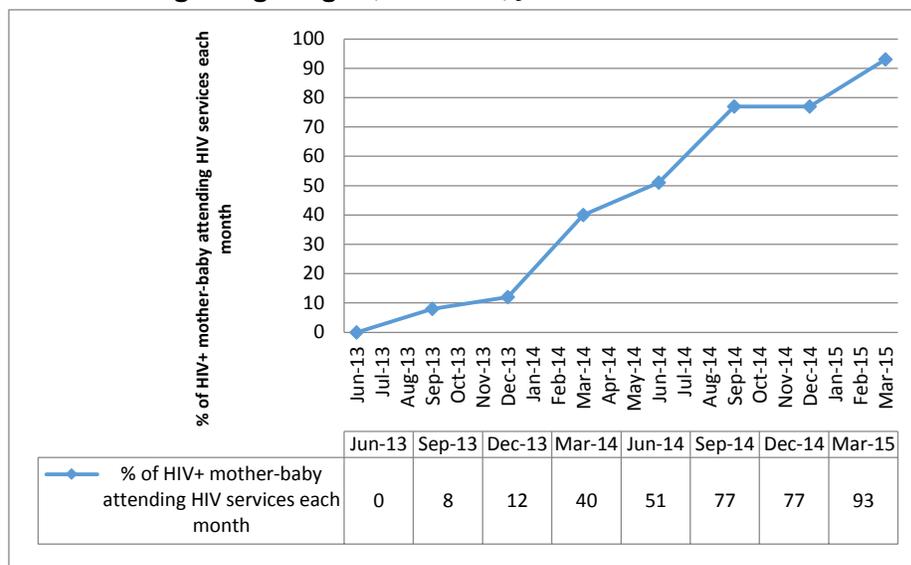
Source: TUNAJALI II monitoring data.

In 2014 the program received additional funding to support integration of MNCH services into the PMTCT platform in selected regions. Integration of services was implemented in 184 sites in Morogoro and Iringa regions, building to some extent on the previous MAISHA, program which was implemented by JHPIEGO. Basic RCH was augmented with emergency obstetrics and newborn care (BEmONC), NACS, focused antenatal care (FANC) and extended postnatal care (PNC) services. Selected facilities were equipped with delivery kits, resuscitation kits for neonates, delivery beds, autoclave machines, and suction machines.

Based on key indicators, the integration of MNCH services into the PMTCT platform could be said to be a success. The number of HIV+ mother and infant pairs accessing MNCH services as part of a broader HIV services package began increasing immediately and the trend has continued unabated (Figure 9). This result may demonstrate that introducing MNCH services substantially increases consistent service access by these mothers for themselves (MNCH and HIV services) and their infants (MNCH services). MNCH is not only a service set in itself to which access is improved but also incentivizes the consistent use of other HIV services by mothers. The proportion of total deliveries in health facilities settled at a high 96% between 2014 and 2015, while the proportion of women giving birth who received uterotonics in the third stage of labor increased from 30% to above 90% across the 48 reporting health facilities (

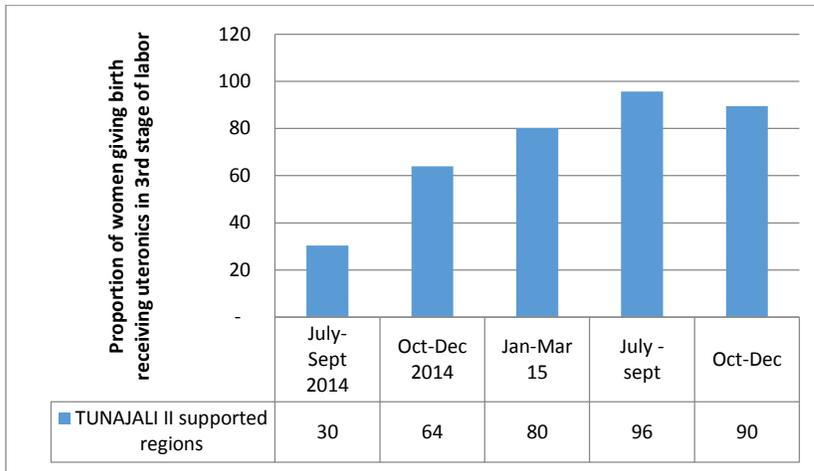
Figure 8). The proportion of newborns receiving a postnatal health check within two days of birth increased from 65% at the beginning of 2015 to 74% in December 2015 (Figure 11) and the number of infants receiving their first HIV test at four weeks has also increased steadily at all the participating Morogoro sites (Figure 12). Despite a falter in the last quarter of 2015, the upward trend is set to persist in the 2016 figures.

Figure 9: Percentage of HIV+ Mother-Baby Pairs Attending HIV Services each Month in 10 Sites in Mafinga Iringa Region, Tanzania, June 2013–March 2015



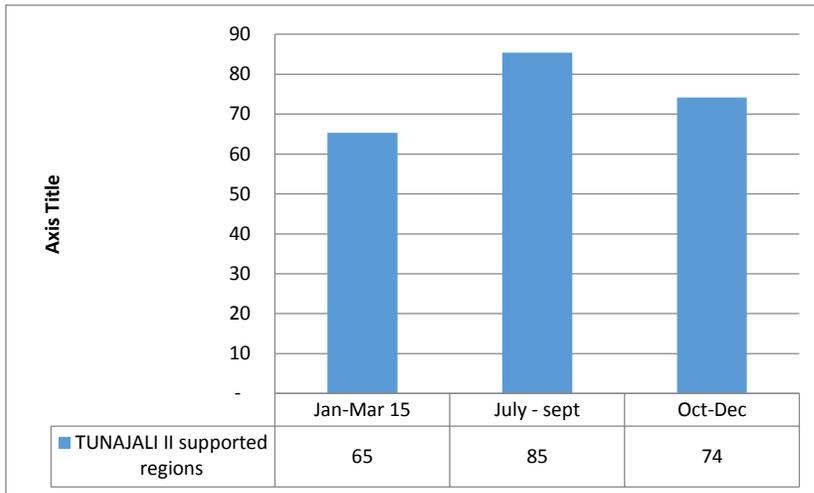
Source: TUNAJALI II monitoring data.

Figure 10: Proportion of Women Giving Birth who Received Uterotonics in the Third Stage of Labor, TUNAJALI II



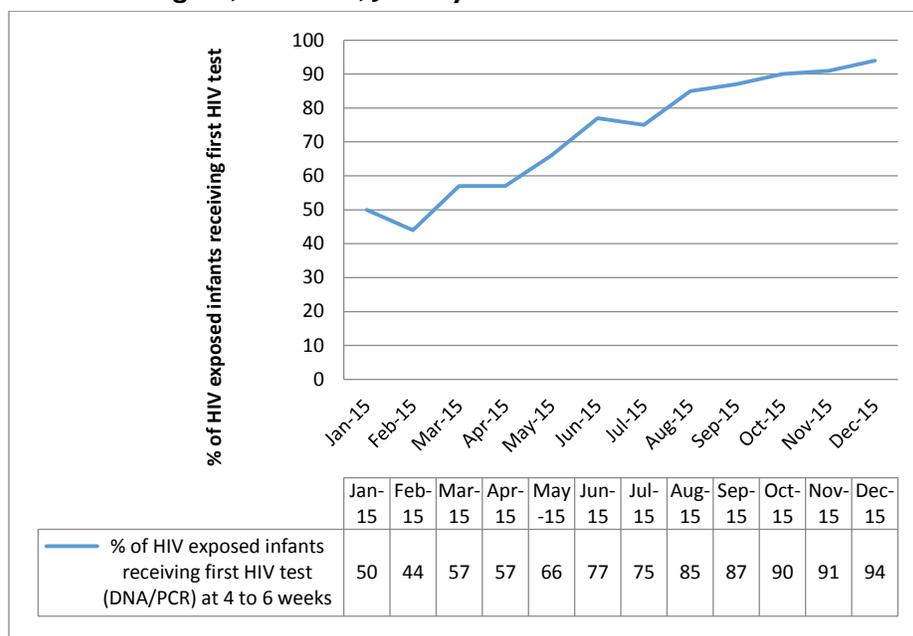
Source: TUNAJALI II monitoring data.

Figure 11: Percentage of Newborns Receiving Postnatal Health Check within Two Days of Birth, TUNAJALI II



Source: TUNAJALI II monitoring data.

Figure 12: Percentage of HIV-Exposed Infants Receiving First HIV Test at 4 Weeks in 20 Sites in Morogoro, Tanzania, January 2014–December 2015.



Source: TUNAJALI II monitoring data.

LIFE

Based on LIFE’s programmatic emphases, evaluation questions 1 and 2 interrogate the performance of PMTCT, RCH, and MNCH services in implementation districts, which are accounted for under LIFE’s objective 1. The questions also apply to CBCS activities, accounted for under LIFE’s objective 2, to the extent that these are directed at strengthening the clinical services being emphasized.

Prevention of Mother-to-Child Transmission

The number of sites offering comprehensive PMTCT services in LIFE districts increased from 967 to 1,376 during the LIFE implementation period. While the formal number is significant, it is the consistency of delivery at sites that is material. Interviews and observations in the field confirmed that consistent service delivery was undermined by key challenges, the most prominent being the supply of essential drugs and commodities. It is in response to these challenges that the program performance is telling. In addition to programmed activities that supported supply chain management, such as TA on inventory management at facilities, LIFE program staff monitored stocks at facilities and redistributed across districts as stock-outs threatened services.

“This project has helped us a lot because they are always there when you need help. For example, it’s always a challenge with test kits and reagents and whenever you call these people that you have run out of stock or [are] about to, they are always there to help, they normally do redistribution (taking it [from] somewhere else to help you).”—
RCH Clinician, Sikonge

Responsive implementation no doubt contributed to the performance reflected in the indicators. The proportion of women attending ANC in LIFE districts that tested for HIV increased from 51 percent in 2012 to 91 percent in 2015, an additional 180,000 women a year

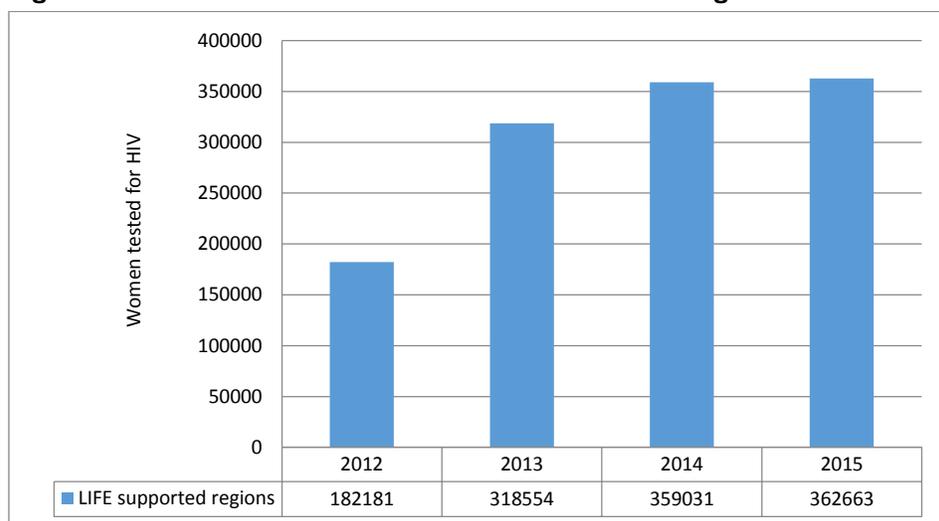
(Figure 13). When looking at the improved quality data from 2014 it is apparent that the number of HIV+ pregnant women enrolled on ART increased (Table 6). Understanding the numbers requires separating figures from 2014 and after from the numbers preceding 2014.²³ Though not directly PMTCT related, the promotion of male partner engagement was effective to the extent that in Lindi and Mtwara the proportion of couples testing is now over 70 percent.

The numbers of HIV exposed infants tested also increased substantially in all regions since program inception (Figure 14); however, the probability of identifying HIV+ infants in LIFE districts became less likely (Figure 15). It is not yet clear whether the low numbers of HIV+ infants diagnosed was a result of a successful PMTCT campaign and the administration of prophylaxis to exposed infants, or a function of the switch in targeting to scale-up districts and high volume sites. It is critical to determine which of the two explanations is most plausible. If it is the latter, there is a danger that HIV+ infants are being overlooked and the gains on PMTCT will falter.

The courier service engaged for EGPAF's C&T program under a CDC mechanism was used for dry blood spot (DBS) sample transportation, appreciably improving turn-around time for EID, and an example of EGPAF's claim that its multiple mechanisms were managed together to augment the CoC. In Tabora, EID turn-around time was further improved with a pilot for results notification on a mobile technology platform.

“These days we receive results within 5 days after sending DBS to Bugando through EMS courier services.” – RCH provider, Nzega district

Figure 13: Increase in Number of Women in ANC Testing for HIV in LIFE Program Districts



Source: LIFE monitoring data.

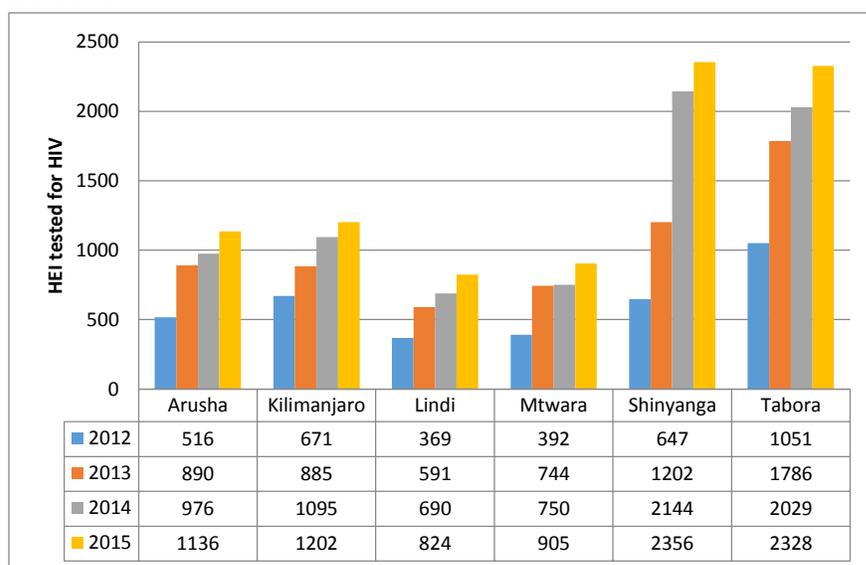
²³ At first glance there appears to be a decrease in the proportion of HIV+ pregnant women being enrolled on ART. This impression is an artefact of an improvement in how this indicator is measured. In 2011-2013 the numbers were collected from three sources: new on ARV/ART in ANC, new on ARV/ART in labor and delivery, and known positive already on ART. With the introduction of option B+ in 2014 the new ART register was launched, which now accounts only for new on ART and current on ART and no longer counts known positives already on ART. The latter, however, are still included in the denominator in calculating the proportion, resulting in a lower proportion being reflected. In addition, the earlier calculation included women who were receiving prophylaxis, which would result in double counting if a woman was transitioned to ART in the same year.

Table 6: Increase in the Proportion of HIV+ Pregnant Women Enrolled on ART, 2014-2015

	Positive Women	Women on ART	Proportion of Positive Women Initiated on ART
2011	9,544	12,712	133 percent
2012	8,796	10,078	115 percent
2013	11,631	10,765	93 percent
2014	13,445	10,454	78 percent
2015	11,742	9,808	84 percent
Total	55,158	53,817	

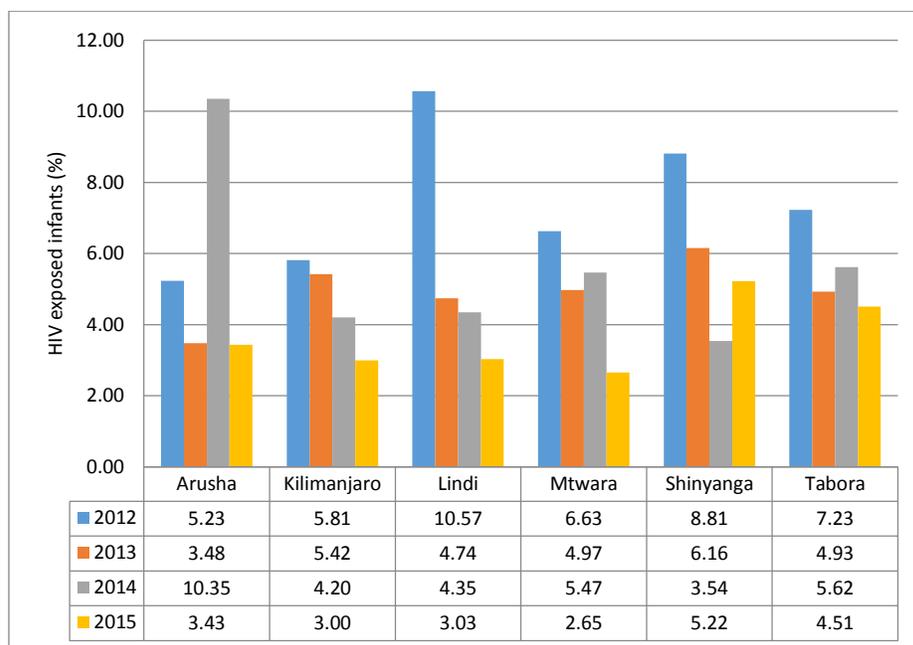
Introduction of B+

Figure 14: Increase in Number of HIV-Exposed Infants Tested for HIV in LIFE Program Districts



Source: LIFE monitoring data.

Figure 15: Decrease in Proportion of HEIs Testing Positive for HIV in LIFE Program Districts



Source: LIFE monitoring data.

Maternal and Newborn Child Health

MNCH interventions were introduced through additional funding in 2014 and implemented in high-volume sites only in the Tabora (102 sites) and Lindi (46 sites) regions. However, the introduction of MNCH support was preceded by efforts to integrate RCH and PMTCT services. RCH is a standard service category in the Tanzanian health system and has a dedicated clinician in charge on CHMTs. RCH includes maternal and child health issues but did not benefit from the focused impetus that the detailed MNCH program emphasis that was introduced by donor and IPs would subsequently confer on it when the focus of the funded activities was brought to bear on these services.

While they differ in detail, MNCH and RCH services plainly overlap, and the integration of RCH into PMTCT services has been supported through LIFE since inception. With the MNCH dedicated funds, however, LIFE implemented a more defined MNCH intervention in the Lindi and Tabora regions. The introduction of a well-defined MNCH program component may have enhanced the results being achieved through the less concentrated RCH integration efforts.

“The fact that we got these MNCH funds, although little, it created that boost that’s why the MNCH in Lindi is doing so well that other sites and even in Tabora, those sites are doing so much better than the rest, it’s because they got that additional MNCH money.” – EGPAF Technical Staff Member

Eleven district hospitals were identified to be developed as centers of excellence. Staff and service providers were trained to provide quality, comprehensive FANC and BEmONC, including the Help Baby Breath guidelines and on-the-job training to reinforce learning. The facilities were equipped with delivery kits, resuscitation kits for neonates, delivery beds, autoclave machines, and suction machines. Ultimately these 11 hospitals would function as the

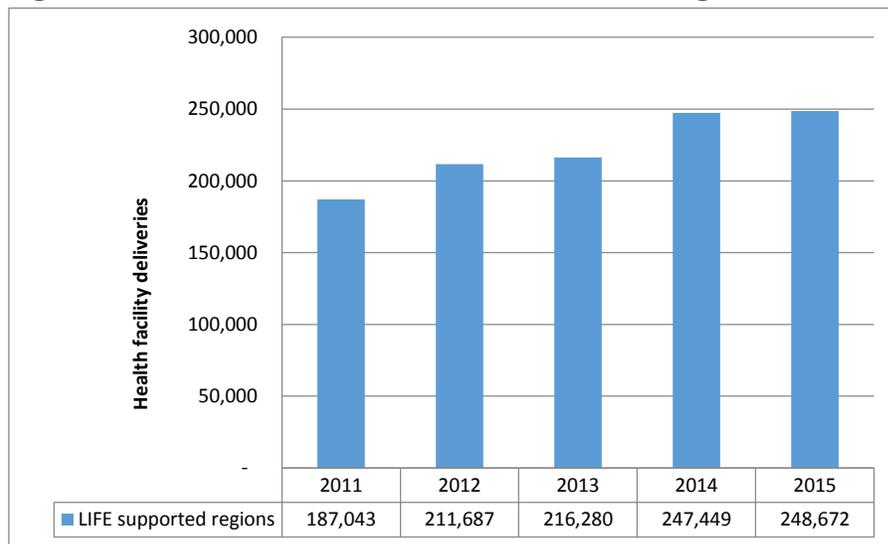
central node in a cluster of networked facilities of various levels to facilitate the referral of complicated pregnancies and deliveries. The community volunteer cadres were also mobilized to work with the districts to ensure that transportation and referral support was available, though the extent to which this feature functioned effectively is unclear. However, interviewees did report benefits from the community outreach component, particularly the efficacy with which new health-seeking behaviors were integrated into existing community practices.

“Now we are not fighting with traditional birth attendants but we are working with them so they escort those women who want to be delivered by TBA, so the TBA will escort the woman to our health facility for delivery.” – CHMT Member, Nachingwea

District Reproductive and Child Health Coordinators (DRCHCOs), whose participation assisted in legitimizing the model described here, were mentored to plan for, supervise, monitor, and improve the quality of MNCH services. They assisted in identifying MNCH mentors at district hospitals who would mentor service providers attached to those hospitals for two-week periods. The district mentors were also trained and supported to assist lower level health facilities to improve RCH care. Interviewees claimed that these attachments and the mentoring of lower-level facilities resulted in reduced referrals of pregnant women to district hospitals, because mentored health workers were subsequently able to identify and better manage risks that appear during labor and delivery.

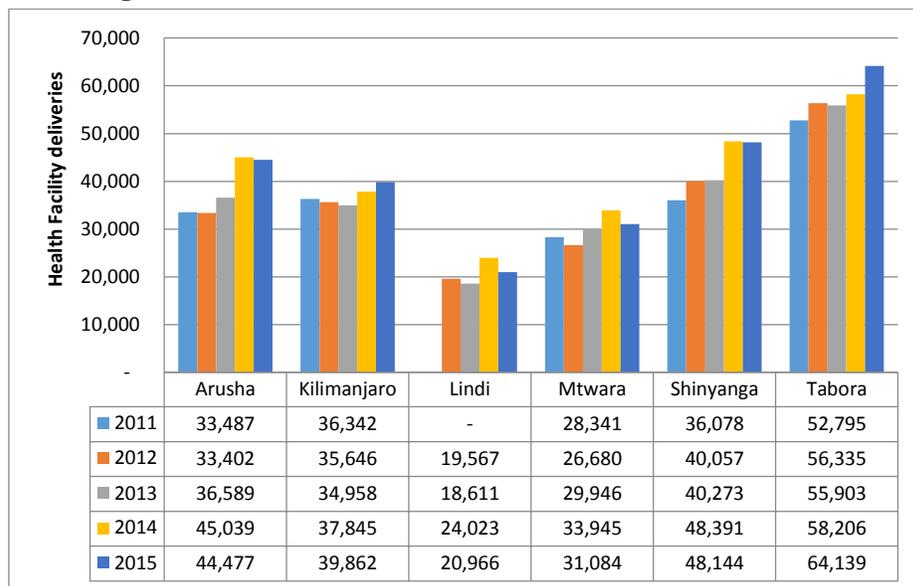
Both the earlier focus on integrating RCH and PMTCT services and the later intensification of efforts with the introduction of the MNCH component appear to have precipitated increases in the numbers of clients accessing a range of services. Perhaps the most telling indicator substantiating this observation is the increase in the number of women giving birth in a health facility, which has trended steadily upward in all LIFE’s implementation regions since 2011 (Figure 16). When looked at by region there does not appear to be any significant difference in the rate of increase between the two MNCH focal regions and the rest (Figure 17), with the exception of Lindi, where the trend over the period is flat.

Figure 16: Increase in the Number of Women Delivering in a Health Facility – LIFE program



Source: LIFE monitoring data.

Figure 17: Increase in the Number of Women Delivering in a Health Facility by Region – LIFE Program

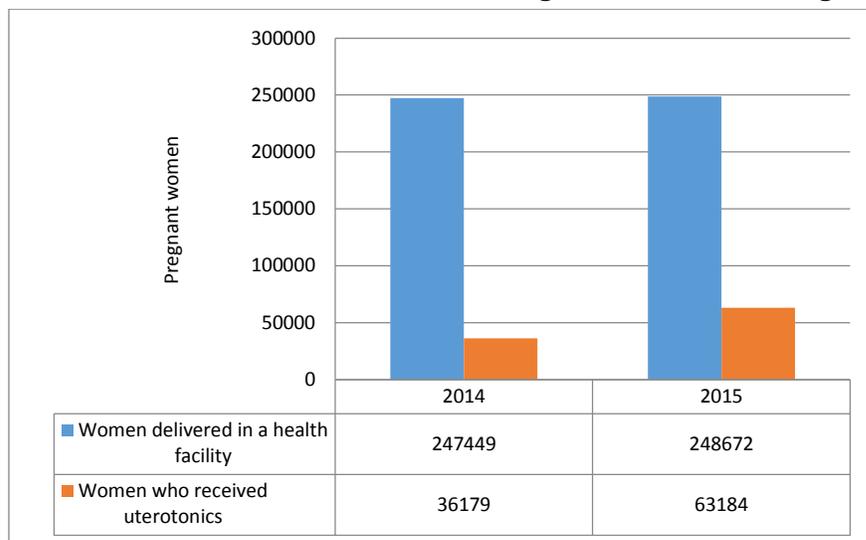


Source: LIFE monitoring data.

It would appear then, that the improvement on this indicator of increased facility-based deliveries was more likely due to the prolonged program focus on integrating RCH and PMTCT services, rather than the later introduction of the MNCH component. EGPAF staff repeatedly referred to the role of community volunteers in securing this result. In fact, anecdotal evidence from the field suggests that the effective mobilization of community volunteer cadres was the crucial factor contributing to this success. This is regardless of the mechanism within which the cadres were mobilized, as LIFE inherited a substantial cohort of community health workers (CHWs) from a preceding mechanism. At a small health facility in Tabora, with a single clinician attending to up to 70 mother-baby pairs each day, the home-based care workers reported having actively encouraged pregnant women to deliver at facilities from program inception, as part of their routine outreach work. In the communities served by the facility it is only involuntarily that women now give birth anywhere other than the small labor ward attached to it. An additional observation potentially supporting the role of community outreach cadres in improving deliveries at facilities is the fact that in Lindi, where performance against this indicator was flat (Figure 17), there was no CHW program.

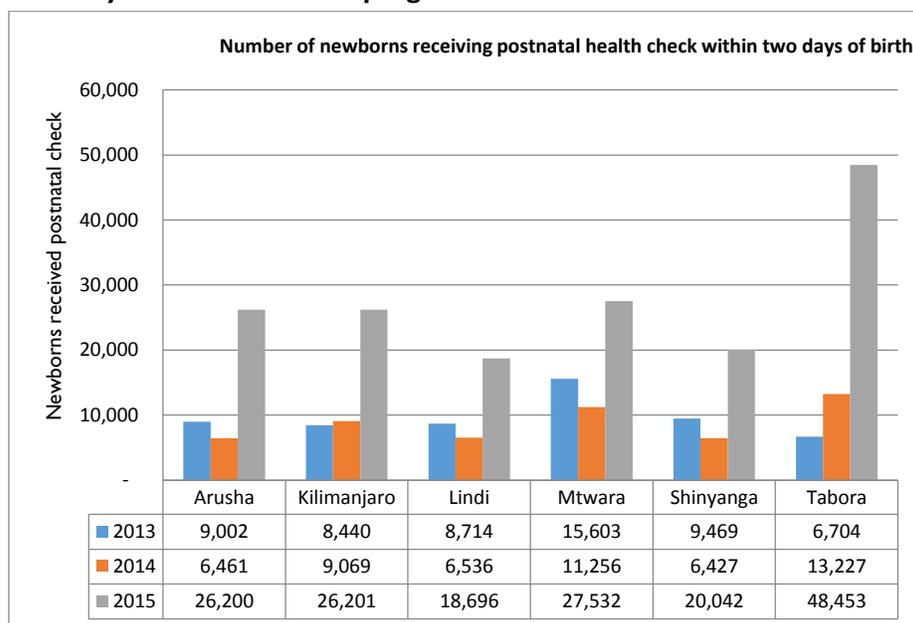
Other indicators, however, do offer some evidence of the later-introduced MNCH component achieving results. For example, the proportion of women who received uterotonics in the third stage of labor increased from 15% in 2014 to 25% in 2015, a significant shift that can only be attributed to the MNCH efforts (Figure 18). An additional example, which pits the early RCH integration endeavors directly against the MNCH component, is the increase in the number of newborns receiving a postnatal health check within two days of birth. While a step-up can be observed across all regions between 2014 and 2015, it is most dramatic in the Tabora region, where, according to EGPAF staff, MNCH is being most effectively implemented (Figure 19).

Figure 18: Increase in the Number of Women Giving Birth who Received Uterotonics in the Third Stage of Labor – LIFE Program



Source: LIFE monitoring data,

Figure 19: Increase in Number of Newborns Receiving a Postnatal Check Two Days after Birth – LIFE program



Source: LIFE monitoring data.

It should be noted that as a region Tabora appears to have benefitted from multiple initiatives not implemented elsewhere, including interventions from other mechanisms such as PLAN, TABASAM, and the Partners for HIV-Free Survival (PHFS) in Nzega district and selection of Nzega, Igunga, and Tabora MC districts for the decentralization of services pilot, which led to the appointment of district coordinators in addition to regional staff.

A number of additional benefits to MNCH integration were claimed. For example, the monitoring of maternal and neonatal deaths is currently being strengthened by supporting the

implementation of the national Maternal and Perinatal Death Surveillance and Response Program; implementation and use of RMNCH scorecards to assess performance at site and district levels; and organizing biannual meetings to discuss program performance and review maternal and neonatal deaths with service providers. The evidence seems emphatic that the integration of MNCH on the PMTCT platform has been an effective tactic for introducing these services and increasing access to them. They are also an obvious complement to PMTCT services, and arguably benefit from the reach PMTCT service delivery has already achieved.

However, because the additional funding for MNCH was limited, the feasibility of scaling-up the MNCH component, or even sustaining its performance, has been questioned by implementing partners. PMTCT programs, even with an RCH focus, are restricted to an allowable set of activities on which funding can be spent. Effective MNCH requires broader implementation parameters that the PMTCT platform does not accommodate when it comes to spending. With the beneficial results apparent, a more openhanded funding allocation seems justified.

“We believe that by developing a strong MNCH platform for all women, that all women come for four ANC visits and promote that all women come to delivery, it will benefit the PMTCT program. However, it has limitation by putting it under the PMTCT platform, that is why we don’t invest heavily in equipment, i.e., how can you buy delivery beds under the PMTCT program?” – EGPAF Technical Staff Member

Effective Practices Contributing to Improvement of Clinical Services

Of course, the quantitative performance analysis is generalized and therefore distanced from the particular hindrances that undermine consistency or impede performance at site level. For example, while cervical cancer screening services are now visibly on offer, the patterns of referral and delivery at individual facilities, and therefore service effectiveness, vary.

Family planning also is not implemented as designed in every instance, and the choice of HIV+ women to continue to have children, as evidenced in some of the focus group discussion data, complicates service delivery. Respondents nevertheless consider family planning to be an effective intervention.

“When a woman who is HIV positive continues to get pregnant, the risk of MTCT also increases because of the decrease in immunity during pregnancy, so this FP counseling and methods which are provided at CTC have helped a lot in reducing the number of pregnancies per woman.”– RCH Clinician, Mafiga HC

It is important, therefore, to try to identify the consensus on effective practices that contribute to good results, and align the qualitative data with confirmatory quantitative results. The evidence suggests that the following are key predictors of program performance.

Increasing Demand and Access through Integration and CBCS

Respondents consistently associate the training, deployment, and support of an extensive network of community volunteer cadres with strong program performance in identifying clients, facilitating client access to services, enrolling and retaining them in treatment, supporting adherence to treatment, and decreasing loss to follow-up. The effective model is comprehensive, with an HBC focal person at the IP regional office; at least one CSO in every district; a large community volunteer workforce at the community level; one supervisor at the

facility level; and PLHIV support groups that the volunteers reach out to and through to the broader community.

“For sure without these people (HBC, CHW, and volunteers) things would have been worse because these people help here at the CTC because they come and work here but also act as an important bridge between us and the community, it’s easy now to tell the community anything because you just tell these people and it reaches there, the only problem is that their coverage is not enough.” – **HBC focal person at a CTC**

The integration of HIV testing and treatment services into routine RCH services has eased the disincentives associated with attempting to access health services—time and cost—making it easier for community volunteers to convince clients to access services.

“With the integration now we can also test more exposed infants and enroll them into care because PMTCT services are also provided at the RCH clinic and so infants when they come for immunization and growth monitoring DBS is taken and results obtained; now women and their children are getting ARTs at RCH and they are very happy now to the extent that they don’t want to go to CTC....” – **HBC and HTC Technical Officers**

The increase in demand for services that are better integrated and of higher quality is also attributed to the work of community volunteers, at least in part.

“You can find a woman come for RCH clinic and demand to be tested or nowadays even people at VCT they come with family members to test. So education which is given to community by our people and the media is working magic. Partner testing is now more evident than other times.” – **CHMT Njombe MC**

Systems that enhance the efficacy of community volunteers, such as client appointment tracking systems, seem to be important enablers, while remuneration and resourcing are key messages from volunteers themselves. At a meeting with volunteers in Tabora the low allowances, late payment, lack of bicycle maintenance, and limited number of team members were the key grievances.

Staff Placements, Data Use, and Quality Improvement

According to respondents, both clinical service delivery and data management and use have been significantly enhanced through the placement of additional staff at CTCs. More clinical officers, nurses, and lab technicians not only reduce waiting times at facilities but prompt an increase in health-seeking behavior in the communities served. The placement of data clerks improves the quality of data and records, as well as their use in client management, client follow-up, and service quality improvements. Supportive supervision at facilities, informed by needs identified in data verification meetings, was seen to have greater effect on service delivery improvements than training.

“We have also initiated [a] data verification and technical assistance meeting which is done quarterly so we meet at the district HQ and we bring together the frontline health care workers and they meet with our team members. We were conducting these meetings with district administrative and facility people and we have prioritized 223 health facilities which are providing CTC, PMTCT, and TB/HIV, these meetings

*have shown a lot of impact rather than the centralized training.”–TUNAJALI
Technical Director*

In fact, supportive supervision that is regular, evidence-based, and resourced is widely seen as the key to sustainable improvements in clinical services performance.

“One thing I can say with confidence that TUNAJALI II has helped is to use the supportive supervision in solving challenges found; in the past we used to make visits but whatever challenges we found we did not know how to solve them but now with the quarterly meeting with other stakeholders in the region after supportive supervision it’s now possible to discuss the challenges and whoever is able to assist does assist. It has brought us and the providers at the facilities to see the rationale for doing supervision.”–CHMT Member, Iringa

Laboratory Services and Mitigating Supply Chain Management Challenges

“There were few laboratories with even a single star but now at least all the regional laboratories have two stars and some up to four stars, like Dodoma and Dar es Salaam, and some will get full accreditation soon.” –TUNAJALI II Laboratory Focal Person

The investment in improving laboratory services through equipment and training has had disproportionate effect on the improvement of clinical services quality generally. A small PIMA machine was supplied to lower-level facilities which are smaller and can test up to 10 clients per day. Complemented by mobile-based notification systems, turn-around times on testing, and by extension the rate at which clients are enrolled in treatment, have been drastically bettered.

“Nowadays we are in WhatsApp group of TUNAJALI staff and CTC in charge of this region and other regions so whenever you run out of stock for reagents or equipment then you just send a text and someone with enough can reply and TUNAJALI staff will help re locating those commodities.”–.CTC Clinician, Mafiga HC

DBS samples are an illustrative case for the influence of improved laboratory services on increasing the quality of clinical services generally. Turnaround time on testing and notification of results has been reduced from more than three months to an average of 2-3 weeks. Quality checks, transport arrangements, and a mobile-based notification system have transformed the service.

“In the beginning you would find out that we are here waiting for the sample result and the mother keeps coming until we don’t have the answer only to find out later that the sample had poor quality so the test could not have been taken but now that’s a history because of this quality checks at the district before sending to central lab and also the communication system, which is properly working.”– CHMT Member, Iringa

“Two weeks ago I received a call from central lab telling me that I had not sent the sample which was registered and supposed to be sent, so I had to check and it was true that the samples were here so I had to take them to district hospital so that they can send the samples, so you can find how this communication system have been helpful to us.” –RCH Clinician, Njombe

These gains, however, and others are frequently threatened by persistent supply chain management deficiencies.

“Again the supply chain—this is still a challenge; they were distributing medicines for opportunistic infections in the beginning but now they are just doing re-distribution, which is also helpful because with these medicines most clients are able to improve their quality of life.” –CTC Clinician, Morogoro

Both programs responded by establishing monitoring mechanisms that forecast potential shortages and then arrange for redistribution of essential drugs and commodities between facilities within their districts. This has become an indispensable feature if program performance is to be sustained.

PERFORMANCE OF CAPACITY DEVELOPMENT INTERVENTIONS

The evaluation posed two questions concerning the performance of the programs in their capacity-building efforts:

- 3. To what extent have capacity-building efforts contributed to LGA performance related to governance, accountability, fiscal management, and technical oversight?**
- 4. How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community HIV services to HIV positive clients and pregnant women and newborns?**

This section presents an integrated analysis of secondary and field data demonstrating the performance of the two programs' capacity-building interventions and offering plausible explanations for the link between interventions and results where evidence allows. The passage of implementation resulted in similar performance and lessons learned for both programs, which is why the analysis is presented together.

Capacity Building of LGAs

The support to local government was an innovation falling outside of direct support to public health operations but crucial to it, especially in light of URT's drive toward the decentralization of service delivery. The primary intervention for engaging LGAs was the provision of conditional grants, together with training and TA to effectively manage those grants. Responding to evaluation question 3 requires an understanding of how capacity-building support to LGAs was undertaken in each program, and then gauging the specific results obtained in improving financial management, accounting to the public on budget allocation and audit findings, and technical oversight of health service delivery. How these results together did or did not enhance LGA governance of health service delivery and more broadly must then be considered. Ultimately, the emphasis on capacity building is driven by an intent to prepare the way for transition, and therefore the response to question 3 must include a reflection on districts' readiness to sustain delivery of services without program support.

Capacity-Building Approaches

TUNAJALI II adopted Deloitte's institutional capacity-building maturity model²⁴ (which aligns closely with the six World Health Organization (WHO) building blocks for health system strengthening)²⁵ as the programmatic framework for interventions with LGAs. Implementation progressed through four phases: engagement, diagnostic review, intervention implementation, and M&E. LIFE also formulated its approach in terms of WHO's six building blocks. Support to LGAs was differentiated according to the priority needs of a district, as identified through administering a number of assessment tools, the ESAT,²⁶ PCAT,²⁷ and MCAT.²⁸ Based on the assessments, district-specific capacity-building plans were developed and a tailored TA package delivered.

Because capacity development with LGAs was largely a demand-driven activity, interventions were launched only when assistance was invited. For TUNAJALI II the process could stall at any of the four phases, as a request from the LGA was needed to initiate the next step in the sequence. Consequently, uptake varied substantially, with more than half of the program's 30 districts completing only 1 or 2 interventions, and 10 districts completing 9 to 20 interventions. However, both programs used their limited grant-making mechanisms as an entry point to deliver at least some training and TA to council sub-partners. The grant mechanism also gave entry to monitor LGA performance narrowly, in the domain of financial management.

Key factors constraining the performance of the capacity development interventions included:

- The high career mobility of council staff: Local capacity-building efforts are diluted as staff are promoted and transferred across the public service.
- The complexity of the public service environment: Capacity-building training was not initially tailored to the public service context, making application of new competencies difficult.
- Onerous government procurement processes: Rather than simplifying spending on local initiatives, the granting of funds to LGAs often increased the burden of accessing finances for CHMTs.

CHMT respondents constantly made the last point. While CHMTs assert that they are indeed positioned to prioritize local procurement spending, the grants mechanism for management through LGAs is not enabling. Instead, protracted procedures, exacerbated by frequent additional requests from financial departments for justifications, and the low priority assigned to managing limited funds with what are perceived to be bothersome parallel accounting requirements, are all cited as prohibiting the effective employment of grant monies. For a results-based grant mechanism to be effective in this context, its design must take into account

²⁴ The maturity model consists of 6 capacity dimensions, which are the strategy environment, leadership and decision making, organizational culture, financial management and sustainability, ICT and human resources.

²⁵ These are leadership and governance, information systems, procurement, quality of service delivery, human resources, and financing.

²⁶ The EGPAF Sustainability Assessment Tool (ESAT) was used to assess the state of the district health system according to the six WHO building blocks. The ESAT was also used to conduct follow-up assessments on an annual basis to monitor capacity improvement.

²⁷ The Project Capacity Assessment Tool (PCAT) was used to monitor program implementation.

²⁸ The Management Capacity Assessment Tool (MCAT) was used to conduct management and financial capacity assessments.

not only the formal procedures for procurement at the local government level but also how efficiently these are implemented in reality, and the extent to which a government function removed from direct health service delivery is motivated to manage the grant as intended. Until the mechanism is designed to better fit the practical context, there is a clear preference among CHMT respondents for avoiding the inclusion of the LGA procurement function into the procurement process.

“We prefer centralized procurement because of the long bureaucratic process that the CHMTs have to go through to procure equipment and supplies.” – CHMT Member

Improving Financial Management

“Training in financial management contributed to improved financial management of TUNAJALI funds because before the training programs were conducted, Councils used to prepare financial reports without supporting documents but now all reports have supporting documents and the right procedures are being followed in spending the funds.” – Regional Program Manager, TUNAJALI II

Capacity-building interventions in financial management improved the timeliness and quality of reporting on funds received by LGAs through the programs’ grant mechanisms; however, the extent to which overall financial management was improved is questionable. In part this is a function of the scope of intervention. All 30 TUNAJALI II councils were trained on compliance with USG financial reporting regulations, while only 8 received any financial management interventions beyond this. All LIFE councils received basic training with some coverage beyond USG compliance, including content on the EPICOR 9.05 Government Accounting system.

Where training beyond basics was delivered, respondents did claim more generalized improvements in financial management capacity, such as the ability to better deal with audit queries. Four TUNAJALI II councils with poor financial management performance were given targeted TA and subsequently achieved unqualified audits from the Controller and Auditor General (CAG), offering perhaps an indication of the depth of intervention required to produce consequential results. LIFE’s TA and mentorship to ensure that CCHPs incorporated donor funding and that donor funding was accounted for in government systems (PlanRep and EPICOR) were the necessary complement to give effect to training.

“Training in financial management and mentorship by the grant officers has contributed to improved financial management, which has resulted in reduced questionable and disallowable costs at the LGA level.” – LIFE Regional Manager

A crucial limit to the efficacy of financial management training is a pertinent observation on the breadth of intervention, beyond just training in financial management. The frequent transfer of council staff across the public service dilutes capacity-building efforts at any single local authority.

“There is frequent transfer to other councils and regions of senior management staff who were trained by TUNAJALI II program. For example, 80 percent of the senior management staff that we started with at the beginning of the program have been transferred. Efforts were made to discuss the issue with the Regional Assistant

Secretary to reduce the transfers but not much progress has been made.” – Regional Program Manager – TUNAJALI II

Career advancement is tied to mobility, and as such the movement of public officials is not likely to be curtailed. The solution would seem to be capacity development on a much larger scale than the programs were positioned to implement, reaching a critical mass of officials so that mobility is mitigated.

Public Engagement on Budget Allocation and Audit Findings

LGA budgeting is regulated and proceeds from the bottom up. Dispensaries submit budgets for consolidation at ward level, and wards submit consolidated budgets to district councils, which are required to come in beneath a ceiling they have already been allocated. Health centers and hospitals similarly submit budgets to district medical officers (DMOs) for consolidation. Budgets are approved at a full sitting of a council. Civil society is engaged to the extent that partners implementing funded programs, including Deloitte and EGPAF, meet with the council to incorporate donor funds into budget planning and coordinate spending. In this already regulated and complicated process there is no established mechanism for the public to hold LGAs to account on budgeting decisions.

To address this omission TUNAJALI II delivered a six-day training program on Public Expenditure Tracking System (PETS) and advocacy skills to 10 of its CSO sub-partners. Two of the four CSOs reported applying the training with some success. Local NGO COCODA lobbied for and received LGA grants to the value of Tsh 15 million over 4 years for 11 support groups. Similarly, by cascading the training to its community volunteers, 21 of SHISO's PLHIV support groups secured LGA grants between 2012 and 2015. Unfortunately, COCODA can only track council expenditure on its own support groups, as no further access to public expenditure data has been permitted.

Once CAG audits are completed, councils are required by law to post the published results on council and ward notice boards and in the press. In addition, the community is invited to attend the full council meeting where audit findings are discussed. Perhaps because public engagement is already legally mandated, TUNAJALI II and LIFE initiated no further interventions to support the engagement of councils with the public on audit findings.

LGA Technical Oversight of Health Service Delivery

“Improved access and quality of services as a result of the support received from TUNAJALI II led to increased demand for services such that the limited infrastructure in health centers is failing to accommodate the increased number of clients.” –

Morogoro Municipal Council Staff Member

TUNAJALI II and LIFE have increased access to quality HIV C&T, PMTCT, and MNCH services, and have transformed laboratory services for the better. The improvement in service quality at facilities over time is plausibly due, at least in part, to building the technical capacity of health management teams and resourcing them for supportive supervision visits (see discussion on Effective Practices Contributing to the Improvement of Clinical Services), despite the modesty of IP claims.

*“We have made a contribution to improvement in service delivery as a result of capacity building to LGAs but we cannot claim attribution.” – TUNAJALI II
Technical Staff Member*

There is also nascent evidence of a shift toward a locally led rather than donor-dominated HIV response. Three themes emerging from interviews with CHMTs and regional program staff are suggestive in this regard: (1) Mentoring RHMTs to consolidate and analyze council-level data has equipped regional leadership to assume a lead role in quality improvement. (2) Conceding the HIV response to donor programs while focusing on non-communicable diseases no longer characterizes CHMTs. (3) There are instances where governance and technical training have been applied to solve health system problems broadly.

The evidence does suggest that, overall, the efforts invested in building the technical capacity of health management teams is equipping local authorities to assume the lead in technical oversight of delivery of health services, HIV-related services in particular.

“Capacity-building efforts have enabled councils to improve performance, resulting in effective management of HIV programs, good data management, and timely reporting.” – TUNAJALI II Regional Program Manager

However, the evidence should be absorbed with caution. The contribution of technical competence is vulnerable to multiple factors that impose on health system efficacy.

Improvement in LGA Governance and District Readiness to Sustain Services

Both TUNAJALI II and LIFE offered training in governance competencies to councils and health management teams. Eight of TUNAJALI II's councils participated in training interventions, while LIFE merged KAIZEN training into its capacity-building activities with CHMTs in year 3 of the program.

“EGPAF did not plan to conduct leadership and management training using the KAIZEN approach but realized along the way that leadership and management capacity of CHMTs cannot be built through supportive supervision alone; hence the introduction of the KAIZEN training.” – LIFE Senior Manager

Training was complemented by some governance-specific TA, for example in succession planning. Financial management and governance interventions largely overlapped, however, and the perceived benefits of governance support were frequently articulated in financial management terms.

*“The training on leadership and governance had enabled the council to know how to effectively manage financial resources better than was done in the past.” – Manager,
Njombe Town Council*

However, a range of competencies beyond transparent and accountable fiscal management constitutes governance. It is the application of the sum of these competencies at a strategic level, informed by technical capacity for operations in the domains overseen. Improvements in governance correlate with readiness to sustain service delivery, and the consensus from respondents and evaluation team observations in the field is that there are still a host of deficiencies and challenges that require attention before such readiness is attained. An extract

from a LIFE report assessing the capacity of Lindi and Kilwa DCs in quarter 3 of 2014 is emblematic of the ground many councils still need to cover:

“There are no formal systems to inform staff on district objectives for the year, activities supported by implementing partners are inadequately integrated into CCHP, districts are not using the HRH database to manage training data, weak system for implementing and tracking patient satisfaction with health care services, districts do not have a plan for absorbing staff supported by IPs, DHIS2 electronic database is not updated, there is no M&E plan that addresses data management strategy and activities, QI activities are not integrated into CCHP, laboratory equipment maintenance plan and budget are inadequately included into CCHP...” – LIFE Quarterly Narrative Report, July– September 2014.

The most conspicuous obstacle to transitioning services is a lack of adequate resources. There are program activities that attempt to address this in limited measure. Technical assistance to LGAs to incorporate donor funding in CCHPs is in part intended to raise awareness of the scale of funding required to deliver health services. Support to improve local revenue collection more directly addresses funding deficits, as do activities encouraging PLHIV to join the community and national health insurance funds. Aside from the significant challenges to the functionality of health insurance for users, resources mobilized through insurance and from local revenue collection are insignificant in proportion to the health financing needs of Tanzania (see discussion in background section). The crisis is exacerbated by severe delays in national-level budgeting and disbursement processes, resulting in dire risks to service delivery.

“Councils do not yet have the capacity to sustain services ... because they cannot even conduct supportive supervision on their own. The project is currently meeting all the costs of conducting supportive supervision, which include transport and per diems to CHMTs.” – TUNAJALI II Regional Manager

Capacity Building of CSOs

Both programs contracted sub-partners and disbursed sub-grants to implement program activities. Consequently, substantial effort and resources were invested to develop organizational and technical capacity. The efficacy of this capacity building is evident in sub-partners' service delivery performance and to some extent in their increasing organizational independence.

Improvements in Service Delivery

The LIFE program focused its capacity building on high level technical partners TRCS and AGPAHI, with a view to transitioning services. AGPAHI received substantial training and technical assistance in specialized service areas, is the lead provider of program services in Shinyanga region, and is also the prime IP on a separate PEPFAR mechanism, receiving direct funding from CDC. TRCS has been receiving support from Pathfinder, another high-level technical sub-partner of EGPAF in the LIFE program. While there are still organizational capacities that need strengthening, TRCS has demonstrated marked technical progress in delivery of CBCS.

Overall TUNAJALI II has, through its CSOs, increased the number of PLHIV served from 39,155 in 2012 to 46,349 in 2015, an increase of 18 percent. The number of PLHIV being served in

CTC increased from 34,609 (88 percent) in 2012 to 45,806 (93 percent) in 2015. The number of PLHIV support groups increased from 583 in 2012 to 875 in 2015 representing a 50 percent increase in four years, while the number of SILC groups increased from 323 in 2012 to 1,085 in 2015 representing a 236 percent increase in four years. There has been a significant increase in SILC contributions, from Tsh 859,232, 464 in 2012 to Tsh 4,608,813,588, an increase of 436 percent. These figures imply a significant contribution to HIV service access through the referral and linking efforts of community-based services. While for many CSOs capacity preceded TUNAJALI II, there is an emphatic consensus from those engaged with interventions from the prime IP have significantly elevated their capacity.

The four CSOs visited during field work reported significant improvements in service delivery, which they attribute to the capacity-building support received from TUNAJALI II. SHISO reported an increased in the number of people accessing HBC services from 1,049 in 2012 to 2,137 clients and has tested 1,766 people. COCODA increased the number of clients being served from 1,454 PLHIV in 2012 to 6,484, consisting of 70 support groups from a baseline of 11, and 59 SILC groups from a baseline of 9. The organization has also counseled and tested 2,524 people, of whom 129 were found positive.

Capacity to Sustain Services

TUNAJALI II implemented a number of interventions to prepare CSOs for program closure. A key component of organizational strengthening included TA to formulate resource mobilization strategies. Three of the four organizations visited reported having mobilized additional financial resources as a result. SHISO has written two proposals, of which one resulted in a five-year agreement with the Clinton Foundation for an annual budget of Tsh 23,482,000. However, this is just 7.6 percent of the current annual budget SHISO is getting from TUNAJALI II. Among other activities to mobilize resources, HACOCA has written and submitted eight proposals, securing funding through the three which were successful. COCODA is now able to access grants from multiple funders, and IMO has been particularly successful, Tshs 1.522b between 2012 and 2015 from nine different funders.

Nevertheless, the magnitude of PEPFAR funding is difficult to match and CSOs still express doubts about their ability to sustain services after program closure.

“While we are able to sustain community-based HIV services and economic empowerment activities, we will not be able to sustain the salaries of the project staff working on TUNAJALI II Program activities except maybe for one or two project staff.”
– **CACODA Respondent**

“We cannot sustain CTC and HBC service provision after the end of the Program because we do not have our own resources or income-generating activities to sustain services provided by TUNAJALI II. All the CTC and HB services will stop at the end of the project because these services are 100 percent donor-dependent.” – **Alamano Center Respondent**

COST EFFECTIVENESS

The cost-effectiveness analysis set out to determine the extent to which the cost per client of each key service offered in the two programs compared favorably against benchmarks in the literature. This appears to be a reasonable objective for cost-effectiveness assessments in a

performance evaluation. A distinction is drawn between financial and economic costs, where economic costs are the estimated total cost of delivering a service, and account for expenditure that is not directly service-related, such as staff salaries, transport costs, etc. It is the economic cost that is of particular interest in the cost-effectiveness analysis. More detail is available in the methodology section of the report. An important reference for the discussion following is Appendix VI, the cost-effectiveness results in tabular formats.

TUNAJALI II

Three key services in TUNAJALI II were identified for cost-effectiveness analysis, namely C&T, PMTCT, and MNCH. The MNCH intervention was introduced in 2014 and implemented in Morogoro and Iringa regions. Alongside these key interventions are supportive interventions, including the collaborative management of TB/HIV co-infection, HBC, HIV testing and counselling, laboratory services, capacity building, and gender mainstreaming. The costs associated with supportive interventions were allocated to the key interventions as relevant, using the number of patients in each of the key interventions as the allocation key.

Financial Cost

The total financial cost for the TUNAJALI II program from 2012 to 2015 was US\$43,560,991. Recurrent costs accounted for 81 percent of the total cost, of which personnel wages and fringe benefits consumed 42 percent. About 12 percent of the total cost was used to purchase medical and nonmedical supplies; and 12 percent was used for travel, per diems, and meetings. The average annual per capita cost of providing ART (excluding PMTCT) is \$133US\$, while the average per capita cost for providing a minimum of one care service is US\$89. The cost for program management included procurement of non-expendable equipment, medical supplies, and consultancies for sub-grantees.

Economic Costs

C&T: The estimated total economic cost for comprehensive C&T for the period was US\$25,676,578. Provision of C&T in TUNAJALI II-supported areas is estimated to cost an average of US\$ 83 per client, ranging from US\$60 to US\$115. The estimated average per capita economic cost of providing a minimum of one care service is US\$52, with a range of US\$32 to US\$69.

PMTCT: The annual average economic cost of providing PMTCT services is estimated to be US\$ 13,778,996. The average economic cost per HIV positive pregnant woman receiving ART prophylaxis (PMTCT+) is US\$403, ranging from US\$278 to US\$494 US\$. The average cost of testing a pregnant woman for HIV through PMTCT services was US\$17 and ranged from US\$14 to US\$20.

MNCH: The analysis indicates that additional funding for MNCH in co-funded regions provided US\$7 per woman who delivered at a health facility, and the estimated cost per newborn receiving a postnatal check within two days of birth was US\$10.

The TUNAJALI II project is estimated to carry forward capital resources valued at US\$1,824,991 (non-expendable equipment US\$ 775,908 and training US\$ 1,049,083).

LIFE

Two key services in the LIFE program were assessed for cost effectiveness, namely, PMTCT and MNCH services. PMTCT mainly entails activities to prevent the transmission of HIV from

mother to child. In 2014 MNHC services were integrated into the PMTCT platform and offered in the Lindi and Tabora regions.

Financial Cost

The total financial cost for the LIFE program from 2012 to 2015 was US\$40,553,539. Recurrent costs accounted for 85 percent of the total cost, with personnel wages and fringe benefits consuming 41 percent of the total cost. Travel, per diems, and meetings consumed about 16 percent of the total cost and 13 percent of the total financial cost was spent on training. The average annual financial cost per HIV-positive pregnant woman receiving ART prophylaxis (PMTCT+) is US\$987. The cost of program management included procurement of non-expendable equipment, medical supplies, and consultancies for sub grantees.

Economic Cost

PMTCT: The estimated total economic cost for PMTCT is US\$26,326,227. PMTCT of HIV in the LIFE-supported regions is estimated to average US\$640 per client, ranging from US\$ 513 to US\$ 780. Testing a pregnant woman for enrollment in PMTCT was estimated to cost on average US\$22, ranging from US\$ 19 to US\$28.

MNCH: The estimated total economic cost for MNHC services is US\$2,200,469. The economic cost of additional funding for MNHC was US\$9 per woman who delivered at a health facility and the average cost per newborn for postnatal checks within two days of birth was US\$21.

The LIFE project is estimated to carry forward capital resources valued at US\$3,302,400 (non-expandable equipment US\$1,019,055 and training US\$2,283,345).

Benchmarking Against Typical Comparative Costs

The average ART cost per patient in the TUNAJALI II project was lower than those calculated in other countries (Menzies et al., 2011). The provision of PMTCT services is efficient in TUNAJALI II- and LIFE-supported regions. The average cost of US\$402 and US\$ 642 per HIV positive woman, for TUNAJALI II and LIFE programs, respectively, compares well with previous studies on PMTCT costing. A systematic review of the cost of providing PMTCT services revealed a mean cost of US\$792 per patient (Galárraga et al., 2012). A lower estimate from this study was probably due to exclusion of ART costs, since the supply chain is managed by another organization.

The economic cost of additional funding for MNCH ranges from US\$7 to US\$9 per woman who delivered at a health facility, and the average cost per new born for postnatal checks within two days of birth ranges from US\$10 to US\$21. In the literature, integrating PMTCT and MNCH services has been shown to reduce PMTCT cost and improve efficiency in averting mother to child transmission (Bollinger & Adesina, 2013). At the range of costs calculated, this evaluation offers evidence suggesting that integrating MNCH on an existing PMTCT platform allows for cost- efficient introduction of MNCH services into existing activities.

V. CONCLUSIONS AND RECOMMENDATIONS

CONCLUSION

All the indicators back the conclusion that in both programs support to clinical services has been effective. Access to the key services of C&T, PMTCT, RCH, and MNCH has increased. Although observations of inconsistent delivery indicate that issues of quality need to be attended to, the quality of services also seems to have been generally improved. Focusing on developing the technical capacity of health management teams, and instituting evidence-informed, joint supportive supervision and quality improvement at facilities appears effective and the core intervention for quality improvement going forward. Programs successfully mitigated performance risks, in particular weak supply chain management resulting in shortages of essential medicines and commodities. Investments in CTC infrastructure and especially laboratory services were central to positive program performance, as was facilitating access through an extensive network of volunteer cadres delivering CBCS.

The integration of MNCH into the PMTCT platform has clearly succeeded in increasing access to relevant services for all mothers and newborns regardless of HIV status, and health outcomes in MNCH are likely to improve if these can be sustained. Additional funding to existing programs has proven a cost-effective strategy for launching the effort. However, the PMTCT funding is restricted to specific expenditure categories and MNCH interventions require broader spending parameters. For MNCH to be scaled up and its full range of intended outcomes to be realized requires more money and probably dedicated technical capacity. The association with PMTCT is natural, beneficial, and probably should be maintained for efficacy's sake. While the reach of the PMTCT platform is useful to MNCH, there is justification for asserting that investment should be boosted if service transformation and potential health outcomes are to be secured over the long term.

In contrast the performance of capacity development interventions is mixed. While the development of CHMT technical capacity is evidently a factor in the successful support to clinical services, the broader intent of orienting local authorities for transition was not effectively served. A number of variables explain this subdued performance. Externalities such as the complex dynamics of the public service, the high career mobility of public servants, and the inflexible procurement and disbursement procedures diluted the expected effects of training and the limited grant-making mechanism to district councils.

These activities do, however, re-engage LGAs with their oversight role in health service delivery. In the light of both URT's drive for decentralization of services and PEPFAR's commitment to country ownership, a limited intervention such as support to LGAs may be useful. LGAs have been distanced from governance of health programming because programs have been donor-driven. In order to ease into transition there is a call for LGAs to become operationally re-familiarized with public health as implemented in their jurisdictions. But ultimately transition demands such a significant effort that it warrants a far more substantial programmatic effort. A stand-alone public sector reform program appears to be indicated.

CSO capacity has been enhanced through the program, and community organizations have benefited substantially from these efforts, both technically and organizationally. While a limited

number have managed to source funding from alternative donors, they remain confronted with the reality that PEPFAR support is difficult to match financially.

Comprehensive cost-effectiveness analysis is usually not feasible, primarily because cost data are not routinely collected in appropriate ways; and the necessary impact evaluation results are seldom available. However, cost analysis that benchmarks costs against what is typical is both feasible and useful. In the case of this evaluation all unit costs for service delivery were within appropriate ranges as established by the pool of relevant cost-effectiveness studies in the literature.

STRATEGIC LEVEL RECOMMENDATIONS

Consider a national-level mechanism to address mounting deficits in health financing. The primary obstacle to successful transition is an acute deficit in health financing. The mechanism would look at supporting URT in national health finance budgeting, improving budget allocation and disbursement procedures, supporting local government to generate and collect revenue, and redesigning the current health insurance mechanisms. Adding on activities to health service delivery and HIV programs is an inadequate response to a severe development challenge.

Consider a national-level intervention to support URT in addressing human resource shortages in the health sector. Currently programs are recruiting and placing young clinicians at facilities within their districts and in that way improving program performance. However, this is an artificial solution and raises the question of whether the skills deficits in the rest of the system are not being exacerbated by the implementation of this strategy in PEPFAR programs. The net national deficit in skills, which is the real problem, is not being addressed in this way.

Relook at the current targeting strategy. It is evident from the current numbers that partners are not likely to reach the new targets by focusing on high-volume sites in scale-up and aggressive scale-up districts. There is a very real argument to be made that certain HIV+ populations are dispersed rather than concentrated. If certainty on the current strategy's validity is not secured, programs risk missing HIV+ individuals completely.

Review and strengthen current mechanisms for addressing supply chain management functionality. Although there are current mechanisms, their efficacy, from the service delivery side of the fence, seems volatile. Serious service delivery interruptions are directly attributable to supply chain failure, justifying the recommendation for a review.

Consider a national public sector reform mechanism that has transition of health sector service delivery as its ultimate goal. The factors that undermined the effectiveness of efforts toward building the capacity development of LGAs (other than the capacity of CHMTs) were identified as inherent to the Tanzanian public sector. Activities that further the strategic priorities of USAID Forward and PEPFAR's commitment to transitioning the implementation of HIV-related services to the URT are necessary, but beyond the scope of C&T mechanisms to realize. These development objectives require intervention at scale.

OPERATIONAL LEVEL RECOMMENDATIONS

Support to Clinical services

Scale up the support to laboratory services. The improvements in testing quality and turnaround time have been a crucial factor in incentivizing health-seeking behavior among clients, and increasing early diagnosis and numbers being treated. The need for laboratory services has not yet been saturated and continued support with equipment maintenance and supply of testing agents will be required to sustain gains. The efficacy was further enhanced by sample transportation solutions and technology notification platforms, and these should be included in a scale-up strategy. Additional investment in this intervention is justified.

Scale up MNCH services. The limited funding and brief window of implementation has proved enormously successful, increasing access to services essential to addressing maternal and newborn health risks as well as wider HIV-related services. The potential gains in health outcomes are promising and additional investment is justified, but also necessary. Integration into the PMCT platform is useful for reach, but MNCH requires its own dedicated technical capacity.

Review and optimize the recruitment, training, deployment, and management of volunteer cadres. The evidence is emphatic that community volunteers' contribution to improving service reach is indispensable. This is despite numerous inefficient and ineffective practices in how this workforce is managed. There are potentially significant gains to be had from a closer look at how to optimize practices in this area.

Formalize and replicate the LIFE MNCH training model for clinicians. The concentrated capacity development effort that focused on clinicians by placing them for a period in higher-level facilities under mentorship proved extremely effective. It is worth documenting and replicating.

Formalize and replicate strategies for SCM. Both TUNAJALI II and LIFE devised effective strategies to mitigate the risk posed to program performance by the dysfunctionalities of the essential drugs and commodities supply chain. These are worth documenting and replicating.

Replicate TUNAJALI II's Back to Treatment Initiative (B2TI) campaign. The campaign was extremely effective in addressing the crisis of loss to follow-up in the districts in which it was implemented.

Scale up data-driven quality improvement initiatives. Data reviews not only equipped CHMTs to provide better supportive supervision and quality improvement interventions, but also empowered RHMTs to assume a strategic leadership role in the HIV response.

Capacity Building Interventions

Develop a strategy to deal with career mobility in local government. Frequent transfers of R/CHMTs and other senior council staff undermine local capacity-building efforts. Potential solutions are to scale up training interventions to cover a larger proportion of officials or to obtain commitments from government to implement transfers more judiciously, such as restricting transfers between program supported areas.

Partner with an organization with expertise in organizational development. High-level non-technical capacity-building expertise will mainly serve NGOs, such as the TRCS and AGPAHI, where technical capacity exceeds organizational management skills.

Place capacity-building technical specialists on regional program teams. While the programs had disease specialists and grant officers at the regional level, there were no capacity-building specialists at the regional level, with the result that this program area was not resourced to the level required for strong performance.

Implement a procurement system that promotes capacity building of LGAs. While procuring materials, equipment, and other supplies centrally has advantages in terms of economies of scale, which results in economic efficiency, it robs capacity-building recipients' skills in this area and sometimes contributes to delay in the supply of equipment and supplies.

ANNEX I. SCOPE OF WORK

Assignment #: 177 [assigned by GH Pro]

Global Health Program Cycle Improvement Project -- GH Pro Contract No. AID-OAA-C-14-00067

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)

Date of Submission: 10/29/2015
2/11/2016

Refer to the USAID [How-To Note: Developing an Evaluation SOW](#) and the [SOW Good Practice Examples](#) when developing your SOW.

I. Title: **TUNAJALI II and LIFE Midterm Evaluation**

II. Requester / Client

USAID Country or Regional Mission

Mission/Division: Health Office / Tanzania

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

- | | | |
|---|--|---|
| <input checked="" type="checkbox"/> 3.1.1 HIV | <input type="checkbox"/> 3.1.4 PIOET | <input type="checkbox"/> 3.1.7 FP/RH |
| <input type="checkbox"/> 3.1.2 TB | <input type="checkbox"/> 3.1.5 Other public health threats | <input type="checkbox"/> 3.1.8 WSSH |
| <input type="checkbox"/> 3.1.3 Malaria | <input type="checkbox"/> 3.1.6 MCH | <input type="checkbox"/> 3.1.9 Nutrition |
| | | <input type="checkbox"/> 3.2.0 Other (specify): |

IV. Cost Estimate: _____ (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period

Expected Start Date (on or about): February 29, 2016

Anticipated End Date (on or about): July 20, 2016

VI. Location(s) of Assignment: (Indicate where work will be performed)

Tanzania

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

- Performance Evaluation (Check timing of data collection)
- Midterm (TUNAJALI) Endline (LIFE) Other (specify): _____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm (TUNAJALI) Endline (LIFE) Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline Midterm Endline Other (specify): _____

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND

If an evaluation, Project/Program being evaluated:

Comprehensive Health Services Delivery		
Project Title:	TUNAJALI II: Comprehensive and sustainable clinical and community HIV/AIDS services	Linking Initiative for the Elimination of HIV (LIFE)
Award Number:	AID-621-A-12-00004	AID-621-A-12-00002
Award Dates:	January 17, 2012 –January 18, 2017	January 1, 2012 – December 31, 2016

Project Funding:	\$103,000,000 ²⁹	\$ 60,000,000 ³⁰
Implementing Organization(s):	Deloitte Consulting Limited	Elizabeth Glaser Pediatric AIDS Foundation (EGPAF)
Project AOR	Patrick Swai	Miriam Kombe

Background of project/program/intervention:

A) Development context

I. Problem or Opportunity Addressed by the Project/Activity being evaluated

The HIV prevalence in Tanzania Mainland has fallen to 5.3 percent (Urban 7.5% and 4.5% in rural)³¹ in 2012 among 15-49-year old population, from 5.8% in 2008 (urban 9.1% and rural 4.8%). The numbers of people living with HIV (PLHIV) has remained the same as a result of population growth and antiretroviral treatment (ART). Over 8 percent of children under the age of 18 years is orphan i.e. deceased with either mothers or fathers, or both.³² In some districts, more than 15 percent of children are orphaned, with obvious consequences for vulnerability to diseases of poverty such as TB and leprosy. Tuberculosis accounts for about 8% of the burden of diseases and 6% of all deaths in Tanzania for people aged 5 years and above, primarily due to HIV/TB co-infection.

It is estimated that 1.4 million people are living with HIV in Tanzania. Emergency national care and treatment initiatives started in early 2005 and by the end of September 2013, PEPFAR/Tanzania was supporting 1,185 care and treatment clinics out of about 1,400 facilities throughout the country. Additionally, 444,368 individuals are currently on (ART) anti-retroviral treatment, reflecting a growth of about 80,000 net new patients on ART since the previous reporting period. Data also showed that the retention of patients on ART was a challenge with many high volume sites reporting over 20 percent of “Lost to Follow-up” (LTFU) patients. Additionally, over 60 percent of registered ART patients were women and only 7-8 percent were children, implying serious challenges regarding getting more men and children on treatment.

Working from the Maternal Child Health (MCH) platform, the national prevention of mother to child transmission (PMTCT) program has been rolled out across Tanzania based on option B+³³ in its ten months of implementation. Based on the 2013 annual progress report (APR), the TUNAJALI II activity counseled and tested 197,343 women (94 percent of target), and of the HIV+ women identified, 7,666 were provided with antiretroviral prophylaxis (ARVs) (which is 69 percent achievement).

The HIV program supports the delivery of health and social services to improve health outcomes and quality of life of people living with HIV (PLHIV) and vulnerable children affected by the epidemic. In the last fiscal year, the Tanzania PEPFAR program reached 665,268 PLHIV, including 444,368 ART clients who are enrolled in HIV/AIDS programs with clinical and community-based care services that ranged from treatment for opportunistic infections and ARV adherence counseling to economic strengthening and social support. Coverage of ART

²⁹ As of 8/13/2015

³⁰ As of 8/13/2015

³¹ Tanzania HIV/AIDS and Malaria Indicator Surveys 2011-12 and 2007-2008

³² The 2010 Tanzania Demographic and Health Survey.

³³ Option B+ refers to the provision of Antiretroviral to all HIV positive pregnant and lactating women irrespective of CD4 count

among HIV-TB co-infected ³⁴clients in the country increased from 38 percent in 2011 to 54 percent in 2012.

TUNAJALI II (Swahili for “we care”) and LIFE (Linking Initiative for the Elimination of HIV) activities were awarded in 2011 and 2012 through solicitation APS 004 and 008. They were designed to implement comprehensive and integrated set of HIV services that would promote greater impact of HIV and MCH resources in Tanzania. These services include: care and treatment, prevention of mother to child transmission, TB/HIV and home- based care services for TUNAJALI II and prevention of mother to child transmission Community Health Worker (CHW), and Maternal Neonatal Child Health (MNCH) services.

2. Target Areas and Groups

These two activities are very similar in design, but they are implemented in different regions. TUNAJALI II is implemented in five regions: Iringa, Njombe, Morogoro, Singida and Dodoma. LIFE covers six regions: Arusha, Kilimanjaro, Lindi, Mtwara, Shinyanga and Tabora. Survey findings prior to launching these activities revealed that the Iringa region had the highest HIV prevalence in Tanzania (15.7% in 2007-08, and 9.1% in 2011-12).

While the activities focused on the HIV positive general population, women and girls were a specific focus of the program with the aim of increasing children living with HIV who are enrolled in ART. Mainstreaming gender in all planning and implementing activity components was intended.

B) Intended Results of the Activities being evaluated

TUNAJALI II

The activity’s highest level goals are to increase delivery of comprehensive HIV/AIDS quality services and build sustainability through cost-effective and locally driven approaches. The TUNAJALI II activity vision was to build the capacity and empower all 24 councils in the 5 implementation regions (Iringa, Njombe, Morogoro, Dodoma and Singida). The initial list of activity regions contained four only, but the Iringa region was subsequently split into Iringa and Njombe.

The activity also aims to address the challenges to implement a comprehensive integrated HIV approach designed to promote greater impact of donor funds in Tanzania, empowering all 24 councils in the 5 regions with the capacity to plan, coordinate, gender mainstream and provide services that are sustainable, integrated, and of a consistently high quality along a continuum of HIV care and support. The activity envisioned to promote ownership by the district councils and drive cost-effectiveness through the efficient use of their limited human resources, as well as mentoring the councils to be cost effective. The program intended to use Fixed Amount Reimbursement (FAR) Method to support Grants Making to support councils, Faith Based Organization (FBO) and Civil Society Organization)

The activity seeks to achieve five key Results:

- **Result 1:** Improved leadership and management capacity of Local Government Authorities (LGAs) for consistently high quality HIV services delivery;
- **Result 2:** Improved capacity of CSOs for consistently high quality HIV and AIDS service delivery;
- **Result 3:** Increased revenues and resources available for integrated HIV and AIDS care;

³⁴ HIV-TB co-infected patient refers to patient infected with both HIV and TB

- Result 4: Improved access to high quality, integrated and comprehensive HIV care and treatment services; and
- Result 5: Improved woman & girl child responsive HIV treatment, care and support.

LIFE:

The activity's goal is to promote the transformation of the delivery of comprehensive prevention of mother-to-child transmission of HIV (PMTCT), reproductive health (RH), and community-based HIV/AIDS care and support services. The overall vision of the activity is the virtual elimination of pediatric HIV infection in the focus regions by increasing the quality, efficiency, and cost-effectiveness of comprehensive HIV/AIDS services, and to ensure a sustainable and locally-owned response.

Working in 6 regions (Arusha, Kilimanjaro, Lindi, Mtwara, Shinyanga and Tabora), activities implemented are focused on PMTCT and MCH. Additionally, LIFE covers community-based care and support services in Tabora, Mwanza, Coast (Pwani), and Zanzibar. In supported districts, the activity builds local government capacity to plan, coordinate, gender mainstream and provide services that are sustainable, integrated, and of a consistently high quality along a continuum of HIV care and support. The activity results are:

- Increased access to integrated, quality, and comprehensive PMTCT, RH, and community-based HIV/AIDS services;
- Strengthened linkages and referral networks across service delivery points, and facility and community-based services to improve services and ensure a continuum of care (CoC);
- Ensured sustainability through a strengthened health system and through the transfer of capacity, management, and oversight of activities to the local government and other local institutions.

C) Approach and Implementation

TUNAJALI II and LIFE proposed to use district based approach as a strategy towards achieving long term program sustainability. To achieve clinical outcomes, they used technical strategies and advice as instructed to them by PEPFAR and GHI.

This approach integrates the concepts of: 1) alignment of activities to the national Health Sector HIV and AIDS strategies, integrated comprehensive HIV and AIDS Care; 2) capacity building for councils and Civil Society Organizations; 3) gender mainstreaming incorporation throughout execution; and 4) overall program management improvements along each of the stages. Sustainability is achieved by transitioning local ownership that is clearly planned at the onset (launch) and executed during program implementation. This approach requires the implementing partner consortium to act as catalysts and not “doers” while the local councils and Civil Society Organizations (CSOs) become the “planners and implementers” of activities.

TUNAJALI Activity approaches:

Result 1 focuses on improved leadership and management capacity of Local Government Authorities (LGAs) for consistently high quality HIV services delivery. It is implemented through two vectors of action: (1) build the capacity of councils to plan, coordinate, implement, monitor and evaluate sustainable gender responsive HIV care, treatment and support services; and (2) implementation through council leadership and management of the HIV services delivery.

Result 2 focuses on improved capacity of local CSOs for consistently high quality HIV and AIDS service delivery by building their capacities for results based program management.

Result 3 aims increased revenues and resources available for integrated HIV and AIDS care. The vectors of action are: (1) advocate for local councils to allocate more resources for health; (2) support PLHIV households to contribute to their own healthcare through better managed Community Health Funds; and (3) scale up approaches to reduce economic vulnerabilities of HIV-affected households.

Result 4 aim is to improve access to high quality, integrated and comprehensive HIV care and treatment services. It will achieved by: (1) support for the provision of high quality adult and adolescent HIV care and treatment services; (2) support for the provision of high quality pediatric HIV care and treatment services; (3) enhancement of integration and scale-up of TB/HIV care and treatment services; and (4) improvements in maternal and new born child health through integrated PMTCT and RCH services; (5) empowerment of PLHIV and their households to access quality community HIV care and support services that are linked to clinical services; (6) selection and training of community volunteers; (7) reduction in stigma and discrimination and raising of awareness of gender issues in communities; (8) promotion of PMTCT services at community level; and (9) strengthening TB/HIV identification and treatment at the community level.

Result 5 aims at improved woman & girl child responsive HIV treatment, care and support. This will be achieved by: 1) expanding the engagement of men and boys as clients, supportive partners, and role models for gender equality; 2) promoting community awareness, particularly for women and girls, on available HIV services including GBV; and 3) other support services both at facilities and communities.

Life Activity approaches:

The LIFE activity will utilize the district approach through systems strengthening as the implementation model across all partners. This approach, proven successful during EGPAF's roll-out of PMTCT services, strengthens the speed and quality of the scale-up process. It also promotes the long-term sustainability of services through the integration of activities into existing government structures and systems. Utilizing this approach, EGPAF actively is building the technical, organizational, and financial capabilities of district and health facility staff through activities collaboratively planned and supported through sub-grants to districts. The LIFE Program will focus efforts at the District Council Health Management Teams (CHMT) level providing targeted technical assistance (TA), mentorship, and supportive supervision (SS) to CHMTs as they provide TA and supervision to health facilities.

EGPAF does not provide direct TA to health facilities. Fundamental to their successful approach is that services provided through the district are part of the MOHSW national strategy and are not parallel or "add-on" services. The LIFE activity will not attempt to replicate or "do" the work of the MOHSW. Instead, it will play the role of process facilitator, while direct service delivery will remain the responsibility of the CHMTs in partnership with Tanzania Red Cross Society (TRCS) at the community level.

The district approach will be implemented through sub-awards, dispersed and managed by EGPAF, to district councils in all LIFE Program regions. Serving as TA partners, EGPAF and Pathfinder will complement sub-grants with hands-on mentorship and support to local partners to strengthen their capacity to plan, deliver, and monitor HIV/AIDS services.

Gender Mainstreaming

The LIFE activity will support the implementation of cross-cutting gender activities, with a focus on women and girls, in line with PEPFAR's approach of "gender mainstreaming." A

growing body of evidence suggests that gender inequality, including gender-based violence (GBV), has a major impact on all four components of the PMTCT strategy. This is because gender inequality affects women's and girls' ability to protect themselves from HIV, controls their fertility, and limits their access and adherence to HIV prevention, care and treatment services. Gender activities will be integrated into all LIFE activity areas and will focus on identifying barriers to access, and developing and implementing strategies to overcome those barriers.

Activity Strategies

Elimination will only be achieved through implementation of integrated approaches that address coverage, quality, and access to closely linked or integrated services, and ensure a strong health system to support the delivery of services. By developing integrated strategies, the Program will build upon existing structures and programs to create synergies between the broad range of services. The activity's integrated approach will increase efficiency in programming and ensure progress towards elimination.

Innovation will be an important component of the LIFE activity. The implementation team proposes utilizing the Program's Challenge Account to initiate and/or roll-out proven innovations that will support achievement of activity goals. Relevant innovations will be assessed by LIFE's leadership and its implementing partner will work closely with USAID to develop a plan for roll-out of innovative approaches and to obtain approval for use of funds through the Challenge Account.

Objective 1: Increased access to integrated quality comprehensive PMTCT, reproductive health, and community-based HIV/AIDS services.

Activities under Objective 1 will address gaps in quality and access to services with a special focus on high-impact interventions that address all four WHO prongs for PMTCT.

Community participation in the development, implementation, and evaluation of service provision will serve as an important approach to ensure that services are demand-driven and address inequalities, with special attention to the needs of women and vulnerable children in rural areas. LIFE Program partners will deliver TA, training, and systems strengthening to build the capacity of the local government and local partners to assume full responsibility for service delivery.

Objective 2: Strengthened linkages and referral networks across service delivery points and facility and community-based services to improve services and ensure a continuum of care.

The cornerstone of LIFE's design is an integrated approach to service delivery with a unified focus across all levels of the health system. This allows for intensified efforts to strengthen referral networks and linkages. There is a vast discrepancy between the number of health facilities offering C&T and the number of RCH clinics offering PMTCT in Tanzania. In EGPAF's supported regions, only 165 of the 1,065 PMTCT sites have the ability to stage women and initiate ART³⁵. Of these 165 sites, CD4 machines are only available at 42. Crucial to the elimination strategy, and in line with the revised WHO guidelines, is that all women with a CD4 count of 350 cells/ml should be initiated on ART.

Objective 3: Ensured sustainability through a strengthened health system and transfer of capacity, management, and oversight of activities to local government and other local institutions.

EGPAF, in consultation and collaboration with LIFE implementing partners Pathfinder, MOHSW, and other key stakeholders, will lead transition and HSS activities. LIFE will

³⁵ WHO stages HIV+ clients in four stages based on how the disease is advanced based on symptoms, presence/absence of opportunistic infections and immunologic parameters such as CD4 count.

transition responsibility for programmatic activities, management, and financial management to local government and CSOs? by the end of the proposed activity. Milestones signaling readiness for transition will be based on national policies, guidelines, and international best practices. The following summarizes the LIFE's HSS and transition strategies.

LIFE Activity's Vision for Transition and Sustainability. In all LIFE activity-supported districts in Tanzania, families and communities will benefit from a sustainable and locally owned core package of high quality PMTCT and accompanying prevention and referral to HIV/AIDS and RCH services. These services will be geographically accessible³⁶, will stimulate demand, and will be guided by health system leadership and management that are both technically sound and responsive to community needs and priorities. Communities, LGAs, and local organizations will be able to independently direct, manage, and sustain facility and community-based HIV/AIDS and RH services in a manner that is responsive to a changing epidemic and changing access to care and treatment. The activity anticipates communities that have the ability to recognize, analyze, and prioritize resources and needs, and then take collective action to maintain and improve their health. The activity envisions traditional and civic leaders and structures that are actively engaged in the promotion of social and normative change. The LIFE activity will strengthen public, private, and civil society networks and structures to maximize available human, financial, and other resources. These resources will be used to support activities that result in no babies being born with HIV and PLWHAs who are empowered and able to exercise improved health seeking behaviors.

It is important to note that both activities were designed to promote ownership of HIV and AIDS activities by the district councils from the beginning and included sustainability promotion in all phases of implementation.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

TUNAJALI	LIFE
<ul style="list-style-type: none"> • <u>Result 1</u>: Improved leadership and management capacity of Local Government Authorities (LGAs) for consistently high quality HIV services delivery; • <u>Result 2</u>: Improved capacity of CSOs for consistently high quality HIV and AIDS service delivery; • <u>Result 3</u>: Increased revenues and resources available for integrated HIV and AIDS care; • <u>Result 4</u>: Improved access to high quality, integrated and comprehensive HIV care and treatment services; and • <u>Result 5</u>: Improved woman & girl child responsive HIV treatment, care and support. 	<ul style="list-style-type: none"> • <u>Objective 1</u>: Increased access to integrated quality comprehensive PMTCT, reproductive health, and community-based HIV/AIDS services. • <u>Objective 2</u>: Strengthened linkages and referral networks across service delivery points and facility and community-based services to improve services and ensure a continuum of care. • <u>Objective 3</u>: Ensured sustainability through a strengthened health system and transfer of capacity, management, and oversight of activities to local government and other local institutions.

³⁶ This means that the program will be rolled out to the lowest level of health facility (health center and dispensary) to enable all who need access to the services get it.

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

TUNAJALI II is implemented in five regions: Iringa, Njombe, Morogoro, Singida and Dodoma.	LIFE covers six regions: Arusha, Kilimanjaro, Lindi, Mtwara, Shinyanga and Tabora.
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IX. SCOPE OF WORK

A. **Purpose:** Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

<p>The purpose of this evaluation is to learn and document:</p> <ol style="list-style-type: none">1. To what extent the two activities' goals, objectives, and results are being achieved, how likely results will be sustained after the end of the activities, and provide guidance for mid-term course correction to improve on the activities results delivery performance and sustainability.2. To what extent the use of an activity that is designed as a PMTCT platform succeeds in strengthening maternity and newborn care outcomes. The Health Office is interested to understand the strength of implementation, on a PMTCT platform, of comprehensive antenatal care, emergency obstetric care, postnatal care and health promotion (through the deployment of community health workers) services in the two activities that received specific MCH funds for services in high volume health facilities in key regions.
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B. **Audience:** Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

<p>The results of this evaluation will be used by USAID/Tanzania and the PEPFAR/Tanzania interagency technical team to inform decisions regarding current and future HIV/AIDS and MNCH service delivery programs including decisions around effectiveness of integrating services delivery provision on the PMTCT platform. The results will also be used by Government of Tanzania and implementing partners for the purposes of learning best practices and planning for sustainability in HIV/AIDS and MNCH programming and service delivery.</p>
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C. **Applications and use:** How will the findings be used? What future decisions will be made based on these findings?

<p>This performance evaluation is being undertaken after about 70 percent of the activities have been implemented, so it is intended to provide significant direction to follow-on activity planning, as well as provide feedback insight and guidance through the end of the projects.</p>

D. **Evaluation/Analytic Questions & Matrix:**

- a) Questions should be: a) aligned with the evaluation/analytic purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation/analytic questions. **USAID policy suggests 3 to 5 evaluation/analytic questions.**
- b) List the recommended methods that will be used to collect data to be used to answer each question.
- c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

	Evaluation/Analytic Question	Research Methods	Application or Data Use
1	<p>For the LIFE and TUNAJALI II-targeted districts: to what extent has the capacity building efforts contributed to improved Local Government Authorities (LGA) performance related to governance, accountability, fiscal management and technical oversight?</p> <p><u>Issues to be considered:</u></p> <ol style="list-style-type: none"> District readiness to sustain delivery of services covered by TUNAJALI and LIFE Improvements in fiscal management, LGAs engagement of the public on budget allocations and audit findings LGA Governance Capacity building approaches to improve access and quality of service delivery of the LGAs and the CSO 	<ul style="list-style-type: none"> Key Informant Interviews Secondary analysis of annual LGA audit findings triangulated qualitative evaluation data from pre-selected districts. 	<ul style="list-style-type: none"> Determine best practices and limitations of LGA capacity building efforts Trends in LGA audit findings for the LIFE and TUNAJALI II-targeted districts from 2011 – 2015 Correlation of local revenues generated by the district councils to increase and/or improve integrated services for HIV/AIDS
2	<p>In LIFE and TUNAJALI II-targeted districts, to what extent have use of quality service delivery increased?</p> <p><u>Issues to be considered:</u></p> <ol style="list-style-type: none"> Differences in outcomes according to gender and/or age Range of services: PMTCT, treatments, care, TB/HIV, and MNCH 	<ul style="list-style-type: none"> Analysis of qualitative data to determine the reasons for gender and age differences Application of national health sector data (from 2011 – 2015), as well as activities monitoring data, to determine the extent of service delivery improvement in the target districts/regions using the following indicators: <u>PMTCT:</u> <ul style="list-style-type: none"> Number of pregnant women with known HIV status (includes women who were 	

		<p>tested for HIV and received their results)</p> <ul style="list-style-type: none"> ○ Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission ○ Number of Health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site <p><u>TREATMENT:</u></p> <ul style="list-style-type: none"> ○ Number of adults and children with advanced HIV infection newly enrolled on ART treatment. ○ Number of adults and children with advanced HIV infection currently receiving antiretroviral therapy ○ Number of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy ○ Number of adults and children who ever started (cumulatively) on ART treatment ○ Number of health facilities that offer ART <p><u>CARE:</u></p> <ul style="list-style-type: none"> ○ Number of eligible adults and children provided with a minimum of one care service ○ Number of HIV-positive persons receiving cotrimoxazole prophylaxis By Age and Sex: <1, <15, 15+; Male, Female, Pregnant Women <p><u>TB/HIV:</u></p>	
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		<ul style="list-style-type: none"> ○ Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings <p><u>MNCH:</u></p> <ul style="list-style-type: none"> ○ Number of USG-supported facilities that received technical support and facility improvements to provide Basic Emergency Obstetric and Newborn Care. ○ Proportion of women giving birth who received uterotonics in the third stage of labor through USG-supported programs (comparison before and after intervention as well as trends since technical support) ○ Percent of newborns receiving postnatal health check within two days of birth. ○ Number of women reached with education on exclusive breastfeeding ○ Number of people trained in Basic Emergency Obstetric and Newborn Care as well as Postnatal care through USG supported programs ○ Number of people trained in postnatal care through USG supported programs ○ Number of people trained as integrated community health workers through USG supported programs 	
3	How and to what extent have the activities contributed to improved access and quality of		

	<p>integrated comprehensive clinical and community HIV services to HIV positive clients and pregnant women and newborns? <u>Issues to be considered:</u></p> <p>a. Capacity building of the CSO and NGOs to provide improved access and quality HIV/AIDS services: PMTCT, treatments, care, TB/HIV, and MNCH</p>		
4	<p>To what extent has integration of clinical and community MNH services into the PMTCT platform improved access to quality MNH services (comprehensive ANC, emergency obstetric and newborn care, postnatal care, integrated CHW visits)?</p> <p>a. Efficiency and effectiveness of PMTCT partners support of MCH interventions</p> <p>b. Best practices and key lessons learned during the roll out of MCH facility and community interventions using the PMTCT platform</p> <p>c. Jhpiego's MAISHA and MCSP projects' support in building PMTCT partner capacity to provide these services</p> <p>d. Integration of MCH service delivery into the PMTCT platform</p> <p>e. Efficiencies in MCH service delivery (e.g. better outputs, increased service utilization)</p> <p>f. Management systems, including integrated supervision of services, availability of medicines, linkages of service to another (e.g. HIV to FP,</p>		

	or to MCH and vice versa)		
5	Using project expenditures, what is the cost effectiveness (i.e., project investment to outcomes)?		

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation or analysis.)

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- E. **Methods:** Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation/analytic questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

<p><i>General Comments related to Methods:</i></p> <p>The evaluation will use a mix of methods to collect both qualitative and quantitative data. Evaluators must design evaluation tools that will collect information /data to address all the evaluation questions. However, given the nature of the activities and the types of evaluation questions included in this scope, USAID/Tanzania proposes to utilize “before and after” and/or “time series” evaluation design which will be based on extensive use of pre-and post-quantitative and qualitative data (e.g., project monitoring data, baseline data, and DHIS2 data). Additional data that will be collected through key informant interviews (KIIs) and focus group discussions (FGDs), and other data collected as part of this evaluation.</p> <p>The team will design and conduct an evaluation that maximizes participation by Local Government Councils (Council Health management teams), Civil Society organization, TUNAJALI II and LIFE program staff and health facility staff while ensuring, to the greatest extent possible, the objectivity and validity of inputs and outputs.</p> <p>There are 24 districts/councils in the 5 regions for TUNAJALI II and 6 regions for LIFE program implementation, and due to time and fund constraints, only a few will be selected as representatives for the purpose of the evaluation. Site selection will be finalized during the Team Planning Meeting in consultation with USAID/Tanzania.</p>

■ **Document and Data Review** (*list of documents and data recommended for review*)

<p>This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:</p> <p>Several documents are available for review for this midterm evaluation of the two activities. These include but are not limited to:</p> <ul style="list-style-type: none"> • TUNAJALI and LIFE program descriptions • TUNAJALI and LIFE cooperative agreements • TUNAJALI and LIFE annual work plans for the past three years • TUNAJALI and LIFE M&E plans • TUNAJALI and LIFE quarterly progress reports • TUNAJALI and LIFE data quality reports • TUNAJALI II treatment audit report • Tanzanian government documents that guided program implementation
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- national guidelines for the management of HIV/AIDS 2012 versions
- Tanzania Health Sector HIV/AIDS Strategic Plan II and III
- Tanzania DHS, 2015 (not yet available), 2010
([http://dhsprogram.com/pubs/pdf/FR243/FR243\[24June2011\].pdf](http://dhsprogram.com/pubs/pdf/FR243/FR243[24June2011].pdf))
- Tanzania HIV/MCH Service Provision Assessment Survey (SPA), 2014-15
(<http://dhsprogram.com/pubs/pdf/PR58/PR58.pdf>)
- Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2011-12
(<http://dhsprogram.com/pubs/pdf/AIS11/AIS11.pdf>); 2007/08
(http://dhsprogram.com/pubs/pdf/AIS6/AIS6_05_14_09.pdf)
- Tanzania health services data: DHIS2

These documents will all be available to the Evaluation team through an external Dropbox.

Secondary analysis of existing data (*This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses*)

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis
TUNAJALI and LIFE expenditure data & project indicator data	Project expenditures Project monitoring indicator data	Expenditure/costing analysis by intervention outcomes/outputs

Key Informant Interviews (*list categories of key informants, and purpose of inquiry*)

Key informants will be purposively selected to be interviewed. These will include:

- TUNAJALI and LIFE project staff
- Local Government Authorities (LGA)/Councils
- Local NGOs/CSOs working with TUNAJALI and/or LIFE projects
- MOHSW representatives
- USAID/Tanzania health and PEPFAR staff

USAID/Tanzania will provide a list of key informant and their contact information, as well as facilitate formal introductions as appropriate.

Focus Group Discussions (*list categories of groups, and purpose of inquiry*)

Discussions will be held with women with children <2 years from TUNAJALI and LIFE target communities to explore their perceptions of access, integration and quality of PMTCT and MNCH services. Similar focus group discussions will be held with PLHIV in TUNAJALI and LIFE target communities to explore their perception of access to quality community and clinical services.

Group Interviews (*list categories of groups, and purpose of inquiry*)

Some of the key informant interviews can be clustered, as long as there are no power differentials, and all respondents feel comfortable in voicing their opinions within the group. (See list and description above under KII.)

Client/Participant Satisfaction or Exit Interviews (*list who is to be interviewed, and purpose of inquiry*)

Optional: Clients of PMTCT and HIV services will be interviewed using a semi-structured questionnaire (survey) to obtain information on their perception of access to quality services.

Facility or Service Assessment/Survey (*list type of facility or service of interest, and purpose of inquiry*)

Cost Analysis (*list costing factors of interest, and type of costing assessment, if known*)

Project expenditures will be analyzed project outputs & outcomes to determine cost effectiveness.

Survey (*describe content of the survey and target responders, and purpose of inquiry*)

Observations (*list types of sites or activities to be observed, and purpose of inquiry*)

Optional: Observations at clinics and LGAs of TUNAJALI and LIFE supported interventions.

Data Abstraction (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

X. HUMAN SUBJECT PROTECTION

The Analytic Team must develop protocols to insure privacy and confidentiality prior to any data collection. Primary data collection must include a consent process that contains the purpose of the evaluation, the risk and benefits to the respondents and community, the right to refuse to answer any question, and the right to refuse participation in the evaluation at any time without consequences. Only adults can consent to participate as part of this evaluation. Minors cannot be respondents to any interview or survey, and cannot participate in a focus group discussion without going through an IRB. The only time minors can be observed as part of this evaluation is as part of a large community-wide public event, when they are part of family and community attendance. During the process of this evaluation, if data are abstracted from existing documents that include unique identifiers, data can only be abstracted without this identifying information.

XI. ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will review both qualitative and quantitative data related to the project/program's achievements against its objectives and/or targets. All information and data shall be disaggregated, whenever possible, by region, district, age and sex/gender to show differential outcomes.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location, whenever feasible. Other statistical test of association (i.e., odds ratio) and correlations will be run as appropriate.

Thematic review of qualitative data will be performed, connecting the data to the evaluation questions, seeking relationships, context, interpretation, nuances and homogeneity and outliers to better explain what is happening and the perception of those involved. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide, and answer questions where other data do not exist.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., project/program performance indicator data, DHS, SPA, THMIS data, etc.) will allow the Team to triangulate findings to produce more robust evaluation results.

The Evaluation Report will describe analytic methods and statistical tests employed in this evaluation. Evaluators should describe any statistical tests that will be used, and how key informant interviews and focus group responses will be documented and analyzed. All information and data shall be disaggregated, to the maximum extent possible, by region, district, age and sex/gender to show differential outcomes between adult and children, regions and district/councils, men and women to meet USAID requirements.

XII. ACTIVITIES

List the expected activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Background reading – Several documents are available for review for this analytic activity. These include TUNAJALI and LIFE cooperative agreements, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS). This desk review will provide background information for the Evaluation Team, and will also be used as data input and evidence for the evaluation.

Team Planning Meeting (TPM) – A four-day team planning meeting (TPM) will be held at the initiation of this assignment and before the data collection begins. The TPM will:

- Review and clarify any questions on the evaluation SOW
- Clarify team members' roles and responsibilities
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
- Review and finalize evaluation questions
- Review and finalize the assignment timeline
- Develop data collection methods, instruments, tools and guidelines
- Review and clarify any logistical and administrative procedures for the assignment
- Develop a data collection plan
- Draft the evaluation work plan for USAID's approval
- Develop a preliminary draft outline of the team's report
- Assign drafting/writing responsibilities for the final report

Briefing and Debriefing Meetings – Throughout the evaluation the Team Lead will provide briefings to USAID. The In-Brief and Debrief are likely to include the all Evaluation Team experts, but will be determined in consultation with the Mission. These briefings are:

- **Evaluation launch**, a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.

- **In-brief with USAID**, as part of the TPM. This briefing may be broken into two meetings: a) at the beginning of the TPM, so the Evaluation Team and USAID can discuss expectations and intended plans; and b) at the end of the TPM when the Evaluation Team will present an outline and explanation of the design and tools of the evaluation. Also discussed at the in-brief will be the format and content of the Evaluation report(s). The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
- **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.
- The Team Lead (TL) will brief the USAID **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.
- The Team will meet with USAID following data collection, **post data collection briefing**, to discuss data collected and planned analyses.
- A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*)
- **Stakeholders' debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be deemed sensitive by USAID.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

Evaluation Report – The Evaluation Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit draft evaluation report to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID's comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the final Evaluation Report, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USIAD separate from the Evaluation Report.

XIII. DELIVERABLES AND PRODUCTS

Select all deliverables and products required on this analytic activity. For those not listed, add rows as needed or enter them under “Other” in the table below. Provide timelines and deliverable deadlines for each.

Deliverable / Product	Timelines & Deadlines (estimated)
<input checked="" type="checkbox"/> Launch briefing	February 29, 2016
<input checked="" type="checkbox"/> Workplan with timeline	March 3, 2016
<input checked="" type="checkbox"/> Analytic protocol with data collection tools	March 4, 2016
<input checked="" type="checkbox"/> In-brief with Mission or organizing business unit	March 7--11, 2016
<input checked="" type="checkbox"/> In-brief with TUNAJALI & LIFE	March 14, 2016
<input checked="" type="checkbox"/> Routine briefings	Weekly
<input checked="" type="checkbox"/> Out-brief with Mission or organizing business unit with Power Point presentation	April 5, 2016
<input checked="" type="checkbox"/> Findings review workshop with stakeholders with Power Point presentation	April 6, 2016
<input checked="" type="checkbox"/> Draft report	Submitted to GH Pro: April 20, 2016 GH Pro submits to USAID: April 27, 2016
<input checked="" type="checkbox"/> Final report	Submitted to GH Pro: May 19, 2016 GH Pro submits to USAID: May 23, 2016
<input checked="" type="checkbox"/> Raw data	Submitted to GH Pro: May 19, 2016 GH Pro uploads to DDL: May 24, 2016
<input type="checkbox"/> Dissemination activity	
<input checked="" type="checkbox"/> Report Posted to the DEC	July 20, 2016
<input type="checkbox"/> Other (specify):	

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 Business days

XIV. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation/Analytic team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations/analytics must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation Specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the activity.
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

Team Qualifications: Please list technical areas of expertise required for this activities
List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for the team as a whole, as well as for the individual team members.

The team should be composed of both international and local experts.

Edit as needed to the Team Lead's position description.

Team Lead: This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The team lead should have significant experience conducting project evaluations/analytics.

Roles & Responsibilities: The team leader will be responsible for (1) providing team leadership; (2) managing the team's activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, (5) leading briefings and presentations, and (6) drafting/finalizing evaluation deliverables, including the evaluation final report.

Qualifications:

- Minimum of 10 years of experience in public health, which includes experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/analytics, utilizing both quantitative and qualitative s methods
- Experience in public health, with technical knowledge and experience with HIV/AIDS interventions, preferably HIV/AIDS programming, and maternal and child health programming, as well as experience with gender programs.
- Excellent skills in planning, facilitation, and consensus building
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the region, and experience in Tanzania is desirable
- Familiarity with USAID
- Familiarity with USAID and PEPFAR policies and practices
 - Evaluation policy
 - Results frameworks
 - Performance monitoring plans

Key Staff I Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.

Qualifications:

- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations
- Experience in design and implementation of evaluations
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools

- Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative, which will be primarily descriptive statistics
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- An advanced degree in public health, evaluation or research or related field; or work experience comparable to the advanced degree.
- Proficient in English
- Experience working in the region, and experience in Tanzania is desirable
- Good writing skills, including extensive report writing experience
- Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
- Experience and demonstrate knowledge in conducting programmatic evaluations and/or assessments related to capacity building
- Experience with cost effectiveness analysis preferred
- Familiarity with USAID and PEPFAR M&E policies and practices
 - Evaluation policies
 - Results frameworks
 - Performance monitoring plans
 - PEPFAR Next Generation Indicators Reference Guidance
 - PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
 - PEPFAR Evaluation Standards of Practice
 - Site Improvement through Monitoring System (SIMS)

Key Staff 2 Title: HIV Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in HIV care, treatment, and PMTCT. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- At least 10 years' experience in public health, with technical knowledge and experience in HIV care and treatment, as well as PMTCT
- Strong background in program design and implementations, with USAID project implementation experience preferred
- Expertise in supply and demand for HIV services at the community and clinical level
- Familiar with PEPFAR guidelines and policies, including
 - PEPFAR Next Generation Indicators Reference Guidance
 - PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
 - PEPFAR Evaluation Standards of Practice
 - Capacity Building and Strengthening Framework
 - Gender Strategy
 - Country Operational Plans (COP)

- Site Improvement through Monitoring System (SIMS)
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and Swahili (desirable)
- Experience working in the region, and experience in Tanzania is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 3 Title: Capacity and Organizational Development (OD) Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing technical expertise to evaluate capacity and organizational strengthening activities, particularly among target LGAs where TUNAJALI program works. S/He will participate in all aspects of the evaluation, including planning, data collection, data analysis and report writing.

Qualifications:

- Background and at least 5 years' experience in organizational capacity development/strengthening.
- Knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies
- Experience working in organizational capacity development/strengthening among governmental and non-governmental entities in developing country settings to strengthen health programs/activities
- Familiar with PEPFAR Capacity Building and Strengthening Framework (<http://www.pepfar.gov/documents/organization/197182.pdf>)
- Experience in implementing and/or evaluating projects working with LGAs in the health field.
- Proficient in English and Swahili (desirable)
- Experience working in the region, and experience in Tanzania is desirable
- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities

Key Staff 4 Title: Costing Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise on expenditure/costing related to program development and implementation. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.

Qualifications:

- Advanced degree or equivalent in health economics or a related field
- Experience in expenditure studies related to project development and implementation
- Demonstrated expertise in designing research instruments and methodologies related to costing and expenditures
- Previous experience in conducting economic analysis research and/or expenditure studies
- Excellent interpersonal skills, including experience successfully interacting with 1) USAID and their implementing partners (IPs); and 2) host government officials; 3) civil society partners; and 4) other stakeholders
- Proficient in English

- Good writing skills, specifically technical and evaluation report writing experience
- Experience in conducting USAID evaluations of health programs/activities is desirable
- Experience in working in a developing country context preferred.

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

Local **Evaluation Logistics /Program Assistant** will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. The Logistics/Program Assistant will have a good command of English and Swahili. S/He will have knowledge of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. S/He may also be asked to assist in translation of data collection tools and transcripts, if needed.

Local Evaluators (3 local consultants) to assist the Evaluation Team with data collection, analysis and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and Swahili. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who:

Significant involvement – If yes, specify who: USAID Mission staff will be included as evaluation team participants while assuring maximum objectivity. Therefore, only Mission staff with no direct roles or responsibilities for activity management will participate.

No

Staffing Level of Effort (LOE) Matrix (Optional):

This optional LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

- For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.
- Immediately below each staff title enter the anticipated number of people for each titled position.
- Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.
- Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.
- At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Activity / Deliverable		Evaluation/Analytic Team					
		Team Lead / HIV Specialist	Evaluation Specialist	OD Specialist	Costing Specialist	Local Evaluators	Logistics/ Program Assist
Number of persons →		1	1	1	1	2-3	1
1	Launch Briefing	0.5					
2	Desk review	5	5	5	5	2	
3	Preparation for Team convening in-country						2
4	Travel to country	2	2	2	2		
5	Team Planning Meeting	4	4	4	4	4	4
6	In-brief with Mission	1	1	1	1	1	1
7	In-brief with project	0.5	0.5	0.5	0.5	0.5	0.5
8	Data Collection DQA Workshop (<i>protocol orientation for all involved in data collection</i>)	2	2	2	2	2	
9	Prep / Logistics for Site Visits	0.5	0.5	0.5	0.5	0.5	2
10	Data collection / Site Visits (including travel to sites)	24	24	24	24	24	24
11	Data analysis	5	5	5	5	5	2
12	Debrief with Mission with prep	1	1	1	1	1	1
13	Stakeholder debrief workshop with prep	1	1	1	1	1	1
14	Depart country	2	2	2	2		
15	Draft report(s)	7	6	6	6	3	1.5
16	GH Pro Report QC Review & Formatting						
17	Submission of draft report(s) to Mission						
18	USAID Report Review						
19	Revise report(s) per USAID comments	3.5	2	2	2		
20	Finalize and submit report to USAID						
21	508 Compliance Review						
22	Upload Eval Report(s) to the DEC						
Total LOE per person		59	56	56	56	44	39
Total LOE		59	56	56	56	88-132	39

If overseas, is a 6-day workweek permitted

Yes

No

Travel anticipated: List international and local travel anticipated by what team members.

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XV. LOGISTICS

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain **Facility Access** only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

- USAID Facility Access
Specify who will require Facility Access: _____
- Electronic County Clearance (ECC) (International travelers only)
- GH Pro workspace
Specify who will require workspace at GH Pro: _____
- Travel -other than posting (specify): _____
- Other (specify): _____

XVI. GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation/analytic team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation/analytic team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production - If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for internal distribution.

XVII. USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities
USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:
Before Field Work
<ul style="list-style-type: none">• <u>SOW</u>.<ul style="list-style-type: none">○ Develop SOW.○ Peer Review SOW○ Respond to queries about the SOW and/or the assignment at large.• <u>Consultant Conflict of Interest (COI)</u>. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.• <u>Documents</u>. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.• <u>Local Consultants</u>. Assist with identification of potential local consultants, including contact information.• <u>Site Visit Preparations</u>. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.• <u>Lodgings and Travel</u>. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.
- Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

- Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

XVIII. ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See [How-To Note: Preparing Evaluation Reports](#))

The **Evaluation/Analytic Final Report** must follow USAID's Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the [USAID Evaluation Policy](#)).

- a. The report must not exceed 30 pages (excluding executive summary, table of contents, acronym list and annexes).
- b. The report will be drafted in MS WORD in 12-point type, with 1" margins top/bottom and left/right.
- c. The structure of the report should follow the Evaluation Report template, including branding found [here](#) or [here](#).
- d. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
- e. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found [here](#).

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

The findings from the evaluation/analytic will be presented in a draft report at a full briefing with USAID and at a follow-up meeting with key stakeholders. The report should use the following format:

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not more than 4 pages);
- Table of Contents (1 page);
- Acronyms
- Introduction: Evaluation Purpose, Audience, Synopsis and Evaluation Questions (1-2 pages)
- Project Background: brief overview of HIV/AIDS program in Tanzania, USAID strategies and priorities, brief description of the TUNAJALI II and LIFE program, purpose of the evaluation (2-3 pages)
- Evaluation Methods and Limitations (1-3 pages)
- Findings/Conclusions/Recommendations: in separate sections for each evaluation question (15-20 pages)
 - Findings: supported by evidence

- Conclusions
- Recommendations: supported by findings, action-oriented, and practical
- Annexes
 - Annex I: Evaluation/Analytic Statement of Work
 - Annex II: Evaluation/Analytic Methods and Limitations
 - Annex III: Data Collection Instruments
 - Annex IV: Sources of Information
 - List of Persons Interviews
 - Bibliography of Documents Reviewed
 - Databases
 - [etc.]
 - Annex V: Disclosure of Any Conflicts of Interest
 - Annex VI: Statement of Differences (if applicable)

The evaluation methodology and report will be compliant with the [USAID Evaluation Policy](#) and [Checklist for Assessing USAID Evaluation Reports](#)

 The Evaluation Report should **exclude** any **potentially procurement-sensitive information**. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.

All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be provided to GH Pro and presented to USAID electronically to the Program Manager. All data will be in an unlocked, editable format.

XIX. USAID CONTACTS

	TUNAJALI Contact	LIFE Contact	Alternate Contact 1	Alternate Contact 2
Name:	Dr. Patrick Swai	Dr. Miriam Kombe	Dr. Jema Bisimba	Moses Busiga,
Title:	AOR TUNAJALI II	AOR LIFE		M&E Specialist
USAID/ Tanzania	Health Office	Health Office	Health Office	Health Office
Email:	pswai@usaid.gov	mkombe@usaid.gov	jbisimba@usaid.gov	mbusiga@id.gov
Telephone :	+255 22 2294490 Ext. 4429	+255 22 2294490 Ext. 4429	+255 22 2294490 Ext. 4425	+255 22 2294490 Ext. 4595
Cell Phone	+ 0713 333661	0764 105020	0655 867600/ 0754 867600	+255-659 269 188 / 0764 269 188

List other contacts who will be supporting the Requesting Team with technical support, such as reviewing SOW and Report (such as USAID/W GH Pro management team staff)

	Technical Support Contact 1	Technical Support Contact 2

Name:	Diana Harper	Lily Asrat
Title:	Senior Evaluation and Program Advisor	Senior Evaluation Advisor
USAID Office	Office of Policy, Planning and Programs, USAID Bureau for Global Health	USAID Office of HIV/AIDS, Bureau for Global Health
Email:	dharper@usaid.gov	aasrat@usaid.gov
Telephone:	571-551-7086	571 551-7192
Cell Phone:	571-228-3619	571-451-6079

XX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above

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ANNEX II. EVALUATION METHODS AND LIMITATIONS

INTRODUCTION

This section describes the methodology adopted for this evaluation. The overall evaluation design is described first, followed by the data collection and analytical strategies adopted for each evaluation component. In conclusion, the limitations to reliability and validity of the findings are summarized.

CONSTRAINTS DETERMINING METHODOLOGICAL CHOICES

The choice of methodology is determined by the purpose and objectives of the evaluation, the limitations of the assignment, and the parameters imposed by the operational context of the programs being evaluated. In this regard the following constraints were the key factors determining methodological choices:

1. The evaluation questions operationalize the purpose and objectives of the evaluation and represent the first of the three constraints determining the methodological choices made. The questions and how these were interpreted by the evaluation team are summarized in the evaluation matrix below.
2. A performance evaluation was requested. While the questions directed the evaluation towards assessing outcomes it is understood that a performance evaluation assigns equal emphasis to documenting implementation lessons learned and effective practices. It is also accepted that the description of outcomes cannot be as rigorous in a performance evaluation as is expected from an outcomes evaluation.
3. The time allowed for the evaluation was limited, with only 3 weeks set aside for fieldwork, and an additional 3 for fieldwork preparation as well as the collection and review of secondary data in-country. Additional time was scheduled for analysis and reporting.
4. The reach of the two activities across districts and facilities was extensive, negating the possibility of representative sampling for primary data collection considering the time constraints.

Table 7: Evaluation matrix

Understanding the Question	Approach to Respond
<p>I. To what extent has the use of quality service delivery increased in TUNAJALI II and LIFE supported districts?</p>	
<p>The focus of this evaluation question was on describing the increase in use of services, and attempting a credible attribution of the trends to activity efforts.</p>	<p>A statistical analysis of routine program data was conducted, tracking the indicators specified in the scope of work focusing on Care and Treatment and PMTCT. Trend analyses within implementation districts was used to demonstrate program performance.</p>

Understanding the Question	Approach to Respond
2. To what extent has integration of clinical and community MNCH services into the PMTCT platform improved access to quality MNH services?	
The evaluation question was directed at determining the extent to which MNCH services were accessed, and considering whether integration with PMTCT contributed to measured performance.	A statistical analysis of routine program data was conducted, tracking the indicators specified in the scope of work and focusing on RCH and MNCH. Trend analyses within implementation districts was used to demonstrate program performance.
3. To what extent have capacity building efforts contributed to improved Local Government Authorities' (LGA) performance related to governance, accountability, fiscal management and technical oversight?	
The question directs the evaluation to analyze how capacity development improved fiscal management, governance and accountability; LGA governance and the health related technical capacity of the CHMTs in particular; and readiness to sustain quality services by local government.	Interview data was collected during fieldwork, supplemented by a through document review.
4. How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community HIV services to HIV positive clients and pregnant women and newborns?	
This question directed the evaluation to consider the comprehensiveness of the continuum of care, and in particular how building NGO and CSO capacity contributed to ensuring access to comprehensive and quality services.	Interview data was collected in the field, complemented by a thorough document review, as well as a consideration of CSO quantitative performance indicators.

EVALUATION DESIGN

The performance evaluation adopted a mixed methods design that integrated an analysis of secondary context, implementation, monitoring and cost data, with primary data generated during fieldwork. The secondary data analysis, utilizing TUNAJALI and LIFE project data, provided the broad foundational evidence for evaluative conclusions. Secondary data, and the clinical services data in particular, was largely quantitative and subjected to descriptive statistical analysis. Assigning preeminence to the secondary data is the rationale choice because it is the most representative data source for assessing the outcomes of interest specified in the scope of work. Under the prevailing implementation constraints, no primary data collection effort would match the level of representivity of the secondary data.

All qualitative data, both primary and secondary, was subjected to thematic content analysis. The primary data, generated through fieldwork, grounded the interpretation of evidence in observations and an understanding of the implementation context. It also offered the evaluators an opportunity to triangulate emerging findings from the secondary data analysis, which was important because data quality issues, prevalent in routine monitoring data (as reported in the data quality assessments of both activities), necessitate a check built-in to the evaluation design. The fieldwork also offered the evaluation team an opportunity to test the validity of emerging

findings with respondents from site to site, and identify effective practices that had not already been documented.

Because the determining constraints do not allow for the conventional guarantees on reliability and validity (such as representative sampling for primary data collection), a number of alternative techniques were adopted to compensate for potential error. These included rapid assessment methods such as continuous expert team data reviews and debriefing (described in the fieldwork section), and ex-post triangulation of multiple sources of primary and secondary data to test emerging findings.

A final validity check was built into the evaluation design. Emerging findings, based on the integration of secondary data and primary data generated in the field, was presented to stakeholders in a workshop towards the conclusion the evaluation's in-country activities. Inputs from participating stakeholders reflecting on the emerging findings were obtained, evidence gaps identified, and incomplete interpretations of evidence addressed.

TEAM PREPARATION

The team convened in-country and spent the first week preparing for the evaluation together. As part of the preparation process each of the technical specialist was assigned the task of reviewing the program documentation we already had access to, and to present a description of the program design and activity implementation in specialty areas. The specialists followed up the descriptive presentations with their proposed approaches for responding to the evaluation questions, grounded in an understanding of the programs. These presentations led to in-depth discussions on each activity, with the objective arriving at a common, thorough understanding of each of the two programs under review, as well as a shared conception of the methodology the team would employ.

In addition to the presentations on program descriptions and proposed methods, a team member with a thorough understanding of the Tanzanian context prepared a presentation to orient the team; and the evaluation was jointly planned. The week culminated in the drafting of an inception report, which was finalized and submitted by the team leader and evaluation specialist.

SECONDARY DATA COLLECTION AND ANALYSIS

Performance of Support to Clinical Services

Indicators of interest that would inform the evaluative conclusions for questions 1 and 2 were specified in the scope of work (see appropriate Annex). These are standard PEPFAR and country health indicators, the data for which are routinely collected through the official health information systems and contributed to by implementing partners, their sub-partners, supported facilities and local government. The indicators demonstrate results at district level, the level at which the analysis for questions 2 and 4 is pitched. The data sets are available from multiple sources, including URT, however are most easily obtained directly from implementing partners.

The evaluation team submitted requests for the relevant secondary data from implementing partners. The data was subjected to descriptive statistical analysis, to expose trends in service access and use. Initial analyses were conducted by the HIV specialists on the team and reviewed by team leader and evaluation specialist. Analyses was then redone, enhanced or followed up on depending on the action deemed necessary. This included interrogating anomalous or telling

results in consultation with implementing partners. Results that most coherently illustrated the findings in response to the evaluation questions were selected from the pool of total results and included in the final report.

Performance of Capacity Development Interventions

Capacity development data was extracted from the existing program documentation submitted by the Mission and implementing partners. The capacity development and evaluation specialists reviewed the data submitted, identified data gaps, and requested additional documents. Data gaps that could not be satisfied through document requests were then addressed in interviews.

The larger proportion of relevant data was qualitative and subjected to content analysis, thematically structured. The NVIVO qualitative data analysis software was used to facilitate and document the analytical effort. The analysis was conducted by the capacity development technical specialist, then reviewed and finalized by the team leader and evaluation specialist. Results that most coherently illustrated the findings in response to the evaluation questions were selected and included in the final report.

FIELDWORK DATA COLLECTION AND ANALYSIS

The primary data, generated through the fieldwork, served to check implementation fidelity, fit to context, implementation performance at sampled sites and persistent challenges across sites as well as effective practices not already documented. It offered the evaluation an opportunity to further triangulate emerging findings from the secondary data analysis with primary data generated through observations and interviews with various categories of key informants. However, time constraints did not allow a fieldwork effort based on representative sampling, and observations from sample sites on fidelity, fit and performance are not reliably generalizable. Instead the value of the fieldwork is grounding the interpretation of evidence in an understanding of the implementation context.

With the objectives of fieldwork as described above in mind, a purposive sample of implementation sites was generated, based on the criteria listed below.

1. Primary Criteria:
 - Both activities (TUNAJALI II and LIFE) should be equally represented;
 - For each activity, districts should be chosen that distinctly illustrate strong and weak performance;
 - Co-funded sites (where MNCH services are integrated in the PMTCT platform) must be represented.
2. Additional Criteria:
 - Some geographic diversity is preferred;
 - Inclusion of less frequently visited districts is preferred;
 - The feasibility of coverage within the given time constraints must be considered.

Seven districts were visited during the fieldwork. Each visit included two facilities – the district hospital, and either a health center or dispensary. Community meetings were facilitated at the health center or dispensary, while interviews with CHMT personnel and government officials were held. Different interview and focus group protocols were developed for each category of respondent. The initial draft of each protocol was developed by the relevant technical specialist

on the team, in collaboration with the team leaders and evaluation specialist. These protocols are available for review in the relevant Annex. The administering of each protocol was vetted in the field by the evaluation specialist attending a data collection activity in each category, and a debrief and protocol review following.

Table 8: Sample and site visit schedule

Date	Activity	Site Number	Tasks
2016/03/20			Travelling to Mtwara
2016/03/21	LIFE	Site 1	Introduction at the region/Data collection Mtwara
2016/03/22	LIFE	Site 1	Data collection Mtwara
2016/03/23	LIFE	Site 2	Introduction at Lindi region /Data collection Nachingwea DC
2016/03/24	LIFE	Site 2	Data collection Nachingwea
2016/03/25			GOOD FRIDAY
2016/03/28			EASTER MONDAY
2016/03/28			Travelling to Iringa Region
2016/03/29	TUNAJALI II	Site 3	Introduction at the Iringa region/districts /data collection
2016/03/30	TUNAJALI II	Site 3	Data collection / Site Visits Iringa
2016/03/31	TUNAJALI II	Site 4	Data collection / Site Visits Njombe TC
2016/04/01	TUNAJALI II	Site 4	Data collection / Site Visits Njombe TC
2016/04/02			Move back to Iringa; Travelling back to Dar
2016/04/04	TUNAJALI II	Site 5	Introduction Morogoro region/districts/Data collection
2016/04/05	TUNAJALI II	Site 5	Data collection Morogoro MC
2016/04/06			Travelling back to Dar and Data analysis continue
2016/04/07			KARUME DAY (TZ)
2016/04/07			Travelling to Tabora/Sikonge MC
2016/04/08	LIFE	Site 6	Data collection at Sikonge and Nzega
2016/04/09	LIFE	Site 6	Data collection at Sikonge and Nzega
2016/04/10			Travelling back to Dar

Due to time constraints it was not feasible to transcribe key informant interviews and focus group discussions. Fieldwork data was captured in a structured format, and these structured fieldwork notes served as primary documents for qualitative analysis. The template for structured field notes was designed by the team, with final vetting falling to the team leader and evaluation specialist. The template is available for review in Annex V: Data Collection Instruments.

Where consent was given interviews and focus group discussions were recorded, and the audio files served as reference and verification for structured field notes data. Initial analysis of fieldwork data took place during regular analytical debriefs by the full evaluation team while in the field.

The fieldwork process included regular, formal debriefing sessions, led by the team leader and evaluation specialist. At these sessions each technical specialization summarized the data collected and their emerging findings, based on the evidence. The quality of the data, its alignment to secondary data and the primary data previously collected, and the plausibility of the emerging interpretations, were interrogated by the entire team. This process assisted in identifying data gaps that needed addressing, and exposed erroneous or poorly substantiated findings. The rigor of the evaluation was consistently strengthened throughout the process as a result.

COST EFFECTIVENESS

Overview and Unit of Analysis

The health economist, in consultation with the team leader and evaluation specialist, determined the approach to cost effectiveness analysis that would be feasible, given the constraints of the assignment, useful for the purposes of a performance evaluation, and repeatable under similar circumstances.

The costing evaluation for the TUNAJALI II and LIFE projects involved costing the activities in II regions providing care and treatment, Prevention of Mother-To-Child Transmission (PMTCT), Maternal Neonatal and Child Health (MNCH) and supportive services, as relevant to each of the two activities (LIFE did not receive funding through USAID for care and treatment services). The analysis adopted a program perspective in which all resources consumed in providing comprehensive and integrated HIV/AIDS prevention, care and treatment services were considered.

A unit cost per key service in each program was calculated and benchmarked against costs for similar services documented in the literature. This resulted in findings determining whether the costs per person for each of the services fell within a reasonable range. A retrospective top down costing approach was used, due to our reliance on financial accounts, and indirect costs were allocated to key services in a step-down fashion, using the number of clients in key services areas as the allocation key.

Data Sources and Analytical Process

The top down costing approach involved scouring expenditure reports for data on the resources used for each key intervention included in the scope of the evaluation. The data was then arranged in program, district and facility level categories. A direct and indirect cost center was identified to further differentiate the data. The direct cost center accounted for resources

expended to provide direct services to the patient and these included Care and Treatment (CTC), PMTCT and MNHC services clinics. The indirect cost center accounted for resources expended to provide supportive services to the direct cost center such as laboratory services, Home Based Care (HBC), HIV Testing and Counseling (HTC), TB/HIV services, Civil Society Organization, project level and sub-guarantee administration.

An additional refinement was introduced by categorizing all resources as capital or recurrent cost. The capital cost, included non-expandable equipment, buildings and training. The non-expendables were defined as equipment if their useful life years were more than a year and/or costing 100 US\$ and above. Recurrent cost included personnel wages fringe benefits and allowances, medical supplies, stationaries, travels and periderms, meetings, fuels, car maintenance, office equipment maintenance, office hire, etc. We employed the step down approach to allocate the indirect cost to the direct cost centers; we used the number of patients in each of the direct cost centers as the allocation key of the shared indirect costs (UNAIDS, 2011).

We computed both financial and economic costs. The financial costs are presented as “explicit” costs i.e. the resources spent by the program in real time to deliver the program interventions. The economic costs are presented as “implicit” costs i.e. we estimated the opportunity costs of resources used in delivering the interventions (more preferred in economic evaluation of interventions). These included, annualizing capital costs over their useful lifespan. We employed the Bank of Tanzania interest rates for 2012- 2015 ranging from 12 to 16 per cent (BOT, 2016). We assumed useful life years of five years for non-expandable equipment and two years for training (Menziés et al., 2011).

REPORTING

Each of the technical specialists worked with the team leader and evaluation specialist to formulate a template for reporting the findings, conclusions and recommendations in their specialty area. Reports were drafted after the in-country portion of the evaluation had been concluded, and submitted to the team leader and evaluation specialist for review. Feedback was responded to in subsequent versions of these drafts, and the cycle was repeated in a number of iterations. The drafts were then compiled in an integrated draft report by the team leader, and edited down to an appropriately concise final performance evaluation report.

DATA MANAGEMENT

The management of data was crucial to the evaluation. The credibility of the evaluation was strengthened through common access to and review of the informing data sets. The following data management arrangements were implemented:

- All secondary data was stored electronically in a navigable folder structure and catalogued in reference database.
- Secondary data external to Mission and the two programs being evaluated was submitted as a deliverable.
- Primary data was captured in a standardized summary format, and these summaries served as the primary documents subjected to qualitative analysis.
- Audio files will be kept as reference as verification sources of primary documents, provided consent for recording is given.

- Primary documents were submitted as a deliverable.
- Audio files (provided consent is given) can be submitted as a deliverable if required.

LIMITATIONS

The following limitations influenced the reliability and validity of the evaluation:

1. A large volume of routine monitoring data was placed at our disposal by both programs and could not be exhaustively interrogated. The statistical analysis was therefore selective, directed by the specific indicators in the scope of work. The volume of documentary data was equally extensive and again had to be approached selectively.
2. The quality of health data is seldom optimal in the settings in which PEPFAR programs are implemented. A number of data quality issues were identified in data quality assessments of the two programs evaluated. These are pertinent to the accuracy of the secondary data analysis but are unlikely to have skewed analysis to the extent of disqualifying findings presented in this evaluation.
3. The fieldwork sample was very small and by no means representative considering the size of the two activities under review. Triangulation of data from the field with the secondary data analysis was constrained by the implied risk to validity.
4. Evaluating two large mechanisms simultaneously poses peculiar challenges on the evaluators, and care had to be taken to ensure that findings were not confounded across mechanisms. Despite meticulous efforts the distinction between mechanisms may not be as discriminating as it should.
5. In the cost effectiveness analysis, a retrospective top down costing approach was employed, due to our reliance on financial accounts. Accuracy of estimates from this method rely on the assumption that variation in clinical practice are negligible and data quality is consistent. In addition, economic costs borne by the other organization such as Government and Faith Based Organization, e.g. cost of salaries, buildings and other administrative activities were not included in our analysis.

ANNEX III. PERSONS INTERVIEWED

SN	NAME	DESIGNATION/ORGANIZATION	REGION/DISTRICT	DATE	TYPE OF INTERVIEW
1	Dr. Mussa Ndille	Delloite –TUNAJALI	Dar es Salaam	16/03/2016	KII
2	Bonita Kilama-	Sr Data Manager –TUNAJALI	Dar es Salaam	16/03/2016	KII
3	Protas Ndayanga-	Technical Director – CSSC –TUNAJALI	Dar es Salaam	16/03/2016	FGD
4	Anthony Leornard	Senior Technical Officer CT – CSSC TUNAJALI	Dar es Salaam	16/03/2016	FGD
5	Athanas Ntaganyamba	Senior Program Manager& SCS TUNAJALI	Dar es Salaam	16/03/2016	FGD
6	Carolyn Mbelwa	Senior Technical Officer HTC – CSSC TUNAJALI	Dar es Salaam	16/03/2016	FGD
7	Okumu Were	Senior Technical Officer – Lab CSSC TUNAJALI	Dar es Salaam	16/03/2016	FGD
8	John Gamaliel	Senior Technical Officer – MNCH – CSSC TUNAJALI	Dar es Salaam	16/03/2016	FGD
9	Agness Kosia	Senior Technical Officer – PMTCT– CSSC TUNAJALI	Dar es Salaam	16/03/2016	FGD
10	Hawa Kisusi	Senior Technical Officer – HBC – CSSC – TUNAJALI	Dar es Salaam	16/03/2016	FGD
11	Christine Kruger	Ag. Director of Grant and Finance –TUNAJALI	Dar es Salaam	16/03/2016	FGD
12	Damasco Peter	Financial Manager –TUNAJALI	Dar es Salaam	16/03/2016	KII
13	Donati Chandika	Grant Manager – TUNAJALI	Dar es Salaam	16/03/2016	KII
14	Nelson B. Ojanji	Director of Operation	Dar es Salaam	17/03/2016	KII
15	Jacques Masawe	Asst. Director Operation	Dar es Salaam	17/03/2016	KII
16	Juma Songoro	Program Manager HIV/Rch	Dar es Salaam	17/03/2016	KII
17	Dr. Chrispine Kimario	Associate Technical Director – EGPAF	Dar es Salaam	17/03/2016	Group Interview

SN	NAME	DESIGNATION/ORGANIZATION	REGION/DISTRICT	DATE	TYPE OF INTERVIEW
18	Kilimba Nuru	Program Coor. – Community Engagement-EGPAF	Dar es Salaam	17/03/2016	Group Interview
19	Dr. Pasiens Mapunda	Deputy Country Director – Pathfinder	Dar es Salaam	16/03/2016	Group Interview
20	Bonita Kilama-Si Data Manager	M&E Manager – Pathfinder	Dar es Salaam	18/03/2016	Group Interview
21	Protas Ndayanga-	SPO – Pathfinder	Dar es Salaam	18/03/2016	Group Interview
2	Mr. Gaston Amos Simbo	Technical Director – CSSC – TUNAJALI	Dar es Salaam	18/03/2016	Group Interview
23	Angelina Mchome	Senior Technical Officer CT – CSSC TUNAJALI	Dar es Salaam	18/03/2016	Group Interview
24	Bertha Mlay	Director Health Services – Red Cross	Dar es Salaam	18/03/2016	Group Interview
25	Estrider Pallingo	HBC Life Program Coordinator – Red Cross	Dar es Salaam	18/03/2016	Group Interview
26	Makoye Rusekwa	Accountant – Red Cross	Dar es Salaam	18/03/2016	Group Interview
27	Gideon K. Betengwa	Chief Accountant – Red Cross	Dar es Salaam	18/03/2016	Group Interview

SN	DATE	Name	Designation/ Organization	TYPE OF INTERVIEW
29	21/03/2016	Dr. Mahela G. Njile	District Medical Officer- Mtwara MC	OD/Costing-Group Interview
30	21/03/2016	Wahida Shemahongo	District Nursing Officer	OD/Costing- Group Interview
31	21/03/2016	Rosalia Arope	District Health Secretary	OD/Costing- Group Interview
32	21/03/2016	Jenifer Nkane	DHBC – Mtwara MC	CHMT Member-FGD
33	21/03/2016	Edward Ngonyani	DTL – Mtwara MC	CHMT Member- FGD
34	21/03/2016	Asumpta Mbawala	DRCHCO – Mtwara MC	CHMT Member- FGD
35	21/03/2016	Mohamed Likombe	DPHARM – Mtwara MC	CHMT Member- FGD
36	21/03/2016	Dr. Lusungu Mselela	DACC – Mtwara MC	CHMT Member- FGD
37	21/03/2016	Fredy Mtoroki	TBHO – Mtwara MC	CHMT Member- FGD
38	21/03/2016	Lilian Mlaponi	DIMFP – Mtwara MC	CHMT Member- FGD
39	22/03/2016	Dr. John Rogers Ritte	EGPAF – Senior Reg.Program Manager	KII
40	22/03/2016	Dr. Charles Makoko	EGPAF – Regional Program Coordinator	KII
41	22/03/2016	Dafrosa Namihambi	EN – Rch Incharge – Ufukoni Dispensary	Group Interview
42	22/03/2016	Mary Simwanza	F /Incharge- Ufukoni Dispensary	Group Interview
43	22/03/2016	Nicholous Joseph	RN-RCH/FP- Ufukoni Dispensary	Group Interview
44	22/03/2016	Zuwena Abdallah	EN-RCH - Ufukoni Dispensary	Group Interview
45	22/03/2016	Naetwe Yoza	EN-CTC- Ufukoni Dispensary	Group Interview
46	23/03/2016	Tetwigis Kapinga	DRCHCO – Nachingwea District Hosp	Group Interview
47	23/03/2016	Magreth Chingwile	Ag. DACC – Nachingwea District Hosp	Group Interview
48	23/03/2016	Anjelina Malindi	Ag. HBC – Nachingwea District Hosp	Group Interview
49	23/03/2016	Samwel Lawrence	DPHARM – Nachingwea District Hosp	Group Interview
50	23/03/2016	Diertich Malibuche	DLT – Nachingwea District Hosp	Group Interview

SN	DATE	Name	Designation/ Organization	TYPE OF INTERVIEW
51	23/03/2016	Mother Support Group	Nachingwea District Hosp	FGD (10 Participants)
52	23/03/2016	HBC	Nachingwea District Hosp	FGD (11 Participants)
53	22/03/2016	HBC & Mother Support	Ufukoni Ward -Mtwara	FGD (11 Participants)
54	22/03/2016	Mother Support Group	Likombe Health Centre	Group Disc. (2 Participants)
55	21/03/2016	CHBC	Likombe Health Centre	FGD (7 Participants)
56	24/03/2016	CHBC	Kihuwe Disp-Nachingwea	Group (2 Participants)
57	24/03/2016	PLHIV	Kihuwe Disp-Nachingwea	Group (4 Participants)
58	05/04/2016	PLHIV – CSO – Wavumo	Morogoro MC	FGD (10 Participants)
59	05/04/2016	Volunteer – CSO Wavumo	Morogoro MC	FGD (10 Participants)
60	04/04/2016	Dr. Getrude Lebby	DACC – Morogoro MC	CHMT-MEMBER (Group discussion)
61	04/04/2016	Immaculata Mhagama	DRCHCO – Morogoro MC	CHMT-MEMBER (Group discussion)
62	04/04/2016	Eugenia Mbeni	DLT – Morogoro MC	CHMT-MEMBER (Group discussion)
63	04/04/2016	Suma Kabuja	DHBCCO – Morogoro MC	CHMT-MEMBER (Group discussion)
64	05/04/2016	Suma Kabuje	CTC Incharge/Sabasaba HC	Group Interview
65	05/04/2016	Nuru Ahmed	Matron / Sabasaba HC	Group Interview
66	05/04/2016	Fransisca Lyoba	RCH Incharge/ Sabasaba HC	Group Interview
67	05/04/2016	Wavumo Cso- Volunteer	TUNAJALI – Morogoro	FGD -10 Participants
68	05/04/2016	Wavumo Cso- Plhiv Clients	TUNAJALI – Morogoro	FGD- 10 Participants
69	04/04/2016	Hacoca -Cso	Morogoro	FGD (6 Participants)
70	04/4/2016	TUNAJALI Regional Office-Capacity Building	Morogoro	Group Discussion (3 ppl)
71	04/04/2016	Raymond Zunda & Mathias Gowelle	TUNAJALI Regional Office Morogoro	KII

SN	DATE	Name	Designation/ Organization	TYPE OF INTERVIEW
72	01/04/2016	Mr. Isaya Madembwa	Shiso-CSO – Executive Director Njombe	KII
73	01/04/2016	Felister Lora	RCN – Incharge- Njombe TC	KII
74	01/04/2016	Pili Komba (En)	CTC Incharge- Njombe TC	KII
75	01/04/2016	Mary Kahemele& Martha Totham	Cocoda- CSO Program Manager & Program Coordinator	KII
76	01/04/2016	CHMT's	Chmt Njombe Town Council	FGD – 7 participants
77	01/04/2016	TUNAJALI Technical Staff	Njombe TC – Njombe	FGD – 5 participants)
78	01/04/2016	Cocoda -CHW	Wanging'ombe	FGD – 6 participants
79	01/04/2016	TUNAJALI Silc Group & PLHIV	Njombe TC	FGD – 10 participants
80	31/03/2016	Njombe Town Council Hospital	Njombe Region	Group Discussion (3 participants)
81	31/03/2016	Capacity Building Staff	Njombe TC	Group Discussion (4 participants)
82	29/03/2026	Municipal Council Staff	Iringa Municipal	FGD (6 participants)
83	29/03/2026	Iringa Regional Hospital	CTC & RCH	Group Discussion (3 participants)
84	30/03/2016	Leah Lubago	TUNAJALI -Senior Grants Officer – Iringa	KII
85	30/03/2016	Sr. Mikela Astegiano & Mr. Christian Mgowa	Alamano Centre Director& Accountant	KII
86	30/03/2016	Alamano Outreach Staff	Iringa	GROUP DISCUSSION
87	30/03/2016	HBC & CHW	Ilala Ward Iringa	FGD- 10 Participants
88	8/4/2016	Dr. Eric Mbuguje	Ag. Dmo Nzega	CHMT-MEMBER(FGD)
89	8/4/2016	Dr. Ndoya Mbogo	DACC	CHMT
90	8/4/2016	Tausi Kibonge	DRCHCO	CHMT
91	8/4/2016	Sylvester Mgawe	DLT	CHMT
92	8/4/2016	Sikalwanda Kiasu	DHS	CHMT

SN	DATE	Name	Designation/ Organization	TYPE OF INTERVIEW
93	8/4/2016	Emmanuel Mwela	DPHARM	CHMT
94	8/4/2016	Teresia Paschal	DSWO	CHMT
95	8/4/2016	Rehema Ngowo	Mwangoye Nzega Dispensary	IDI
96	8/04/2016	Plha	Nzega – Tabora	Group Discussion (4 participants)
97	8/04/2016	Nzega District Council	Acting District Executive Director Health Accountant Health Secretary	Group Discussion (3 participants)
98	08/04/2016	Sikonge District-Tabora	HBC – LIFE	FGD (7 participants)
99	9/04/2016	Alphaxard Lwitakubi	Senior Technical Manager Life Project – Tabora	KII
100	9/04/2016	Samson Kishumbuh	LIFE Regional Coordinator – Tabora	KII
101	09/04/2016	Christopher Nhonge	TCRC Ag. Regional Coordinator	KII

ANNEX IV. SOURCES OF INFORMATION

In addition to the literature referenced in the report and listed in the footnotes, the evaluation team reviewed over 130 sources of secondary and reference data. These sources are arranged in categories and listed in the section following.

COUNTRY INFORMATION

- A Performance Audit on the Monitoring, Evaluations and Budget Allocation for Maternal Health Care Activities in Tanzania, National Audit Office, 2011
- Futures Group Policy Brief on Financing the HIV Response in Tanzania, 2015
- Tanzania Country Profile, UNAIDS, 2014
- Tanzania Demographic and Health Survey, 2004-2005
- Tanzania HIV/AIDS and Malaria Indicator Survey 2007-2008
- Tanzania HIV/AIDS and Malaria Indicator Survey 2011-2012
- Tanzania Service Provision Assessment Survey, 2006
- Tanzania Third National Multi-Sectoral Strategic Framework (NMSF) for HIV and AIDS (2013/14 – 2017/18)
- World Bank Development Indicators Data Bank

PEPFAR GUIDANCE

- GHI Guidance 2.0, 2011
- PEPFAR Guidance on Integrating Prevention of Mother to Child Transmission of HIV, Maternal, Neonatal, and Child Health and Pediatric HIV Services

TANZANIA MISSION AND HEALTH OFFICE

- Abbreviated Project Appraisal Document: Comprehensive Health Service Delivery (2013-2018)
- Audit of USAID/Tanzania's HIV Treatment Activities, Office of the Inspector General, Audit Report NO. 4-621-14-007-P, August 14, 2014
- Five-Year Partnership Framework in Support of the Tanzanian National Response to HIV and AIDS, 2009-2013
- PEPFAR/Tanzania Transition Strategy for Facility-Based HIV/AIDS Services (undated)
- Performance Evaluation of the Strengthening Pediatric HIV and AIDS Services in Tanzania Program, 2015
- Tanzania Global Health Initiative Strategy, 2010 -2015

TUNAJALI II PROGRAM DOCUMENTS

- Annual and quarterly reports, from 1st quarter of 2012 to final quarter of 2015
- Annual Workplans and Annexes, 2012-2013, 2013-2014, 2014-2015
- Audit Report: Building Organization Capacity for Results, PWC, 2012
- Audit Report: TUNAJALI II, PWC, 2013
- Back to Care Initiative Report
- Data Quality Assessments of C&T (2014) and PMTCT (2015) by MEASURE
- Data Verification and TA Reports
- Financial Reports and Financial Data, 2012-2015
- Joint Planning and Program Meeting Minutes, 2014 to 2015
- Joint Planning and Program Meeting Presentation, March 2016
- Laboratory Mentorship Reports
- Performance Monitoring Plan
- TUNAJALI II Cooperative Agreement Documents, including technical and financial proposals of 2011, and the revised project document of 2013
- TUNAJALI II Mini Case Studies
- TUNAJALI II Monitoring Data submitted by implementing partner

LIFE PROGRAM DOCUMENTS

- Annual and Quarterly Reports, from 1st quarter of 2012 to final quarter of 2015
- Annual Workplans and Annexes, 2012-2013, 2013-2014, 2014-2015
- Continuum of Care Meeting Reports, 2013-2015
- Data Quality Assessment Report, TMEAS, 2014
- DAW Action Plans 2013-2015
- Financial Reports and Financial Data, 2012-2015
- Joint Planning and Program Meeting Minutes, 2014 to 2015
- Joint Planning and Program Meeting Presentation, March 2016
- LIFE Cooperative Agreement, 2011
- Mini Data Quality Assessment Report, MEASURE, 2013
- Performance Monitoring Plan, Strategy and Protocols and Program Results Framework

ANNEX V. DATA COLLECTION INSTRUMENTS

CLINICAL SERVICES DATA COLLECTION

Protocol for CHMT/RHMT Members and Facility Staff

This protocol is aimed at collecting data from implementing health facility staff and CHMT/RHMT members to answer evaluation question one outlined below:

Evaluation Question I: To what extent have use of quality service delivery increased?

Sub-evaluation Questions:

- a. Range of services provided (PMTCT, treatments, care, TB/HIV, and MNC) pre- and post-implementation.
- b. Access to services pre- and post-implementation.
- c. Differences in outcomes according to gender and/or age.

Protocol Instructions

- Look at project documents to assess and list the range of services provided through implementation of the project; increase in service delivery points; increase in access to services pre- and post-implementation; and differences in outcomes according to gender and/or age.
- Confirm the findings with health facility staff and CHMT/RHMT members.
- Compare service delivery (range of services, service delivery points and access to services) across their districts (is the service delivery uniform in each district? If not what are the differences?).
- Request any monitoring data and reports that confirm the claims.

Protocol Questions

a. Range of services provided pre- and post-implementation.

- What ranges of services were are provided in this facility/district?
 - Probe for the mode of delivery of these services.

b. Access to services pre- and post-implementation.

- Are clients accessing more services during a visit?
 - Probe for examples for service integration
- What changes (outcomes) did you see in your facility/district as a result of the activities implemented under TUNAJALI /LIFE project?

c. Differences in outcomes according to gender and/or age.

- Were there any gender and age differences in the outcomes of project?
 - Probe for specific differences and possible reasons for the differences
- What are your observations and experience of extent to which the mechanisms have managed to address gender and age related priorities?

Additions for Specific CHMT Members

Questions for RCHC (USAID Heading 5)

- Please describe the range of services offered to pregnant women. Describe the process of delivering those services, from beginning to end. How is a client identified? How are her needs assessed? To which services is she referred? When do the various services end?
- How are services offered at a facility? Does a client receive all services on the same day? Does she have to come on different days for different services? How are referrals managed within a facility across departments?
- If you had to rank the services in order of quality, which would you say are the best, and which require quality improvement?
- Is this range of services consistently offered to all pregnant women? Can you describe the typical uptake of the range of services?
- Has the LIFE/TUNAJALI program improved the range of services offered and their quality? If yes, can you describe how?

Questions for HBC

- Please describe the role of HBC in delivering services at the facilities in the District. How does HBC contribute to identifying clients, helping them access services, follow-up and retention, and any routine contribution HBC makes?
- How does HBC support adherence, nutrition and other priorities such as household economic strengthening?
- How are HBC volunteers recruited and supported to do their work? How are they trained? Are they equipped with tools? Do they receive any material support?
- How important is HBC to effective delivery of health services? How important has the LIFE/TUNAJALI program been in developing the volunteer workforce? Can the district sustain the work of HBCs after the close of donor support?

Questions for DACC

- Please describe how the partner has assisted the CHMT in fulfilling its supportive supervision function?
- Please describe how the partner has supported the CHMT with the implementation of quality improvement programs at facilities?
- Has the partner's support changed the way the CHMT routinely works?
- Has the partner's support introduced new tools and systems to support the CHMT in its work?
- Overall, what has the impact of the partner's support been on the CHMT and on health service delivery in the District? Which departments or programs have benefitted most?
- Will the close of the partner's program in the District affect how well the CHMT can do its work?

Questions for the Others

- Pharmacy – Please describe the situation with regards to the supplies of medicines and commodities. How well is service delivery supported by consistent supply chain management?
- Lab – Please describe the situation with regards to laboratory services in the District. How well is service delivery supported by consistent, high quality laboratory services?

THE FOLLOWING QUESTIONS ONLY APPLY IN DISTRICTS WHERE MCH WAS INTEGRATED INTO THE PMTCT PLATFORM

This protocol is aimed at collecting data from health facility staff and CHMT/RHMT members to answer evaluation question two outlined below:

Evaluation Question 2: To what extent has integration of clinical and community MNH services into the PMTCT platform improved access to quality MNH services (comprehensive ANC, emergency obstetric and newborn care, postnatal care, integrated CHW visits)?

Sub-evaluation Questions:

- a. Efficiency and effectiveness of PMTCT partners support of MCH interventions.
- b. Best practices and key lessons learned during the roll out of MCH facility and community interventions using the PMTCT platform.
- c. Integration of MCH service delivery into the PMTCT platform.
- d. Efficiencies in MCH service delivery (e.g. better outputs, increased service utilization).
- e. Management systems, including integrated supervision of services, availability of medicines, linkages of service to another (e.g. HIV to FP, or to MCH and vice versa).

Protocol Instructions

- Look at project documents to assess integration of clinical and community MNH services into the PMTCT platform.
- Confirm the findings with health facility staff and CHMT/RHMT members
- Compare integration of clinical and community MNH services into the PMTCT platform across their districts (are the findings uniform in each district? If not what are the differences?).
- Request any monitoring data and reports that confirm the claims.

Protocol Questions

- a. Efficiency and effectiveness of PMTCT partners support of MCH interventions.**
 - Can you mention partnerships and collaborative efforts formed/observed in supporting MCH interventions under PMTCT platform in implementation of TUNAJALI II or LIFE project?
- b. Best practices and key lessons learned during the roll out of MCH facility and community interventions using the PMTCT platform.**
 - What are the key lessons learned in rolling out of MCH facility and community interventions using the PMTCT platform through TUNAJALI /LIFE project?
 - *Probe for lessons in coordination and collaboration as well as project design.*
 - What success story/stories in line with the achievements of rolling out of MCH facility and community interventions using the PMTCT platform through TUNAJALI /LIFE project?
- c. Integration of MCH service delivery into the PMTCT platform.**
 - What changes (outcomes) did you observe as a result of integrating MCH service delivery into the PMTCT platform?
 - *Probe for uptake and access of MCH services.*
 - What 3 Key challenges faced in integrating MCH service delivery into the PMTCT platform?
 - *Probe for specific examples, in programming, M&E, coordination, etc.*
 - How were the challenges mentioned above resolved or responded?
 - *Probe for approaches used and concrete examples.*

- What 3 key recommendations would you make towards enhancing effectiveness of Integration of MCH service delivery into the PMTCT platform?
- d. Efficiencies in MCH service delivery (e.g. better outputs, increased service utilization).**
- According to your observations and experience what contributed to increased efficiency in MCH service delivery under PMTCT platform?
- e. Management systems, including integrated supervision of services, availability of medicines, linkages of service to another (e.g. HIV to FP, or to MCH and vice versa).**
- How is supervision carried out?
 - *Probe: How is supervision integrated among contributing actors; Availability of supervisions checklists and plans/schedules; Availability of supervision feedback reports.*
- Were there any drug stock outs in the last 12 months?
- What mechanisms do you use to refer or link clients to other services?

Protocol for Regional Program Staff

This protocol is aimed at collecting data from Implementing Partners/Project Staff to answer evaluation question two outlined below:

Evaluation Question 1: To what extent have use of quality service delivery increased?

Sub-evaluation Questions:

- a. Range of services provided (PMTCT, treatments, care, TB/HIV, and MNC) pre- and post-implementation.
- b. Access to services pre- and post-implementation.
- c. Differences in outcomes according to gender and/or age.

Protocol Instructions

- Look at project documents to assess and list the range of services provided through implementation of the project; increase in service delivery points; increase in access to services pre- and post-implementation; and differences in outcomes according to gender and/or age.
- Confirm the findings with implementing partners and project staff.
- Compare service delivery (range of services, service delivery points and access to services) across their districts (is the service delivery uniform in each district? If not what are the differences?).
- Request any monitoring data and reports that confirm the claims.

Protocol Questions

- a. Range of services provided pre- and post-implementation.**
 - What ranges of services were introduced/supported as part of the project?
 - *Probe for the mode of delivery of these services.*
- b. Access to services pre- and post-implementation.**

- Did the project contribute to increase in service delivery points?
 - Probe for newly service delivery points where service integration was introduced.
- What are your observations and experience of service delivery before and after the mechanisms focussed on extending comprehensive care?
- To what extent did access to services improve?
 - Probe for challenges and opportunities observed; how were the challenges addressed.
 - Probe on how they would improve access to services given the opportunity to implement again.
- What changes (outcomes) did you see as a result of the activities implemented under TUNAJALI /LIFE project?

c. Differences in outcomes according to gender and/or age.

- Were there any gender and age differences in the outcomes of project?
 - Probe for specific differences and possible reasons for the differences
- What are your observations and experience of extent to which the mechanisms have managed to address gender and age related priorities?

THE FOLLOWING QUESTIONS ONLY APPLY IN DISTRICTS WHERE MCH WAS INTEGRATED INTO THE PMTCT PLATFORM

This protocol is aimed at collecting data from Implementing Partners/Project Staff to answer evaluation question four outlined below:

Evaluation Question 2: To what extent has integration of clinical and community MNH services into the PMTCT platform improved access to quality MNH services (comprehensive ANC, emergency obstetric and newborn care, postnatal care, integrated CHW visits)?

Sub-evaluation Questions:

- Efficiency and effectiveness of PMTCT partners support of MCH interventions.
- Best practices and key lessons learned during the roll out of MCH facility and community interventions using the PMTCT platform.
- Jhpiego's MAISHA and MCSP projects' support in building PMTCT partner capacity to provide these services.
- Integration of MCH service delivery into the PMTCT platform.
- Efficiencies in MCH service delivery (e.g. better outputs, increased service utilization).
- Management systems, including integrated supervision of services, availability of medicines, linkages of service to another (e.g. HIV to FP, or to MCH and vice versa).

Protocol Instructions

- Look at project documents to assess integration of clinical and community MNH services into the PMTCT platform.
- Confirm the findings with implementing partners and project staff.
- Compare integration of clinical and community MNH services into the PMTCT platform across their districts (are the findings uniform in each district? If not what are the differences?).
- Request any monitoring data and reports that confirm the claims.

Protocol Questions

- a. **Efficiency and effectiveness of PMTCT partners support of MCH interventions.**
 - Can you mention partnerships and collaborative efforts formed/observed in supporting MCH interventions under PMTCT platform since the inception of TUNAJALI II or LIFE project?
- b. **Best practices and key lessons learned during the roll out of MCH facility and community interventions using the PMTCT platform.**
 - What are the key lessons learned in rolling out of MCH facility and community interventions using the PMTCT platform through TUNAJALI /LIFE project?
 - *Probe for lessons in coordination and collaboration as well as project design.*
 - What success story/stories in line with the achievements of rolling out of MCH facility and community interventions using the PMTCT platform through TUNAJALI /LIFE project?
- c. **Jhpiego's MAISHA and MCSP projects' support in building PMTCT partner capacity to provide these services (TUNAJALI).**
 - What approach did Jhpiego's MAISHA and MCSP projects handled over MNCH services to TUNAJALI?
 - *Probe for capacity building activity or hand over meetings*
- d. **Integration of MCH service delivery into the PMTCT platform.**
 - What changes (outcomes) did you observe as a result of integrating MCH service delivery into the PMTCT platform?
 - *Probe for uptake and access of MCH services.*
 - What 3 Key challenges faced in integrating MCH service delivery into the PMTCT platform?
 - *Probe for specific examples, in programming, M&E, coordination, etc.*
 - How were the challenges mentioned above resolved or responded?
 - *Probe for approaches used and concrete examples.*
 - What 3 key recommendations would you make towards enhancing effectiveness of Integration of MCH service delivery into the PMTCT platform?
- e. **Efficiencies in MCH service delivery (e.g. better outputs, increased service utilization).**
 - What approaches contributed to improved MCH service delivery?
- f. **Management systems, including integrated supervision of services, availability of medicines, linkages of service to another (e.g. HIV to FP, or to MCH and vice versa).**
 - How are supervision carried out?
 - *Probe: How are supervisions integrated among actors? Availability of supervisions checklists and plans/schedules; Availability of supervision reports.*

- Were there any drug stock outs in the last 12 months?
- What mechanisms do you use to refer or link clients to other services?

CAPACITY DEVELOPMENT DATA COLLECTION

Protocol for LGAs

This protocol is aimed at collecting data from Local Government Authorities (LGAs) based on the following evaluation question:

Evaluation Question 3: To what extent has the capacity building efforts contributed to improved Local Government Authorities (LGA) performance related to governance, accountability, fiscal management and technical oversight?

Sub-evaluation Questions:

- a. Capacity building approaches to improve access and quality of service delivery of LGAs
- b. Improvements in fiscal management
- c. Improvements in governance
- d. LGAs engagement of the public on budget allocations and audit finding

Protocol Instructions

- Look at project documents that will provide evidence of the capacity building interventions provided to LGAs
- Confirm claims made by the project on capacity building interventions especially those implemented across LGAs
- Request any monitoring data and reports that confirm the claims

Protocol Questions

- a. *Capacity Building Approaches*
 - What capacity building interventions you supported with by the project?
 - - Probe for capacity building interventions that were successful and why
 - Probe for capacity building interventions that were least successful and why
 - What major challenges did you face in implementing capacity building interventions? -Probe for major challenges faced and how they were resolved, if at all they were resolved. If not, why they were not resolved
 - What major improvements have capacity building efforts made to the overall performance of your council's ability to deliver quality health services in general?
 - Probe for verifiable evidence in improvement in performance
- b. *Governance/Fiscal Management*
 - What capacity building support did you receive from the project to improve governance and fiscal management?
 - Did capacity building interventions work in these areas? If so, what worked and if not, what did not work?
 - If interventions worked, to what extent did performance improve?
 - What challenges did you face in implementing capacity building interventions in these areas?
 - Do you have any monitoring data and reports that can confirm your responses to the questions?
- c. *Councils' Engagement with the Public on resource allocation and audit findings*

- What particular interventions supported public engagement on budget allocations and audit findings?
 - To what extent did these interventions result in meaningful engagement and participation by the communities in governance processes?
 - What effect has this engagement made?
 - Do you have any monitoring data and reports that can confirm your responses to the questions?
- d. *District readiness to sustain delivery of services covered by TUNAJALI and LIFE*
- Do you think the capacity building support you have received would enable you to sustain quality comprehensive service delivery independent of PEPFAR support?
 - If yes, probe for the reasons why
 - What challenges do you think you are most likely to face in sustaining quality comprehensive service delivery?

Protocol for CSOs

This protocol is aimed at collecting data from CSOs and NGOs that are receiving capacity building support from TUNAJALI or LIFE to answer evaluation question 3 outlined below:

Evaluation Question 4: How and to what extent have the activities contributed to improved access and quality of integrated comprehensive clinical and community HIV services to HIV positive clients and pregnant women and newborns?

Sub-evaluation Questions:

- Capacity building process, approaches and interventions.
- Readiness of CSO and NGOs to provide and sustain improved access and quality HIV/AIDS services: PMTCT, treatments, care, TB/HIV, and MNCH.

Protocol Instructions

- Look at project documents that will provide evidence of the capacity building support provided to CSOs and NGOs
- Confirm claims made by the project on capacity building interventions especially those implemented across CSOs and NGOs
- Request any monitoring data and reports that confirm the claims

Protocol Questions

- e. *Capacity Building Approaches*
- What type of capacity building support have you received from TUNAJALI or LIFE?
 - Probe for capacity building interventions that were successful and why
 - Probe for capacity building interventions that were least successful and why
 - What major challenges did you face in implementing capacity building interventions that the project provided to you?
 - -Probe for major challenges faced and how they were resolved, if at all they were resolved and if not, why they were not resolve
 - What overall improvement has capacity building support made in your organization?
- f. *CSOs/NGOs readiness to sustain delivery of services covered by TUNAJALI and LIFE*
- Have you reached the graduation stage? If not, why?
- probe for readiness or preparedness to receive direct funding from USAID
- What challenges do you think you will face in seeking direct funding from USAID or any other donor?

- Have you mobilized any funding from other sources other than from TUNAJALI /LIFE as a result of the capacity building efforts you have received?
- - probe for the significance of this funding to sustaining current activities
- What has been the major service delivery improvements made as a result of capacity building support you have received? More services? Better services (quality)? Serving more people?
- To what extent are you ready to sustain delivery of services covered by TUNAJALI and Life at community level?

COMMUNITY DATA COLLECTION

Protocol for Community Volunteer Cadres

Community volunteer cadres include home-based care workers, community health workers and similar groups that support delivery of services directly to clients, usually on a volunteer basis.

Recruitment and Training of Volunteers

1. How did you become community volunteers?
 - Probe for manner of their selection, if the community leadership had a say in their selection etc.
2. Describing the training you received.
 - Probe for length of training, content and refreshers
3. What other support do you get, in addition to training, to help you do your volunteer work?

Identifying and Enrolling/Referring Clients

4. Who are your clients?
 - Probe for HIV affected and infected, other health issues such as TB and NCDs, and especially children and pregnant women
5. How do you identify new clients?
 - Describe the process of referring new clients for services.
 - Probe for how they ensure referrals are completed
 - Probe for effective practices such as accompanied referrals
 - Probe for descriptions of tools used
 - Ask for copies of tools used
6. Do you refer clients to any services, other than clinical services at clinics or dispensaries?
 - Probe for clinical services at service points other than facilities
 - Probe for referral to non-clinical services
 - Probe for successful uptake of clients into these additional services

Other Support to Clients

7. In addition to identifying and referring clients for services, in what other ways do you support clients? Please describe these other types of support
 - Probe for types of support such as nutrition, adherence, income generating activities
8. Does the health facility request that you support clients in other ways, such as locating clients lost to follow up?

Burden on Volunteers

9. How long do you keep following-up or checking up on clients you've been helping?
10. How many clients are you supporting at the moment?
11. What are the challenges that make your volunteer work difficult?
 - Probe for skills or expertise they feel they don't have, the cost of doing the work etc.

Challenges of Accessing Health Care

12. What are the challenges that members of your community face in trying to get health care?

- Probe for stigma and cost; adherence related issues such as nutrition and stock-outs; experience of services at the health facilities like waiting times, repeat visits for services that should be integrated, and stock-outs etc.
13. How have health care services changed in the last few years, since you've been a volunteer?
- Is the community getting more services than before? Probe on comprehensive care related services, including PMTCT, MNCH and other CTC services.
 - Have the services improved? Probe on experience of services at the health facilities like waiting times, repeat visits for services that should be integrated, and stock-outs etc.

Protocol for Community Groups

1. Please tell us how being a member of this group has helped you?

Let respondents offer testimonies; give them time to talk; ask for a number of such testimonies. Make sure that responses cover the themes listed below. If there are gaps in the participants' responses, ask the prompting questions of the whole group after the testimonies are completed.

Responses should cover:

- Dealing with stigma (prompt: How has it helped you to live with your HIV positive status?)
- Knowledge about and changes in health seeking behavior (prompt: How has it helped you take care of your health and that of your children?)
- Knowledge about and changes in parenting practices (prompt: Has it changed the way you raise your children? How? Think about children you were raising when you were not a member of this group; Think about how children are raised by mothers in aren't in such groups).
- Knowledge about and changes in accessing other services (Has it helped you in other ways, such as working together on income generating activities?)

2. Please tell us a little more about participating in this group.

- How did you join the group?
- How often do you meet with each other?
- When you meet what do you do?

3. Do you think it would be helpful for mothers who are not HIV positive to be in groups like this? Why?

4. What is still difficult for you as mother that you feel the group and those who support the group might be able to help with?

GUIDES FOR PREPARING FIELD NOTES

Overview

Due to time constraints the evaluation team will not be transcribing fieldwork interviews and discussions. Instead the team will submit detailed field notes, prepared in a consistent format, as the raw data. The field notes will serve as the primary documents for data analysis. As such they need to be clear and sufficiently detailed. This protocol provides guidance for preparing detailed field notes in a consistent format.

Recording Interviews and Discussions

All interviews and discussions should be recorded, provided consent is given. The recordings of interviews and discussions serves as a reference both in the preparation of the field notes, and if the content of the field notes should require verification at some later stages.

Consent should be obtained verbally before recording is commenced. Once the recording is underway the verbal consent should be confirmed for the record. When confirming consent remind the respondents that:

1. The recording is primarily a reference for preparing notes;
2. It is also a record of discussion should some of the content need to be confirmed at a later stage;
3. The audio recordings are kept confidential, accessible only by the evaluation team and USAID staff;
4. The respondents can, after the interview, request that they not be directly linked to some or all of their responses.

In the latter case only the evaluation team will have access to the full recording.

Format of Field Notes

Field notes must be submitted in MS Word format on a weekly basis. It is recommended that the field notes be captured on a daily basis; then reviewed and submitted to the Team Leader or uploaded to the shared drive by the Saturday morning of each week.

Field notes should be prepared in a document structured according to the questions posed, as per the field work protocols prepared ahead of the field work. The template for the fieldwork is presented on the following page.

Interview Details		
<i>Interviewer</i>	<i>Date</i>	<i>Location</i>
<i>Interviewee</i>	<i>Affiliation</i>	<i>Designation</i>
Question: <i>Type the main question being posed here</i>		
<ul style="list-style-type: none"> • Type up responses to the question in as much detail as possible, based on your interview notes. Check against the audio recording to ensure that the important content is captured. • Included the probing or clarification questions posed in this section. <i>Type the probes in italics, underline and punctuate with a question mark?</i> • These notes should be prepared as full sentences. However, bullet points instead of full paragraphs will suffice. 		
Question: <i>Type the next main question being posed here</i>		
<ul style="list-style-type: none"> • Have a separate section for each main question. 		
Key Themes and Highlights		
<ul style="list-style-type: none"> • Review your interview or discussion notes and type up the key facts or thematic highlights. <p><i>“For each key fact or thematic highlight include a quotable quote that illustrates the point. Type the quotes in italics, and inverted commas.”</i></p> <ul style="list-style-type: none"> • The number of key facts or thematic highlights should be limited, 5 being a rough rule of thumb. 		
List of Corroborating Sources		
<ul style="list-style-type: none"> • Conclude your notes by typing up a list of corroborating data that the respondents may have referred you to. • Note if you have already obtained the additional data, or if that remains an action point for you to follow up on. 		

ANNEX VI. DETAILED ECONOMIC AND FINANCIAL COST ANALYSIS TABLES

This Annex presents the tables detailing the cost analyses for the TUNAJALI II and Life programs. Economic and financial cost analyses per relevant service area in each program are presented in separate tables. The tables summarize cost categories that were included in the calculations, both capital and recurrent costs, and the resultant unit cost (cost per client) per delivered service. Clarifying notes are included where necessary.

This Annex is the companion piece to the cost analysis discussion in the main evaluation report.

TUNAJALI II Data

Table 1: The annual financial cost of providing comprehensive HIV/AIDS care and treatment. PMTCT and MNCH in TUNAJALI II supported Regions, 2012 (US\$)

Cost category	Care & Treatment	Laboratory	TBHIV	PMTCT	HBC	Capacity Building	CSSC	Central Project Mgt.	Sub Grant Mgt.	Total cost	percent	
Capital												
Buildings	0	0	5685	0	0	0	0	0	10520	16205	0.2%	
Equipment	226346	0	62513	48037	56753	0	20718	154252	143000	711619	10.5%	
Vehicles	0	0	0	0	0	0	0	0	0	0	0.0%	
Training	31261	18204	0	120960	176441	1099	0	0	59520	407484	6.0%	
Total capital costs	257607	18204	68198	168997	233194	1099	20718	154252	213040	1135308	16.8%	
Recurrent											0	0.0%
Personnel	0	0	0	0	198747	0	139252	1464463	813340	2615802	38.8%	
Supplies	195157	670212	43769	116	6819	0	0	0	129205	1045277	15.5%	
Vehicle operation and maintenance	0	0	0	0	0	0	20893	354015	0	419226	6.2%	
Challenge account	0	0	0	0	0	0	0	0	33857	33857	0.5%	
Travel. Per diems and Meetings	108242	844	47212	0	154856	113049	0	412283	19795	856281	12.7%	
Other (Recurrent)	0	1942	0	21031	0	0	2084	558773	90473	640447	9.5%	
Total recurrent costs	303399	672999	90980	21147	360422	113049	162229	2789535	1097131	5610890	83.2%	
TOTAL COSTS	561005	691202	159178	190144	593615	114148	182947	2943787	1310171	6746198	100.0%	
percent	8.3%	10.2%	2.4%	2.8%	8.8%	1.7%	2.7%	43.6%	19.4%	100%		
Unit Cost												
Patient current on ART treatment excluding PMTCT			57109									
Patient who receiving a minimum of one care services			105830									
Cost per patient current on ART			\$118									
Cost per patient who received a minimum of one service			\$64									

Table 2: The annual financial cost of providing comprehensive HIV/AIDS care and treatment., PMTCT and MNCH in TUNAJALI II supported Regions, 2013 (US\$)

Cost category	Care & Treatment	Laboratory	TBHIV	PMTCT	HBC	Capacity Building	CSSC, GTI and MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	391735	13872	67841	6438	0	0	0	0	10493	0	490380	4.2%
Equipment	26942	170833	0	40005	0	0	0	48340	122233	27230	435584	3.7%
Vehicles	0	0	0	0	0	0	0	0	70269	0	70269	0.6%
Training	218745	37739	37633	18452	9	369083	95140	0	2353	70464	1015685	8.7%
Total capital costs	637422	222444	4	2	369083	95140	0	48340	205347	97694	2011918	17.3%
Recurrent												
Personnel	0	0	0	0	500637	0	521826	2108723	1862467	0	4993653	42.9%
Supplies	179372	1168344	24521	21676	12542	0	7360	341	118907	0	1533064	13.2%
Vehicle operation and maintenance	0	0	0	0	0	0	138052	409591	67580	0	615223	5.3%
Challenge account	0	0	0	0	0	0	0	2974	0	0	9089	0.1%
Travel. Per diem and Meetings	263940	2803	19863	41175	229909	100498	0	884668	199346	0	1742203	15.0%
Other (Recurrent)	0	13871	0	0	0	0	18568	621278	86679	0	734281	6.3%
Total recurrent costs	443312	1185018	44384	62851	743088	100498	685806	4027575	2334980	0	9627512	82.7%
TOTAL COSTS	1080734	1407462	8	3	1	195638	685806	4075916	2540327	97694	0	100%
percent	9.3%	12.1%	1.3%	2.5%	9.6%	1.7%	5.9%	35.0%	21.8%	0.8%	100%	
Unit Cost												
Patient current on ART treatment excluding PMTCT				71127								
Patient who receiving a minimum of one care services				11903								
				5								
Cost per patient current on ART				\$164								
Cost per patient who received a minimum of one service				\$98								

Table 3: The annual financial cost of providing comprehensive HIV/AIDS care and treatment, PMTCT and MNCH in TUNAJALI II supported Regions, 2014 (US\$)

Cost category	Care & Treatment	Laboratory	TBHI V	HVT C	PMTCT	MNC H	HBC	Capacity Building	CSSC. GTI and MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital														
Buildings	645847	0	4063	0	4991	0	0	0	0	0	23212	0	678113	4.7%
Equipment	1202	243822	1593	0	7934	74650	0	6520	28503	335960	406962	26174	113332	7.9%
Vehicles	0	0	0	0	0	0	0	0	0	0	168735	0	168735	1.2%
Training	156762	65728	3263	1444	50643	0	14081	341715	67704	0	3053	45516	124807	8.7%
			3	8	0	0	0	0	0	0	0	0	1	
Total capital costs	803811	309550	3828	1444	51935	88731	341715	74224	28503	335960	601963	71690	322823	22.6%
Recurrent														
Personnel	0	0	0	0	0	0	140759	0	972116	2404512	161510	0	513248	35.9%
Supplies	4058	1178507	0	0	6521	0	346518	116	15338	10130	122294	21676	170515	11.9%
Vehicle operation and maintenance	0	0	0	0	0	0	0	0	120205	869749	609807	0	159976	11.2%
Challenge account	0	0	0	0	0	0	0	0	0	244658	0	0	256873	1.8%
Travel. Per diems and Meetings	111452	28452	0	0	0	0	176131	232133	14185	617869	261261	22942	146442	10.2%
Other (Recurrent)	0	25021	0	0	43398	18465	1542	0	25635	717531	71313	9983	900673	6.3%
									114747		267977		110593	
Total recurrent costs	115511	1231980	0	0	49920	18465	664949	232249	9	4864449	5	54601	77	77.4%
TOTAL COSTS	919321	1541530	3828	1444	56927	10719	100666	306473	117598	5200409	328173	12629	142876	100%
percent	%	6.4%	10.8	0.3%	0.1%	4.0%	0.8%	7.0%	2.1%	8.2%	36.4%	23.0%	0.9%	
Unit Cost														
Patient current on ART treatment excluding PMTCT					84975									
Patient who receiving a minimum of one care services					13208									
					0									
Cost per patient current on ART					\$168									

Table 4: Financial cost of providing comprehensive HIV/AIDS care and treatment, PMTCT and MNCH in TUNAJALI II supported Regions, 2015 (US\$)

Cost category	Care & Treatment	Laboratory	TBHI V	HVTC	PMTCT	MNC H	HBC	Capacity Building	CSSC, GTI and MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)		
Capital																
Buildings	99845	0	0	0	473	0	0	0	7136	0	24040	0	131494	1.2%		
Equipment	0	0	0	93431	0	22121	0	1013	75663	74887	3805	1122	272042	2.5%		
Vehicles	0	0	0	0	0	0	66797	0	0	0	0	57374	124170	1.1%		
Training	243279	50148	5014	8530	11975	44830	2	4	0	132649	0	190114	0	1242924	11.4%	
Total capital costs	343124	50148	5014	10196	12022	47042	5	5	66797	133661	82799	74887	217959	58496	1770630	16.3%
Recurrent																
Personnel	0	0	0	0	0	0	0	51133	112391	200454	173691	0	5376700	49.4%		
Supplies	12273	273981	149	0	0	0	3612	10776	16900	12108	217414	38083	585297	5.4%		
Vehicle operation and maintenance	0	0	0	0	0	0	0	0	142982	636660	28564	0	808206	7.4%		
Challenge account	0	0	0	0	0	0	0	0	0	27102	0	0	39197	0.4%		
Travel, Per diems and Meetings	119661	5089	0	33104	0	0	25499	8	129748	50006	395144	12977	77566	1078293	9.9%	
Other (Recurrent)	49355	35585	149	0	18263	20602	2	1	20	0	23027	673363	71366	0	1229425	11.3%
Total recurrent costs	181289	314656	299	33104	18263	20602	2	1	4	140524	7	0	2	8	9117117	83.7%
TOTAL COSTS	524413	364804	5044	13506	30285	67644	83676	1	274185	143962	382380	228519	17414	1088774	100%	
percent	4.8%	3.4%	0.5%	1.2%	2.8%	6.2%	7.7%	2.5%	13.2%	35.1%	21.0%	1.6%	100%			
Unit Cost																
Patient current on ART treatment excluding PMTCT					97877											
Patient who receiving a minimum of one care services					13071											
					4											
Cost per patient current on ART					\$111											
Cost per patient who received a minimum of one service					\$83											

Table 5: The annual economic cost of providing comprehensive HIV/AIDS care and treatment in TUNAJALI II supported Regions, 2012 (US\$)

Cost category	Care & Treatment	Laboratory	TBHIV	HBC	Capacity Building	CSSC	Central Project Mgt.	Sub Grant Mgt.	Total cost	percent
Capital										
Buildings	0	5005	5685	0	0	0	0	6838	17528	0.5%
Equipment	226346	0	62513	9137	0	3336	13372	23022	337726	9.9%
Vehicles	0	0	0	0	0	0	0	0	0	0.0%
Training	31261	6251	0	61259	382	0	0	20439	119592	3.5%
Total capital costs	257607	11256	68198	70396	382	3336	13372	50300	474845	13.9%
Recurrent										
Personnel	0	0	0	0	0	90514	512562	528671	1131747	33.1%
Supplies	195157	435638	43769	129185	0	0	0	83983	887732	26.0%
Vehicle operation and maintenance	0	0	0	4432	0	13580	123905	28807	170725	5.0%
Challenge account	0	0	0	0	0	0	0	29807	29807	0.9%
Travel. Per diems and Meetings	108242	549	47212	0	73482	0	144299	12867	386650	11.3%
Other (Recurrent)	0	0	0	100657	0	1355	195571	36800	334382	9.8%
Total recurrent costs	303399	436187	90980	234274	73482	105449	976337	720935	2941043	86.1%
TOTAL COSTS	561005	447442	159178	304671	73863	108784	989709	771235	3415888	100%
percent	16.4%	13.1%	4.7%	8.9%	2.2%	3.2%	29.0%	22.6%	100%	
Unit Cost										
Patient current on ART treatment excluding PMTCT			57109							
Patient who receiving a minimum of one care services			105830							
Cost per patient current on ART			\$60							
Cost per patient who received a minimum of one service			\$32							

Table 6: The annual economic cost of providing comprehensive HIV/AIDS care and treatment in TUNAJALI II supported Regions, 2013 (US\$)

Cost category	Care & Treatment	Laboratory	TBHIV	HBC	Capacity Building	CSSC	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital											
Buildings	391735	9017	61241	0	0	0	0	6820	0	468813	5.7%
Equipment	55500	28069	13489	9045	0	3302	24585	22791	4474	161256	2.0%
Vehicles	0	0	0	0	0	0	0	11546	0	11546	0.1%
Training	132541	6188	1041	134846	32848	0	0	20234	24329	352028	4.3%
Total capital costs	579777	43274	75771	143892	32848	3302	24585	61391	28803	993643	12.2%
Recurrent											
Personnel	0	0	0	325414	0	339187	1800754	1210604	0	3675958	45.0%
Supplies	179372	759424	22135	8152	0	4784	292	77290	0	1051449	12.9%
Vehicle operation and maintenance	0	0	0	0	0	89734	349772	30203	0	469708	5.7%
Challenge account	0	0	0	0	0	0	2540	0	0	6514	0.1%
Travel. Per diems and Meetings	260083	1822	17931	149441	65324	0	755466	129575	0	1379641	16.9%
Other (Recurrent)	0	0	0	0	0	12069	530543	56 341	0	594979	7.3%
Total recurrent costs	439455	761246	40065	483007	65324	445774	3439366	1504013	0	7178250	87.8%
TOTAL COSTS	1019232	804520	115836	626899	98172	449076	3463951	1565404	28803	8171893	100%
percent	12.5%	9.8%	1.4%	7.7%	1.2%	5.5%	42.4%	19.2%		100%	
Unit Cost											
Patient current on ART treatment excluding PMTCT				71127							
Patient who receiving a minimum of one care services				119035							
Cost per patient current on ART				\$114.89							
Cost per patient who received a minimum of one service				\$68.65							

Table 7: Economic cost of providing comprehensive HIV/AIDS care and treatment in TUNAJALI II supported Regions, 2014 (US\$)

Cost category	Care & Treatment	Lab. Service	TBHIV	HVTC	HBC	Capacity Building	CSSC, GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	645847	3669	3669	0	0	0	0	0	15088	0	668273	8.2%
Equipment	53633	26980	13304	0	8694	1550	3174	23631	21907	4301	157175	1.9%
Vehicles	0	0	0	0	0	0	0	0	28876	0	28876	0.4%
Training	118254	22944	15825	5043	5563	54516	0	0	1066	34645	257856	3.2%
Total capital costs	817734	53593	32799	5043	14258	56066	3174	23631	66937	38945	1112181	13.6%
Recurrent												
Personnel	0	0	0	0	91493	0	631875	1562933	1049689	0	3335990	40.8%
Supplies	3664	766029	0	0	225236	75	11315	6585	79491	14090	1106486	13.5%
Vehicle operation and maintenance	0	0	0	0	0	0	84245	565337	396375	0	1045956	12.8%
Challenge account	0	0	0	0	0	0	0	159027	7940	0	166967	2.0%
Travel. Per diems and Meetings	110435	18494	0	0		150886	0	401615	169820	14912	866162	10.6%
Other (Recurrent)	0	0	0	0	1002	0	22114	466395	38414	6489	534414	6.5%
Total recurrent costs	114100	784523	0	0	317732	150962	749549	3161892	1741728	35491	7055976	86.4%
TOTAL COSTS	931834	838116	32799	5043	331990	207027	752723	3185523	1808665	74436	8 168 157	100%
percent	11.4%	10.3%	0.4%	0.1%	4.1%	2.5%	9.2%	39.0%	22.1%	0.9%	100%	
Unit Cost												
Patient current on ART treatment excluding PMTCT												84975
Patient who receiving a minimum of one care services												132080
Cost per patient current on ART												\$96
Cost per patient who received a minimum of one service												\$62

Table 8: The annual economic cost of providing comprehensive HIV/AIDS care and treatment in TUNAJALI II supported Regions, 2015 (US\$)

Cost category	Care & Treatment	Laboratory	TBHIV	HVTC	HBC	Capacity Building	CSSC., GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	99845	0	0	0	0	0	4638	0	15626	0	120109	2.0%
Equipment	40015	22353	10424	15989	7203	1094	10076	19578	20673	3755	151161	2.6%
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0.0%
Training	134840	19009	13216	7156	23317	65249	0	0	67247	29357	359390	6.1%
Total capital costs	274700	41362	23640	23145	30520	66343	14714	19578	103546	33112	630661	10.7%
Recurrent												
Personnel	526	644	0	0	332367	0	730543	1302953	1128992	0	3496025	59.0%
Supplies	12273	178088	136	0	2348	7004	10985	7870	141319	13041	373064	6.3%
Vehicle operation and maintenance	0	3308	0	0	0	0	92938	413829	18567	0	528642	8.9%
Challenge account	0	23130	0	0	0	0	0	17616	7862	0	48608	0.8%
Travel. Per diems and Meetings	119661		0	21518		84336	18597	0	8435	50418	302964	5.1%
Other (Recurrent)	49210	136	136	0	13	0	14968	437686	38526	0	540675	9.1%
Total recurrent costs	181670	205306	272	21518	334728	91340	868031	2179955	1343701	63459	5289980	89.3%
TOTAL COSTS	456370	246669	23912	44663	365248	157683	882745	2199533	1447247	96570	5920640	100%
percent	7.7%	4.2%	0.4%	0.8%	6.2%	2.7%	14.9%	37.2%	24.4%	1.6%	100.0%	
Unit Cost												
Patient current on ART treatment excluding PMTCT						97877						
Patient who receiving a minimum of one care services						130714						
Cost per patient current on ART						\$60						
Cost per patient who received a minimum of one service						\$45						

Table 9: Annual economic cost of providing PMTCT services in TUNAJALI II supported Regions, 2012 (US\$)

Cost category	PMTCT	Laboratory	TBHIV	HBC	Capacity Building	CSSC	Central Project Mgt.	Sub Grant Mgt.	Total cost	percent
Capital										
Buildings	0	0	680	0	0	0	0	3682	4362	0.2%
Equipment	48037	0	1852	6747	0	1796	13372	12397	84202	3.9%
Vehicles	0	0	0	0	0	0	0	0	0	0.0%
Training	64610	3366	143	136213	0	0	0	11006	215338	10.0%
Total capital costs	112 648	3366	2 675	142 961	-	1 796	0	27 084	290530	13.5%
Recurrent										
Personnel	0	0	0	0		48738	512562	284669	845969	39.2%
Supplies	116	234574	5235	95398	0	0	0	15454	350779	16.3%
Vehicle operation and maintenance	0	0	0	3273	0	7312	123905	15511	150002	7.0%
Challenge account	0	0	0	0	0	0	0	0	11850	0.5%
Travel. Per diems and Meetings	20036	296	5647	0	0	0	144299	6928	177206	8.2%
Other (Recurrent)	989	680	0	74331	39567	730	195571	31665	331682	15.4%
Total recurrent costs	21140	235550	10882	173002	39567	56780	976337	354228	1867487	86.5%
TOTAL COSTS	133 788	238 915	13557	315 963	39567	58576	976337	381313	2158017	100%
percent	6.2%	11.1%	0.6%	14.6%	1.8%	2.7%	45.2%	17.7%	100%	
Unit Cost										
Number of HIV positive pregnant women receiving ART			7759							
Number of pregnant women tested for HIV			157917							
Cost per HIV positive pregnant women receiving ART			\$278							
Cost per pregnant women tested for HIV			\$14							

Table 10: Annual economic cost of providing PMTCT services in TUNAJALI II supported Regions, 2013 (US\$)

Cost category	PMTCT	Laboratory	TBHIV	HBC	Capacity Building	CSSC	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital											
Buildings	6438	4855	6600	0	0	0	0	3672	0	21566	0.6%
Equipment	10325	15114	1491	6747	0	1727	13238	12272	6214	67128	1.8%
Vehicles	0	0	0	0	0	0	0	6217	0	6217	0.2%
Training	162528	3332	115	136213	17564	0	0	10895	13100	343747	9.1%
Total capital costs	179290	23302	8207	142961	17564	1727	13238	33057	19314	438659	11.6%
Recurrent											
Personnel	0	0	0	242742	0	177421	738053	651864	0	1810079	47.8%
Supplies	21676	408921	2386	6081	0	2519	119	41617	0	483319	12.8%
Vehicle operation and maintenance	21676	0	0	0	0	47012	143357	16263	0	228307	6.0%
Challenge account	0	0	0	0	0	0	1041	0	0	3181	0.1%
Travel. Per diems and Meetings	0	981	1933	111475	34861	0	309634	69771	0	528654	13.9%
Other (Recurrent)	41175	4855	0	0	0	6380	217447	30337	0	298054	7.9%
Total recurrent costs	84527	414756	4318	360298	34861	233331	1409651	809853	0	3351596	88.4%
TOTAL COSTS	263817	438058	12525	503259	52425	235058	1422889	842910	19314	3790255	100%
percent	7.0%	11.6%	0.3%	13.3%	1.4%	6.2%	37.5%	22.2%	0.5%	100%	
Unit Cost											
Number of HIV positive pregnant women receiving ART				7666							
Number of pregnant women tested for HIV				191797							
Cost per HIV positive pregnant women receiving ART				\$494							
Cost per pregnant women tested for HIV				\$20							

Table 11: Annual economic cost of providing PMTCT services in TUNAJALI II supported Regions, 2014(US\$)

Cost category	PMTCT	Laboratory	TBHIV	HVTC	HBC	Capacity Building	CSSC. GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	4991	0	353	0	0	0	0	0	7892	0	13236	0.3%
Equipment	11972	14113	1282	0	6287	584	1660	12361	11459	2250	61966	1.4%
Vehicles	0	0	0	0	0	0	0	0	15105	0	15105	0.3%
Training	365250	12002	1525	2638	18770	28516	0	0	557	18122	447380	10.3%
Total capital costs	382213	26114	3160	2638	25056	29099	1660	12361	35013	20371	537687	12.3%
Recurrent												
Personnel	0	0	0	0	66157	0	330519	817534	549134	0	1763344	40.4%
Supplies	5569	400692	0	0	162863	39	6560	3444	41580	7370	628118	14.4%
Vehicle operation and maintenance	0	0	0	0	0	0	46981	295715	207335	0	550030	12.6%
Challenge account	0	0	0	0	0	0	0	83184	0	0	87337	2.0%
Travel. Per diems and Meetings	0	9674	0	0	82781	78925	0	210075	88829	7800	478085	11.0%
Other (Recurrent)	37060	0	0	0	725	0	14167	243961	24246	3394	319400	7.3%
Total recurrent costs	42629	410366	0	0	312526	78965	398228	1653913	911124	18564	3826314	87.7%
TOTAL COSTS	424842	436480	3160	2638	337582	108064	399888	1666274	946137	38936	4364001	100%
percent	9.7%	10.0%	0.1%	0.1%	7.7%	2.5%	9.2%	38.2%	21.7%	0.9%	100%	
Unit Cost												
Number of HIV positive pregnant women receiving ART prophylaxis						9128						
Number of pregnant women tested for HIV						226982						
Cost per HIV positive pregnant women receiving PMTCT+						\$478						
Cost per pregnant women tested for HIV						\$19						

Table 12: Annual economic cost of providing PMTCT services in TUNAJALI II supported Regions. 2015 (US\$)

Cost category	PMTCT	Laboratory	TBHIV	HVTC	HBC	Capacity Building	CSSC. GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	473	0	0	0	0	0	2426	0	8174	0	11073	0.3%
Equipment	0	11692	974	8364	5209	567	5270	10241	10814	1964	55095	1.6%
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0.0%
Training	127930	9943	1159	3743	16860	34130	0	0	35175	15356	244297	7.0%
Total capital costs	128403	21636	2133	12107	22069	34697	7697	10241	54163	17320	310465	8.9%
Recurrent												
Personnel	0	337	0	0	240327	0	0	681544	590550	0	1512758	43.6%
Supplies	0	93154	12	0	1698	3664	382130	4117	73921	6821	565517	16.3%
Vehicle operation and maintenance	0	0	0	0	0	0	5746	216465	9712	0	231922	6.7%
Challenge account	0	0	0	0	0	0	48614	9215	4112	0	61941	1.8%
Travel. Per diems and Meetings	182632	1730	0	11255	119849	44114	0	134349	0	26372	524715	15.1%
Other (Recurrent)	0	12	12	0	9	0	17002	228943	24264	0	266131	7.7%
Total recurrent costs	182632	95233	24	11255	361883	47778	453492	1274633	702859	33194	3162983	91.1%
TOTAL COSTS	311036	116868	2157	23362	383952	82475	461189	1284874	757021	50514	3473448	100%
percent	9.0%	3.4%	0.1%	0.7%	11.1%	2.4%	13.3%	37.0%	21.8%	1.5%	100.0%	
Unit Cost												
Number of HIV positive pregnant women receiving ART												9657
Number of pregnant women HIV tested for PMTCT												240226
Cost per HIV positive pregnant women receiving ART												\$360
Cost per pregnant women HIV tested for PMTCT												\$14

Table 13: Annual economic cost of providing PMTCT services in TUNAJALI II supported Regions, 20145 (US\$)

Cost category	PMTCT	Laboratory	TBHIV	HVTC	HBC	Capacity Building	CSSC, GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Capital												
Buildings	473	0	0	0	0	0	2426	0	8174	0	11073	0.3%
Equipment	0	11692	974	8364	5209	567	5270	10241	10814	1964	55095	1.6%
Vehicles	0	0	0	0	0	0	0	0	0	0	0	0.0%
Training	127930	9943	1159	3743	16860	34130	0	0	35175	15356	244297	7.1%
Total capital costs	128403	21636	2133	12107	22069	34697	7697	10241	54163	17320	310465	9.0%
Recurrent												
Personnel	0	337	0	0	240327	0	0	681544	590550	0	1512758	43.7%
Supplies	0	93154	12	0	1698	3664	382130	4117	73921	6821	565517	16.3%
Vehicle operation and maintenance	0	0	0	0	0	0	5746	216465	9712	0	231922	6.7%
Challenge account	0	0	0	0	0	0	0	0	4112	0	52726	1.5%
Travel. Per diems and Meetings	182632	1730	0	11255	119849	44114	0	134349	4412	26372	524715	15.1%
Other (Recurrent)	0	12	12	0	9	0	65 616	228943	20152	0	266131	7.7%
Total recurrent costs	182632	95233	24	11255	361883	47778	453492	1265418	702859	33194	3153768	91.0%
TOTAL COSTS	311036	116868	2157	23362	383952	82475	461189	1275659	757021	50514	3464233	100%
percent	9.0%	3.4%	0.1%	0.7%	11.1%	2.4%	13.3%	36.8%	21.9%	1.5%	100.0%	
Unit Cost												
Number of HIV positive pregnant women receiving ART					9657							
Number of pregnant women HIV tested for PMTCT					240226							
Cost per HIV positive pregnant women receiving ART					\$359							
Cost per pregnant women HIV tested for PMTCT					\$14							

Table 14: Carried forward capital resources in the TUJALI II comprehensive HIV/AIDS care and treatment Project (US\$)

Cost category	Care & Treatment	PMTCT	MNHC	Lab. Service	TBHIV	HVTC	HBC	Capacity Building	CSSC, GTI & MUHAS	Central Project Mgt.	Sub Grant Mgt.	M&E	Total cost	(percent)
Cost category														
Capital														
Equipment	105437	27223	124 319	161205	12216	209911	11818	11331	53194	2950	43353	12952	775908	42.5%
Training	291455	0	420 939	0	0	4887	38264	151768	0	0	108905	32866	1049083	57.5%
Total costs	396 892	27223	545 258	161205	12216	214798	50082	163098	53194	2950	152257	45818	1824991	100.0%
percent	22%	1%	30%	9%	1%	12%	3%	9%	3%	0%	8%	3%	100%	

LIFE Data

Table 1: The annual financial cost of providing comprehensive PMTCT and MNHC Services in LIFE supported Regions, 2012 (US\$)

Cost category	PMTCT	HBC	Central Project Mgt.	Pathfinder	Red Cross	Total cost	percent
Capital							
Buildings	0	8800	0	0	0	8800	0.1%
Equipment	9 980	0	329607	1487	0	341074	4.3%
Vehicles	0	0	0	0	0	0	0.0%
Training	287 577	94248	493047	0	0	874872	10.9%
Total capital costs	297 557	103 048	822 654	1 487	0	1 224 746	15.3%
Recurrent						0	0.0%
Personnel	1 387	5442	2497612	385688	0	2890129	36.1%
Supplies	109 977	143790	154897	15558	0	424222	5.3%
Vehicle operation and maintenance	0	0	0	0	0	0	0.0%
Building operation and maintenance	0	0	0	0	0	0	0.0%
Travel, Per diem and Meetings	435 274	0	481416	475695	0	1392385	17.4%
Other (Recurrent)	0	373183	468210	1199652	42919	2083963	26.0%
Total recurrent costs	546 637	522 414	3 602 135	2 076 593	42 919	6 790 699	84.7%
TOTAL COSTS	844 194	625 463	4 424 789	2 078 080	42 919	8 015 445	100.0%
percent	11%	8%	55%	26%	1%	100%	
Unit Cost							
HIV positive pregnant women receiving ART for prevention (PMTCT+)			10078				
Pregnant women at ANC tested for HIV			182181				
Number of women delivered at a health facility			211687				
Cost per HIV positive pregnant women receiving ART for prevention			\$795				
Cost per pregnant women tested for HIV			\$44				
Cost per a women delivered at a health facility			\$38				

Table 2: Annual financial cost of providing comprehensive PMTCT and MNHC Services in LIFE supported Regions, 2013 (US\$)

Cost category	PMTCT	HBC	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross	Total cost	percent
Capital								
Buildings	0	8800	0	0	0	0	8800	0.1%
Equipment	19 475	0	69683	28540	0	0	117698	1.2%
Vehicles	0	0	0	0	0	0	0	0.0%
Training	300 100	81599	724925	0	0	0	1106624	11.4%
Total capital costs	319 575	90 399	794 608	28 540		0	1 233 122	12.7%
Recurrent								
							0	0.0%
Personnel	44 628	47036	3337050	425593	125849	35420	4015576	41.2%
Supplies	147 477	25134	381211	6112	10712	5234	575880	5.9%
Vehicle operation and maintenance	0	0	0	0	0	0	0	0.0%
Building operation and maintenance	0	0	0	792587	361	0	792948	8.1%
Travel, Per diems and Meetings	534 190	140354	627638	0	49617	83720	1435519	14.7%
Other (Recurrent)	77 775	0	462734	927670	16784	197626	1682589	17.3%
Total recurrent costs	804 070	212 525	4 808 633	2 151 962	203 322	322 000	8 502 512	87.3%
TOTAL COSTS	1 123 645	302 923	5 603 241	2 180 502	203 322	322 000	9 735 633	100.0%
percent	12%	3%	58%	22%	2%	3%	100%	

Unit Cost

HIV positive pregnant women receiving ART for prevention (PMTCT+)	10765
Pregnant women at ANC tested for HIV	318554
Number of new born receiving post-natal checks within two days of birth	57932
Cost per HIV positive pregnant women receiving ART for prevention	\$904
Cost per pregnant women tested for HIV	\$31
Cost per a new born receiving postnatal checks within two days of birth	\$168

Table 3: Annual financial cost of providing comprehensive PMTCT and MNHC Services in LIFE supported Regions, 2013 (US\$)

Cost category	PMTCT	HBC	MNCH	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross	Total cost	percent
Capital									
Buildings	0	0	0	0	0	0	0	0	0.0%
Equipment	38515	0	0	57005	0	0	0	95520	0.8%
Vehicles	0	0	0	0	0	0	0	0	0.0%
Training	770006	47361	276425	1030009	0	0	0	2123801	17.0%
Total capital costs	80521	47361	276425	1087014	0	0	0	2219320	17.8%
Recurrent									
Personnel	26 720	56561	5207	4109036	437330	370261	46750	5051865	40.5%
Supplies	57 078	18748	62859	498942	102436	4280	0	744342	6.0%
Vehicle operation and maintenance	0	0	0	0	0	0	0	0	0.0%
Building operation and maintenance	0	0	0	60384	76158	23536	0	160078	1.3%
Travel, Per diems and Meetings	625 155	81395	65917	824766	77418	86061	114334	1875046	15.0%
Other (Recurrent)	865 008	73986	21615	607094	389316	196417	278850	2432286	19.5%
Total recurrent costs	1573961	230690	155598	6100222	1082658	680556	439934	10263618	82.2%
TOTAL COSTS	2382482	278050	432022	7187236	1082658	680556	439934	12482938	100.0%
percent	19%	2%	3%	58%	9%	5%	4%	100%	
Unit Cost									
HIV positive pregnant women receiving ART for prevention (PMTCT+)				10454					
Pregnant women at ANC tested for HIV				359031					
Number of new born receiving postnatal checks within two days of birth				52976					
Cost per HIV positive pregnant women receiving ART for prevention				\$1194					
Cost per pregnant women tested for HIV				\$35					
Cost per a new born receiving postnatal checks within two days of birth				\$236					

Table 4: Annual financial cost of providing comprehensive PMTCT and MNHC Services in LIFE supported Regions, 2015 (US\$)

Cost category	Sub grantees				Project Management	CSOs			Total cost	percent
	PMTCT	HBC	MNCH	PMI	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross		
Capital										
Buildings	0	0	0	0	0	0	0	0	0	0.0%
Equipment	3 123	0	901	0	41231	0	7345	0	52600	0.5%
Vehicles	0	0	0	0	0	0	0	0	0	0.0%
Training	199 098	116881	62997	56756	854327	0	0	0	1290059	12.5%
Total capital costs	202 221	116881	63898	56 756	895 558	0	7 345	0	1 342 659	13.0%
Recurrent									0	0.0%
Personnel	56 884	43318	0	21035	3798171	217566	388044	174544	4699562	45.5%
Supplies	25 897	24662	7011	11975	868861	16603	15565	7544	978118	9.5%
Vehicle operation and maintenance	0	0	0	0	0	0	0	0	0	0.0%
Building operation and maintenance	0	0	0	0	148254	129075	3774	0	281103	2.7%
Travel, Per diem and Meetings	110 284	446075	0	190832	729621	31593	80827	123450	1712682	16.6%
Other (Recurrent)	306 118	80111	24910	38901	420539	190594	209724	34500	1305398	12.6%
Total recurrent costs	499 183	594166	31921	262744	5 965 447	585 431	697 933	340 038	8 976 863	87.0%
TOTAL COSTS	701 404	711047	95819	319500	6 861 005	585 431	705 278	340 038	10 319 522	100.0%
percent	7%	7%	1%	3%	66%	6%	7%	3%	100%	
Unit Cost										
HIV positive pregnant women receiving ART for prevention (PMTCT+)					9808					
Pregnant women at ANC tested for HIV					362663					
Number of new born receiving postnatal checks within two days of birth					167124					
Cost per HIV positive pregnant women receiving ART for prevention					\$1 052					
Cost per pregnant women tested for HIV					\$28					
Cost per a new born receiving postnatal checks within two days of birth					\$62					

Table 5: Annual economic cost of providing comprehensive PMTCT Services in LIFE supported Regions, 2012 (US\$)

Cost category	PMTCT	HBC	Central Project Mgt.	Pathfinder	Red Cross	Total cost	percent
Capital							
Buildings	0	5720	0	0	0	5720	0.1%
Equipment	2 576	0	55293	249	0	58118	1.1%
Vehicles	0	0	0	0	0	0	0.0%
Training	122 390	32723	171184	0	0	326296	6.3%
Total capital costs	124 966	38 443	226 477	249	0	390134	7.5%
Recurrent							
Personnel	1 082	0	1623448	250697	0	1875227	36.3%
Supplies	109 977	3537	100683	10113	0	224310	4.3%
Vehicle operation and maintenance	435 274	93463	300312	86827	0	915877	17.7%
Building operation and maintenance	0	397422	0	0	0	397422	7.7%
Travel, Per diem and Meetings	0	0	12608	227805	0	240413	4.6%
Other (Recurrent)	0	0	304337	779774	42919	1127029	21.8%
Total recurrent costs	546 332	494 422	2 341 388	1 355 216	42 919	4 780 277	92.5%
TOTAL COSTS	671 298	532 865	2 567 864	1 355 465	42 919	5 170 411	100.0%
percent	13%	10%	50%	26%	0,8%	100%	
Unit Cost							
HIV positive pregnant women receiving ART for prevention (PMTCT+)				10078			
Pregnant women at ANC tested for HIV				182181			
Cost per HIV positive pregnant women receiving ART for prevention				\$513			
Cost per pregnant women tested for HIV				\$28			

Table 6: Annual economic cost of providing comprehensive PMTCT Services in LIFE supported Regions, 2013 (US\$)

Cost category	PMTCT	HBC	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross	Total cost	percent
Capital								
Buildings	0	5720	0	0	0	0	5720	0.1%
Equipment	7 399	0	66982	5037	0	0	79419	1.2%
Vehicles	0	0	0	0	0	0	0	0.0%
Training	165 943	28331	304229	0	0	0	498503	7.6%
Total capital costs	173 342	34051	371 212	5 037	0	0	583 642	8.9%
Recurrent								
							0	0.0%
Personnel	44 628	0	2169083	276635	125849	35420	2651614	40.3%
Supplies	147 477	30574	247787	3973	10712	5234	445757	6.8%
Vehicle operation and maintenance	534 190	16337	407965	80505	49617	83720	1172334	17.8%
Building operation and maintenance	0	45615	0	515182	0	0	560797	8.5%
Travel, Per diems and Meetings	0	0	0	0	0	0	0	0.0%
Other (Recurrent)	77 775	45615	300777	522481	16784	197626	1161058	17.7%
Total recurrent costs	804 070	138141	3 125 611	1 398 775	202 961	322 000	5 991 559	91.1%
TOTAL COSTS	977 412	172192	3 496 823	1 403 813	202 961	322 000	6 575 201	100.0%
percent	15%	3%	53%	21%	3%	5%	100%	
Unit Cost								
HIV positive pregnant women receiving ART for prevention (PMTCT+)				10765				
Patient who receiving a minimum of one care services				318554				
Cost per HIV positive pregnant women receiving ART for prevention				\$611				
Cost per pregnant women tested for HIV				\$21				

Table 7: Annual economic cost of providing comprehensive PMTCT Services in LIFE supported Regions, 2014 (US\$)

Cost category	PMTCT	HBC	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross	Total cost	percent
Capital								
Buildings	0	0	0	0	0	0	0	0.0%
Equipment	7 399	0	21252	4788	0	0	33439	0.5%
Vehicles	0	0	0	0	0	0	0	0.0%
Training	165 943	16443	606551	0	0	0	788937	11.4%
Total capital costs	173 342	16443	627 803	4 788	0	0	822 377	11.9%
Recurrent								
							0	0.0%
Personnel	44 628	0	2670873	284265	125849	35420	3161034	45.7%
Supplies	147 477	36765	324312	66583	10712	5234	591083	8.5%
Vehicle operation and maintenance	534 190	12186	536098	50322	49617	83720	1266133	18.3%
Building operation and maintenance	0	52907	39250	49503	0	0	141659	2.0%
Travel, Per diem and Meetings	0	0	0	0	0	0	0	0.0%
Other (Recurrent)	77 775	0	394611	253056	16784	197626	939852	13.6%
Total recurrent costs	804 070	101858	3 965 144	703 728	202 961	322 000	6 099 761	88.1%
TOTAL COSTS	977 412	118301	4 592 948	708 515	202 961	322 000	6 922 137	100.0%
percent	14%	2%	66%	10%	3%	5%	100%	

Unit Cost

HIV positive pregnant women receiving ART for prevention (PMTCT+)	10454
Pregnant women at ANC tested for HIV	359031
Cost per HIV positive pregnant women receiving ART for prevention	\$662
Cost per pregnant women tested for HIV	\$19

Table 8: Annual economic cost of providing comprehensive PMTCT Services in LIFE supported Regions, 2015 (US\$)

Cost category	Sub grantees			Project Management	CSOs			Total COST	percent
	PMTCT	HBC	PMI	Central Project Mgt.	Pathfinder	AGPAHI	Red Cross		
Capital									
Buildings	0	0	0	0	0	0	0	0	0.0%
Equipment	10 746	0	0	28211	0	379	0	39336	0.5%
Vehicles	0	0	0	0	0	0	0	0	0.0%
Training	528 390	57024	19706	584539	0	303	0	1189962	15.5%
Total capital costs	539 136	57 024	19 706	612 750	0	682	0	1 229 298	16.1%
Recurrent									
Personnel	25 897	0	13673	2598749	141418	77609	174544	3031889	39.6%
Supplies	416 843	28157	7784	594484	10792	3113	7544	1068717	14.0%
Vehicle operation and maintenance	0	4076	124041	499214	20536	16165	123450	787482	10.3%
Building operation and maintenance	0	342021	0	101437	83899	755	0	528112	6.9%
Travel, Per diem and Meetings	0	0	0	0	0	0	0	0	0.0%
Other (Recurrent)	499 625	0	25286	287737	123886	41945	34500	1012979	13.2%
Total recurrent costs	942365	374254	170783	4081622	380530	139587	340038	6429179	83.9%
TOTAL COSTS	1481501	431278	190489	4694372	380530	140269	340038	7658477	100.0%
percent	19%	6%	2%	61%	5%	2%	4%	100%	
Unit Cost									
HIV positive pregnant women receiving ART for prevention (PMTCT+)				9808					
Pregnant women at ANC tested for HIV				362663					
Cost per HIV positive pregnant women receiving ART for prevention				\$781					
Cost per pregnant women tested for HIV				\$21					

ANNEX VII. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project
<p>As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.</p> <p>Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:</p> <ol style="list-style-type: none">1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

 _____

Signature

Date 20/01/2016

Terence Edmond Beney _____

Name

Title Mr

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	28/01/2016
Signature	Date
ROSE ERNEST	
Name	Title

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 - (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Signature

Date 01/13/2016

NEEMA FRITZ MATEE
Name

Title EVALUATION SPECIALIST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

04/02/2016

Name

SODE NOYATUS MATIKU

Title

Consultant.

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Dr GEORGE MUGAMBAGE RUMAGO

Signature

[Handwritten Signature]

Date

10/02/2016

Name

Title

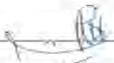
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

	01.10.2016
Signature	Date
Kennedy Musonda	Title Managing Consultant
Name	

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

23/07/2016

Name

DEODATUS JOSEPH MWINGI

Title

ENUMERATOR

For more information, please visit
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