APPENDIX

Joint Terminal Evaluation Report on the Health Systems Strengthening for HIV/AIDS Services Project in United Republic of Tanzania

The
Ministry of Health and Social Welfare

and

Japan International Cooperation Agency

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
C&T	Care and Treatment
CDC	Center for Disease Control and Prevention
CHMT	Council Health Management Team
CSS	Comprehensive Supportive Supervision
CSS&M	Comprehensive Supportive Supervision and Mentoring
D/D	Detailed Design
FY	Fiscal Year
GFATM	Global Fund to fight against AIDS, Tuberculosis and Malaria
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
GOJ	Government of Japan
GOT	Government of Tanzania
HBC	Home-Based Care
HF	Health Facility
HIV	Human Immunodeficiency Virus
HSHSP	Health Sector HIV/AIDS Strategic Plan
HSSP	Health Sector Strategic Plan
IT	Information Technology
I-TECH	International Training and Education Center for Health
JCC	Joint Coordination Committee
JICA	Japan International Cooperation Agency
JPY	Japanese Yen
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
MTR	Mid-Term Review
NACP	National AIDS Control Program
NSGRP	National Strategy for Growth and Reduction of Poverty
OJT	On-the-Job Training
PCM	Project Cycle Management
PDM	Project Design Matrix
PEPFAR	President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counseling
PMTCT	Prevention of Mother to Child Transmission
PO	Plan of Operation
QI	Quality Improvement
RAS	Regional Administrative Secretary
RCH	Reproductive Child Health
R/D	Record of Discussions
RHMT	Regional Health Management Team
RRHMT	Regional Referral Hospital Management Team
SS	Supportive Supervision

STI	Sexually Transmitted Infection
SWAp	Sector-Wide approaches
TB	Tuberculosis
TSH	Tanzanian Shilling
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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1. Introduction

1-1 Background of the Terminal Evaluation

In the United Republic of Tanzania (hereinafter referred to as Tanzania), Acquired Immune Deficiency Syndrome (AIDS) epidemic has grown as a national emergency and a great threat to the development of the country since the advent of the epidemic in 1983. Despite efforts to control the disease starting with prevention interventions to care and treatment, constraints in human and financial resources and weaknesses in health systems have been the key bottlenecks for the expansion of the interventions and delivery of quality services. Successful scale-up and utilization of broad range of Human Immunodeficiency Virus (HIV) and AIDS related services, such as Voluntary Counseling and Testing (VCT), Provider-Initiated Testing and Counseling (PITC), Prevention of Sexually Transmitted Infection (STI), Prevention of Mother to Child Transmission (PMTCT), Care and Treatment (C&T), Prevention of Tuberculosis (TB)/HIV, Home-Based Care (HBC), Laboratory Services, and Pharmaceutical Services, require a well-functioning health system.

One of the challenges identified in the current health systems is an operationalization of the Monitoring and Evaluation (M&E) system. Strengthening M&E system is one of the top priority areas of Ministry of Health and Social Welfare (MOHSW) as stipulated in the Health Sector Strategic Plan III (HSSP III) (2009-2015). Due to the cross-cutting nature of M&E, the National AIDS Control Program (NACP) through the Health Sector HIV/AIDS Strategic Plan III (HSHSP III) (2013-2017) is striving to establish comprehensive M&E system for the health sector response to HIV/AIDS. Another weakness is the quality of Comprehensive Supportive Supervision and Mentoring (CSS&M) for HIV/AIDS services. MOHSW has developed the National Supportive Supervision (SS) Guidelines for Quality Health Care Services, and National AIDS Control Program (NACP) has developed the Quality Improvement Guidelines for HIV/AIDS Prevention, Care, Treatment and Support Services. And NACP in cooperation with Japan International Cooperation Agency (JICA) has developed Supervision and Clinical Mentoring Manual. All these documents need to be operationalized in the health delivery system to achieve the desired outcomes.

The Health Systems Strengthening for HIV/AIDS Services Project (hereinafter referred as the "Project") began operation in October 2010 with a proposed duration of four years. JICA has implemented a former project entitled "Project for Institutional Capacity Strengthening for HIV Prevention Focusing on STIs and VCT Services" from March 2006 to July 2010 in Tanzania. The Project has built on the outcomes and experiences from the former project, especially in the area of policy guidelines, training package and M&E framework for VCT/STI management. In the formulation of the Project, NACP and MOHSW identified new managerial challenges on effective operationalization of CSS&M and M&E systems for HIV/AIDS services in a concrete and realistic manner.

The Project was launched in October 2010 and will be completed in October 2014. Approximately after half-life of the Project, the Joint Mid-Term Review (MTR) was conducted from 11 to 27 April 2013 in accordance with the JICA Evaluation Guidelines of June 2010 in order to review the status of the Project progress and to consider necessary measures to be taken for improving the implementation of the Project during the remaining period of the Project. The MTR Team found that the Project is on the right track to accomplish its purpose; however, the evidence was limited.
Before the completion of the Project, the Joint Terminal Evaluation Team (hereinafter

referred to as Evaluation Team) conducted the terminal evaluation of the Project from 1 September to 20 September 2014 in accordance with the JICA Evaluation Guidelines of June 2010.

1-2 Objectives of the Terminal Evaluation

The objectives of the terminal evaluation are:

(1) to review the current status of the Project progress based on inputs, outputs, Project purpose, and identify the problems negatively affecting the Project implementation;

(2) to evaluate the Project in accordance with the five evaluation criteria namely, relevance, effectiveness, efficiency, impact, and sustainability;

(3) to consider the necessary actions to be taken and make recommendations for the remaining period of the Project; and

(4) to draw lessons learned from the Project for improving planning and implementation of similar technical cooperation projects in the future.

1-3 Joint Terminal Evaluation Team

The Terminal Evaluation is jointly carried out by the JICA Terminal Evaluation Team and concerned authorities of Tanzania consisting of the following Tanzania side and Japanese side members.

Tanzania Side

Name	Job Title	Position
Dr. Sylvester. M. BUDEBA	Team Leader	Head of Referral Services for Patients Abroad/Principal Medical Officer, MOHSW

Japanese Side

Name	Job Title	Position
Dr. Tomohiko SUGISHITA	Team Leader/ Health Systems Expert	Senior Advisor (Health), JICA Headquarters
Mr. Kimio ABE	Cooperation Planning	Representative, JICA Tanzania Office
Ms. Catherine SHIRIMA	Team Member	Health Policy Specialist, JICA Tanzania Office
Dr. Mahmood Ul Zaman KHAN	Evaluation Analyst	President, Japan Soft Tech Consultants, Japan

1-4 Schedule of the Terminal Evaluation

A series of meetings and discussions were held from 1 September to 20 September 2014 with the Counterparts, Development Partners, Japanese Experts, and among Evaluation Team.

Details of the Schedule of the Terminal Evaluation are given in Annex 1 and the List of Persons interviewed in Annex 2.

1-5 Methodology of the Terminal Evaluation

The status of the Project progress was reviewed based on the latest version 4.1 of Project Design Matrix (PDM) of 14 March 2014 (hereinafter referred to as the PDM, Annex3), which is a summary table describing the outline of the Project. Evaluation Team examined the following points referring to the PDM.

(1) Verification of Project Performance

The degree of Project achievements, such as Outputs and Project purpose, was assessed with reference to Objectively Verifiable Indicators stated in the PDM. To carry out this, various methods were applied including documents review, questionnaire, interviews, discussions with relevant stakeholders, and field visits to the targeted sites.

(2) Examination of Project Implementation Process

The process of the Project implementation was assessed from the viewpoints of Project management.

(3) Evaluation by Five Evaluation Criteria

The following five evaluation criteria are applied to the Project evaluation according to DAC Criteria for Evaluating Development Assistance[1].

Relevance: A criterion for considering the validity and necessity of a project by examining the extent to which the project is appropriate to implement. It is referred to the validity of the project purpose and overall goal in compliance with development policies of the government of the partner country, Japanese policies as well as the needs of the target group.

Effectiveness: A criterion for considering whether the implementation of the project has benefited (or will benefit) the intended target group. It is referred to if the expected benefits of the project have been achieved as planned and if the benefit is brought about as a result of the project (not of the external factors).

Efficiency: A criterion for considering how economic resources/inputs are converted to results. It is referred to the productivity of the implementation process and examined if the inputs of the project were efficiently converted into the outputs.

Impact: A criterion for considering the effects of the project on the longer term effects including direct or indirect, positive or negative, intended or unintended effects caused by implementing the project.

Sustainability: A criterion for considering whether produced effects continue after the termination of the assistance. In other words, it is referred to the extent that the project can be further developed by the recipient country and the

[1] http://www.oecd.org/development/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

benefits generated by the project can be sustained under the recipient country's policies, technology, systems and financial status.

The Evaluation Team conducted the terminal evaluation of the Project in accordance with the JICA Evaluation Guidelines of June 2010. For the evaluation of performance of the Project, the Evaluation Team used three categories of **Very Satisfactory, Satisfactory, and Unsatisfactory** with the following definitions.

Very Satisfactory: The Project produced extraordinary results for all indicators for Outputs, Project purpose and Project Goal designed in the Project Design Matrix (PDM).

Satisfactory: The Project produced acceptable results for all indicators for Outputs, Project purpose and Project Goal as designed in the PDM.

Unsatisfactory: Satisfactory: The Project could not produced acceptable results for all indicators for Outputs, Project purpose and Project Goal as designed in the PDM.

For the evaluation of the Project in light of five evaluation criteria of Relevance, Effectiveness, Efficiency, Impact, and Sustainability the Evaluation Team used the following categories.

For the evaluation of Relevance of the Project, the Evaluation Team used five categories of **Excellent, Good, Average, Below Average, and Poor.**

For the evaluation of Effectiveness of the Project, the Evaluation Team used five categories of **Excellent, Good, Average, Below Average, and Poor.**

For the evaluation of Efficiency of the Project, the Evaluation Team used five categories of **Excellent, Good, Average, Below Average, and Poor.**

For the evaluation of Impact of the Project, the Evaluation Team used two categories of **Positive or Negative.**

For the evaluation of Sustainability of the Project, the Evaluation Team used two categories of **Expected or Unexpected.**

(4) Recommendations and Lessons Learned

Evaluation Team made the recommendations to the Project Team, Council Health Management Teams (CHMTs) and Regional Health Management Teams (RHMTs), NACP, MOHSW, and JICA and drawn lessons learned based on the results of joint terminal evaluation.

1-6 Limitations of the Terminal Evaluation

There have been following limitations in the terminal evaluation of the Project, which may have influenced the results of the terminal evaluation of the Project.

(1) The time for terminal evaluation of the Project was limited, thus there may have been

aspects which may not be thoroughly analyzed or evaluated.

(2) Due to the limited time for the terminal evaluation of the Project, the number of people interviewed and time for interviews was limited, thus there is a possibility that some information may be skewed or reflecting the opinions of the interviewees.

(3) Limited number of data samples which may have influenced the quality of analysis.

2. Outline of the Project

2-1 Summary of the Project

The outline of the Project described in the PDM for the terminal evaluation is as follows:

(1) Overall Goal

Health system is strengthened through CSS&M and effective M&E system for health sector HIV/AIDS services.

(2) Project Purpose

CSS&M and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up*[1].

*1 The Project focuses on the modeling exercise for effective M&E and CSS&M in two model regions (Pwani and Dodoma) during the Project period. Expansion of the approved activities to other regions apart from the model regions will be done with the initiative of the MOHSW/NACP in collaboration with implementing partners.

(3) Outputs

1) Essential indicators for routine monitoring of HIV/AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national M&E system through the initiative of the MOHSW.

2) M&E system in model regions is strengthened.

3) CSS&M at national level is strengthened.

4) CSS&M in model regions is strengthened.

5) Synergetic effect between M&E system and CSS&M is enhanced.

(4) Project Period

October 2010 to October 2014 (4 Years)

2-2 Administration of the Project

The implementation arrangements for the Project as agreed in the Record of Discussions (R/D) signed on 12 August 2010 are as follow:

2-2-1 Tanzania Side

(1) Counterparts and Administrative Personnel

(1) Project Director
Chief Medical Officer, MOHSW

(2) Project Manager
Program Manager, NACP, MOHSW

(3) Assistant Project Manager
Assistant Program Manager, NACP, MOHSW

(4) Technical staff in charge
All Units Heads, NACP, MOHSW

(5) Regional focal persons
Regional Medical Officers in Model Regions

(2) Buildings and Facilities

(1) Office spaces and necessary facilities for JICA Experts and related staff in the MOHSW

(2) Buildings and facilities necessary for the implementation of the Project in the MOHSW

(3) Other facilities will be mutually agreed upon as necessary

(3) Joint Coordinating Committee (JCC)

1) Functions

The JCC meeting will be held at least once a year and whenever necessity arises. Its functions are as follows:

(1) To authorize the annual activity plan of the Project

(2) To endorse major achievements and products of the Project

(3) To monitor and review overall progress and supervise the Project

(4) To review and discuss on major issues arising from or concerning the Project

2) Composition

The JCC shall be composed of the following members.

(1) Chairperson:
Chief Medical Officer, MOHSW

(2) Members:
- Program Manager, NACP, MOHSW
- Assistant Program Manager, NACP, MOHSW
- All Unit Heads, NACP, MOHSW
- Director of Preventive Services, MOHSW
- Director of Policy and Planning, MOHSW
- Director of Curative Services, MOHSW
- Director of Human Resource Development, MOHSW
- Head of Reproductive and Child Health Section, MOHSW
- Head of M&E Section, MOHSW
- Head of Hospital Reform Team, MOHSW
- Chief Pharmacist, MOHSW
- Program Manager, National TB and Leprosy Program
- Regional Focal Persons (Two Regional Medical Officers in Model Regions)
- Other persons appointed by the Chairperson

(4) Observers:
- Officials of the Embassy of Japan
- Representatives of other organizations invited by the Chairperson

2-2-2 Japanese Side

(1) Long-Term Japanese Experts

1) Chief Advisor
2) Epidemiology Specialist/M&E Advisor
3) Project Coordinator/Training Specialist

(2) Short-Term Japanese Experts
Other related fields mutually agreed upon as necessary, such as Baseline and Endline Surveys

(3) Equipment

1) Project office equipment (Photocopy and Fax machine)
2) Information Technology (IT) equipment for District Health Information System (DHIS) operations in model regions (Personal Computers, software, and others if necessary)
3) Vehicles and office equipment provided by the Project for Institutional Capacity Strengthening for HIV Prevention on STIs and VCT Services (NACP/JICA) will be continuously used for the implementation of the Project
Additional equipment may be provided when the Government of Tanzania (GOT) and JICA agreed that it is needed.

3. Achievements of the Project

3-1 Actual Inputs

3-1-1 Inputs from the Tanzania Side – as of September 2014

(1) Counterparts Assigned for the Project

List of Counterparts assigned for the Project are given in Annex 4-1.

(2) Provision of Building and Facilities

(1) Office spaces, utilities and necessary facilities for JICA Experts and related staff in the MOHSW/NACP

(2) Office space and facilities for the implementation of the Project in the Regional Hospital in Dodoma

3-1-2 Inputs from the Japanese Side – as of September 2014

(1) Long-Term Japanese Experts

Details of Long-Term Japanese Experts are given in Annex 4-2.

(2) Counterpart Personnel Trainings/Workshops

Details of Trainings/Workshops for Counterpart Personnel are given in Annex 4-3.

(3) Provision of Equipment and Materials

Details of Equipment and Materials provided by the Japanese Side are given in Annex 4-4.

(4) Operational Expenses

Details of Operational Expenses from the Japanese Side are given in Annex 4-5.

3-2 Achievement of Outputs

The achievement level of **Output 1** is shown below.

Output 1:	Essential indicators for routine monitoring of HIV/AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national M&E system through the initiative of the MOHSW.
Objectively Verifiable Indicators	Achievement Level
1-1 Endorsed essential indicators will be in place.	• Endorsed essential HIV/AIDS Indicators are in place. • **100% Achieved.**
1-2 Essential indicators will be integrated into the National HIV/AIDS Scorecard Indicators.	• Essential HIV/AIDS Indictors are integrated into the National HIV/AIDS Scorecard Indicators. • **100% Achieved.**

The progress and overall assessments of **Output 1** are shown below.

Progress for Indicator 1-1

- A set of essential indicators for each intervention of HIV/AIDS services at the national level were selected by each Unit of NACP, initiated by Epidemiology Unit, in February 2012.

Progress for Indicator 1-2

- The selected essential indicators were integrated into the HIV/AIDS Scorecard Indicators for routine monitoring of HIV/AIDS services in May 2012 and subsequently endorsed by NACP in June 2012.
- The members of pilot RHMTs and CHMTs in the model regions were oriented on the HIV/AIDS Scorecard Indicators in August 2012 and this activity has been continued as need arises throughout the life of the Project.

Overall Assessments of Output 1

- Activities under Output 1 are designed to strengthen data management for HIV/AIDS services at the national level. The HIV/AIDS Essential Indicators for HIV/AIDS services were introduced as an entry point to help and empower the RHMTs and CHMTs to get familiar with data analysis, visualization and interpretation. The set of Essential indicators were integrated into HIV/AIDS Scorecard Indicators and endorsed by the NACP to tract and visualize the current situation of HIV/AIDS in the country.

HIV/AIDS SCORE CARD FOR NATIONAL AND REGIONAL ACCOUNTABILITY AND ACTION: Data source (NACP M&E Unit) 2014

	Populations	HIV epidemic			Prevention index		care, treatment and support			Service outlets		
Regions	Total population	HIV prevalence (%) 15 -49 years THMS 11/12	Estimated number of adolescents and adults living with HIV (Based on prevalence)	Estimated number of pregnant women HIV positive	Percent of estimated pregnant women HIV positive receiving PMTCT services	% HIV exposed infants DBS PCR tested who are HIV positive	Estimated number of children in need of ART	children in need of ART receiving ART		Facilities providing HIV care and ART	Facilities providing STI services	Outlets for HIV counselin g and testing
								Number	%			
Arusha	1,694,310	3.2	54,218	3741	60.7	10.1	1126	1538	137	47	151	253
Dar es salaam	4,364,541	6.9	301,153	20780	343.3	2.7	14112	5453	38.6	70	127	161
Dodoma	2,083,588	2.9	60,424	4169	30.6	32.9	3108	1095	35.2	37	234	81
Iringa	941,238	9.1	85,653	5910	254.5	53.6	11533	3842	33.3	47	322	149
Kagera	2,458,023	4.8	117,985	8141	36.7	8.1	4048	1059	26.2	57	146	154
Kigoma	2,127,930	3.4	72,350	4992		19.1	992	387	39.0	29	114	46
Kilimanjaro	1,640,087	3.8	62,323	4300	68.7	1.8	1386	1859	134	45	213	261
Lindi	864,652	2.9	25,075	1730	67.5	36.5	1608	473	29.4	71	185	238
Manyara	1,425,131	1.5	21,377	1475	17.7	4.8	1086	401	36.9	30	136	129
Mara	1,743,830	4.5	78,472	5415	27.0	23.3	4076	593	14.5	50	157	133
Mbeya	2,707,410	9	243,667	16813	101.0	9.1	9127	2067	22.6	54	337	301
Morogoro	2,218,492	3.8	84,303	5817	46.7	38.9	4182	1255	30.0	51	248	223
Mtwara	1,270,854	4.1	52,105	3595	51.8	17.6	1803	654	36.3	85	124	292
Mwanza	2,772,509	4.2	116,445	8035	152.1	24.3	8670	1642	18.9	73	323	228
Pwani	1,098,668	5.9	64,821	4473	94.3	7.3	2630	835	31.7	50	150	214
Rukwa	1,004,539	6.2	62,281	4297	32.6	41.9	3111	569	18.3	30	226	97
Ruvuma	1,376,891	7	96,382	6650	73.1	26.0	3390	859	25.3	57	231	166
Shinyanga	1,534,808	7.4	113,576	7837	42.3	16.8	12652	1508	11.9	39	260	152
Singida	1,370,637	3.3	45,231	3121	50.5	12.7	1572	421	26.8	30	201	161
Tabora	2,291,623	5.1	116,875	8064	49.8	14.1	6346	1288	20.3	80	167	221
Tanga	2,045,205	2.4	49,085	3387	65.5	43.0	3342	1659	49.6	42	291	307
Njombe	702,097	14.8	103,910	7170						38		146
Katavi	564,604	5.9	33,312	2299								35
Simiyu	1,584,157	3.6	57,030	3935								69
Geita	1,739,530	4.7	81,758	5641								111
Tanzania	43,625,354	5.1	2,199,809	151,787	71.9	15.8	110859	29457	26.6	1180	4343	4329

Good | Fair | Poor

- Staff of NACP reported that the activities under Output 1 resulted in a transformation of data management system for HIV/AIDS services at the national level.
- Although the Project attained high level of achievement, NACP is expected to review and revise essential indicators regularly supervised by MOHSW according to the Post 2015 Development Agenda and related global and local contexts.
- NACP has expended Scorecard Indicators in a nationwide scale and presented the results to RHMTs and stakeholders in April 2014 (see the figure above).

- **The Output 1 was considered 100% achieved at the time of MTR and achievement level was rated as very satisfactory.**

The achievement level of **Output 2** is shown below.

Output 2:	M&E system in model regions is strengthened.
Objectively Verifiable Indicators	Achievement Level
2-1 By the end of the Project, data feedback will be given twice a year from 2 RHMTs to CHMTs and from at least 7 out of 13 CHMTs to Health Facilities (HFs) in the model regions.	• Data feedback is not given twice a year from any of the RHMTs to CHMTs, but seven out of 13 CHMTs to HFs in the model regions. • **0% for RHMTs.** • **100% Achieved for CHMTs (7 CHMTs/target 7 CHMTs among 13 CHMTs).**
2-2 By the end of the Project, 90% of members of RHMTs and CHMTs in the model regions will have started utilizing the data.	• 100% of members of RHMTs and CHMTs in the model regions started utilizing the data. • **More than 100% Achieved (100%/target 90%).**

The progress and overall assessments of **Output 2** are shown below.

Progress for Indicator 2-1

- Data feedback is defined as "a cycle in which the routinely collected data are analyzed, explained by table and/or figure with interpretation and returned to the field as necessary information for their health services. It can be an essential component of data utilization."
- The Baseline Survey revealed that none of the RHMTs had provided data feedback in the model regions to CHMTs and no CHMTs had done so to HFsHIV/AIDS.
- The Project provided IT equipment, including desktop computer, color printer, software, antivirus software, USB Key, UPS, surge protector, digital camera, etc. at the regional and council levels in the model regions. The Project Team has been continuously monitoring the conditions of IT equipment provided by the Project at the regional and council levels in the model regions.
- The Project prepared training for data analysis, visualization and interpretation; assisted the development of data feedback plan, and conducted on-the-job training (OJT) on data analysis, visualization and interpretation for officers from RHMTs and CHMTs in the model regions. The training was conducted in cooperation with the University of Dar Es Salaam Computing Center. OJT on data analysis, visualization and interpretation has been continued throughout the life of the Project to build the skills and knowledge on data analysis, visualization and interpretation of officers of RHMTs and CHMTs in the model regions. The Project trained 31 officers of RHMTs and CHMTs in the model regions in September 2012.
- During the period of October 2012 to August 2014, Dodoma RHMT conducted data feedback twice and Pwani RHMT conducted data feedback three times, but not in accordance to the set definition of data feedback and, therefore, these could not be counted as successful data feedback.
- Total number of Data feedback conducted by all RHMTs and CHMTs in the model regions was 49 with the average of 3.3±2.1 times.
- None of the RHMTs as compared to the targeted two RHMTs have provided data feedback to CHMTs, but seven CHMTs have provided data feedback twice a year to HFs covering HIV/AIDS services in the model regions. Therefore, the target for CHMTs has been achieved.

Progress for Indicator 2-2

- For the definition of the indicator, the numerator is the number of respondent of the RHMTs and CHMTs who responded that they are utilizing data and the denominator is the total number of respondents of the RHMTs and CHMTs in the model regions.
- The number of interviewees was 75 (five members from each health management team) members in the model regions for the Baseline Survey. 70 members out of total 75 members responded that they were utilizing the data.
- HIV/AIDS Scorecard Indictors for HIV/AIDS services were quarterly collected and stored from August 2012 to August 2014. Average collection and storage rate was 73.8±13.0% (Highest rate was 100% for Dodoma Manispaa and Kongwa Districts and lowest rate was 57.1% for Dodoma Region, Mpwapwa District and Bagamoyo District).
- The Project organized OJT review meetings for Dodoma and Pwani in February and March 2013 respectively.
- The RHMTs and the CHMTs prepared 53 kinds of Data Feedback materials (Average 3.5 ± 2.1, Highest was 8 for Mkuranga District and Lowest was 1 for Mpwapwa District) from October 2012 to August 2014.
- Data Feedback was conducted 46 times from October 2012 to August 2014 in all targeted districts in the

model regions. Average Data Feedback was 3.1±1.9 times (Highest was seven times for Mkuranga District and lowest was one time for Mpwapwa District and Rufiji District).
- The number of targeted interviewees was again 75 (five members from each health management team) members in the model regions, same as for the Baseline Survey for the End Line Survey. 74 members out of total 75 members responded and all stated that they are utilizing the data, which is 100% achievement.

Overall Assessments of Output 2
- Activities under Output 2 were designed to strengthen data analysis, visualization and interpretation; data feedback; and data utilization for HIV/AIDS services in the model regions.
- During the first half of the Project, the Project focused on the situation analysis, redesign of the project outputs and activities, IT environment and skill assessment and installation of IT equipment at the regional and council levels in the model regions; developing and conducting trainings on data analysis, visualization and interpretation; and developing the data feedback plan. In the second half of the Project, the Project focused on strengthening of data feedback and data utilization.
- The trainings on data analysis, visualization and interpretation are well received by the participants and the quality of training materials, methodology for the training, and expertise of the trainers is highly appreciated by the participants. The participants particularly appreciated the use of Microsoft Excel instead of complicated statistics software like Statistical Package for the Social Sciences (SPSS) for data analysis and management which made them easier to understand and use the data analysis, visualization and interpretation.
- Several officers of RHMTs and CHMTs in the model regions reported that their skills and knowledge on data analysis and management, data feedback, and data utilization are significantly improved by the activities of Output 2. Few members of CHMTs reported that now they can use tables, charts, graphs and figures for data feedback and can utilize the data for knowing the problems for HIV/AIDS services in the HFs under their jurisdiction better than before. They further reported that they are now using data for knowing problems, such as stock of drugs available at HFs, for knowing the exact current situation of HIV/AIDS in their jurisdiction, and for preparing their presentation to the community leaders, political leaders, and for national, regional and international meetings and conferences. However, they also reported for the need of frequent retraining for data analysis and management in the future.
- Five councils (Dodoma Manispaa, Bahi, Kongawa, Kondoa, Mkuranga) have conducted data utilization for improving health services. Dodoma Manicipaa and Mkuranga presented their practices at the 20th International AIDS Conference (IAC) 2014. Bahi presented their analysis at the 17th International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) 2013.
- NACP is anticipated to scale up data management practices including data collection, analysis, feedback and documentation to all CHMTs.
- **The progress and achievement level of Output 2 is satisfactory.**

The achievement level of **Output** 3 is shown below.

Output 3:	CSS&M at national level is strengthened.
Objectively Verifiable Indicators	Achievement Level
3-1 One coordinated schedule will be in place at the national level.	• Coordinated CSS&M plan for HIV/AIDS services of NACP is in place at the national level. • **100% Achieved.**
3-2 By the end of the Project, retrievable documentation rate will be 70% of all supervision conducted by NACP in the past one year.	• Retrievable documentation rate is 54% of all supervision conducted by NACP in the past one year. • **77% Achieved (54%/target 70%).**
3-3 By the end of the Project, execution rate of mentoring visits in response to the needs identified will be 50% of all needs identified and documented by national supervisors in the past one year.	• Execution rate of mentoring visits in response to the needs identified is 75% of all needs identified and documented by national supervisors in the past one year. • **More than 100% Achieved (75%/target 50%).**

The progress and overall assessments of **Output 3** are shown below.

Progress for Indicator 3-1
- The Baseline Survey revealed that there is no coordinated SS schedule is available at NACP. Each Unit of

NACP conducted SS at its convenient time with availability of funds from donors.

- The Quality Improvement (QI) Unit was established under NACP in January 2012 to coordinate with other Units of NACP to implement the cross-units CSS&M activities. The establishment of QI Unit has enabled NACP to plan, budget, implement and report on CSS&M activities to all other Units of NACP. The NACP mobilized the external resources, particularly the Global Fund to fight against AIDS, Tuberculosis and Malaria (GFATM) and Center for Disease Control and Prevention (CDC), to plan and implement Comprehensive Supportive Supervision and mentoring (CSS&M) at the national level since the beginning of 2013.
- The Endline Survey revealed that the QI Unit of NACP had already started to coordinate the schedule, depending on the availability of funds.

Progress for Indicator 3-2

- The retrievable documentation of supervision conducted by NACP is defined as "CSS reports are archived as shared documents, to which all staff of NACP can have access any time." To calculate the percentage of retrievable documentation, the numerator is the number of CSS reports submitted and archived as shared documents in the past one year and the denominator is number of CSS conducted in the past one year.
- The Baseline Survey revealed that the percentage of retrievable documentation was 0% of all supervision conducted by NACP because there were none CSS report accessible and retrievable to NACP staff. SS reports were compiled by each intervention and they were not accessible.
- The Project developed a standardized training package for CSS&M on HIV/AIDS services in August 2011. The training package includes a Participant's Guide, Facilitator's Guide and Tools. The Project conducted training of trainers (TOT) in June 2011 and August 2012 and trained a total of 42 trainers. The trained trainers have been utilized for facilitation of CSS&M training financed by other partners.
- The Project also trained 50 supervisors and 44 mentors for CSS for HIV/AIDS services at the national level.
- The End Line Survey revealed that the number of retrievable CSS reports covering all interventions for the past one year became 14. The number of regions visited by the national supervisors was 26 (Dodoma region was visited two times). Therefore, the documentation rate was 54% as compared to the target of 70% (which is 77% of the target) of all supervision conducted by NACP in the past one year.

Progress for Indicator 3-3

- To calculate the execution rate of mentoring to attend needs identified and documented, the numerator is the number of mentoring needs attended by national mentors and documented in response to the needs identified by the national supervisors in the past one year and the denominator is the number of needs identified for mentor dispatch and documented by national supervisors in the past one year. Number of mentoring needs attended by national mentors was used for the numerator to calculate the rate instead of number of mentoring visits.
- The Baseline Survey revealed that the execution rate of mentoring at the national level was 0% because no mentoring needs had been identified by supervisors and no mentors had been dispatched from the national level.
- The Project developed the Standard Operating Procedures (SOP) for CSS&M and shared with the NACP and the model regions in October 2012 and in January 2013 respectively. The Project also revised the Manual and Tools for CSS&M during December 2013 – April 2014 and printed them in August 2014.
- The End Line Survey revealed that four mentoring needs were identified at the regional hospitals by supervisors in the model regions in the past one year. In total three mentoring needs were attended by national mentors during March to May 2014. The execution rate of mentoring was 75% as compared to the target of 50% (which is 150% of the target) of all needs identified and documented by national supervisors in the past one year.

Overall Assessments of Output 3

- Activities under Output 3 were designed to strengthen the CSS&M for HIV/AIDS services at the national level through the development and implementation of one coordinated CSS&M plan for HIV/AIDS services and documentation of the activities.
- Currently a coordinated biannual CSS&M plan at the national level is available with an annual budget, but the timeline of the CSS&M activities depends on the actual disbursement and availability of funds from the donors, which is unpredictable.
- The development of the SOP and the Manual and Tools for CSS&M for HIV/AIDS services are highly appreciated by the officers of CHMTs and RHMTs in the model regions, staff of NACP and MOHSW, and representatives of other development partners. The development of new tools is appreciated because the previous tools were too lengthy and were not user-friendly. The Head of QI Unit of NACP has reported that

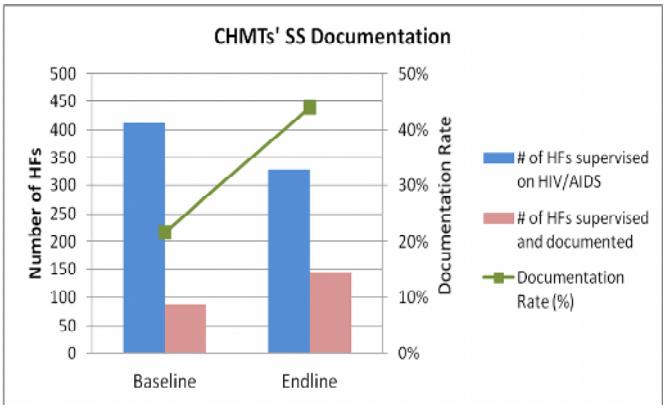
the SOP is still not implemented 100% because of lack of financial and human resources. He further suggested that SOP, the Manual and Tools for CSS&M for HIV/AIDS services require regular revisiondue to the development of new policies and approaches.

- The quality of training package, methodology of the training and skills and expertise of the trainers for the CSS&M training are well received by the participants of the training. The participants particularly appreciated the theoretical and practical approaches for CSS&M. Participants also appreciated the pre- and post-training assessments to know the improvement in the skills and expertise of the participants. The participants emphasized for the continuation of the training in the future for improving their skills and expertise in the light of development of new policies and approaches.
- The Project developed and install a web-based archive system for CSS&M for HIV/AIDS services at NACP in April 2012 to share the information by all staff of the NACP. The Project also prepared a User Manual for the web-based archive system and oriented the staff of NACP for the use of the system in October 2012 and October 2013 to further facilitate the documentations of CSS&M at the national level. The Head of QI Unit of NACP highly appreciated the development of the web-based archive system and orientation to the staff of NACP for its use. However, he has reported that there are some technical problems that should be overcome soon. Currently, the web-based archive system is in use and will be revised in light of gained experiences before the completion of the Project in October 2014.
- **The progress and achievement level of Output 3 is satisfactory.**

The achievement level of **Output 4** is shown below.

Output 4:	CSS&M in model regions is strengthened.
Objectively Verifiable Indicators	Achievement Level
4-1 By the end of the Project, retrievable documentation rate will be 50% of all SS to both regional hospitals and CHMTs covering HIV/AIDS services in the past one year in the model regions.	• Retrievable documentation rate is 28% of all SS of RHMTs to both regional hospitals and CHMTs covering HIV/AIDS services in the past one year in the model regions. • **56% Achieved (28%/target 50%).**
4-2 By the end of the Project, execution rate of mentoring visits in response to the needs identified will be 50% of all needs identified and documented by regional supervisors in the past one year.	• The execution rate of mentoring visits in response to the needs identified is 33% of all needs identified and documented by regional supervisors in the past one year. • **66% Achieved (33%/target 50%).**
4-3 By the end of the Project, retrievable documentation (health facility specific) rate of SS visits on HIV/AIDS to HFs by all councils in the model regions will be 25%.	• Retrievable documentation (health facility specific) rate of SS visits on HIV/AIDS services to HFs by all councils in the model regions is 44%. • **More than 100% Achieved (44%/target 25%).**
4-4 Execution rate of mentoring visits in response to the needs identified will be 25% of all needs identified and documented by regional supervisors in the past one year.	• Execution rate of mentoring visits in response to the needs identified is 53.8% of all needs identified and documented by regional supervisors in the past one year. • **More than 100% Achieved (54%/target 25%).**

Improvement in Documentation of supportive supervision of CHMTs covering HIV/AIDS services is shown in the figure.



The progress and overall assessments of **Output 4** are shown below.

Progress for Indicator 4-1

- The retrievable documentation of CSS visits by regional supervisors means that SS reports submitted by regional supervisors covering HIV/AIDS services can be retrieved easily. To calculate the percentage of retrievable documentation rate, the numerator is the number of SS reports covering HIV/AIDS services for the past one year which are retrievable and the denominator is the number of SS visits to Regional Hospitals and CHMTs on HIV/AIDS conducted in the past one year.
- The Baseline Survey revealed that the retrievable documentation rate for the period of July 2010 to June 2011 was 0%. The Dodoma RHMT conducted SS to the Regional Hospital and the CHMTs. Five SS reports were available covering 23 HF visits. However, no SS visit to the Regional Hospital and the CHMTs were documented. There was no Regional Hospital in Pwani region at the time of Baseline Survey. The Pwani RHMT conducted SS covering HIV/AIDS services. Four SS reports were available covering 35 HF visits. However, no SS to the CHMTs were documented.
- The Project conducted trainings for CSS&M for HIV/AIDS services for members of RHTMs and CHMTs from January to March 2012 and trained 104 supervisors and mentors. The Project also oriented the members of RHMTs and CHMTS for CSS&M at the beginning of the Project and reoriented them from January to February 2013.
- The End Line Survey revealed that during the period of May 2013 to April 2014, the Dodoma RHMT conducted 18 SS visits in total covering HIV/AIDS services to the Regional Hospital and the CHMTs, of which four reports were retrievable. The Pwani RHMT conducted seven SS visits, of which three reports were retrievable. Therefore, the documentation rate increased from 0% to 28% as compared to the targeted 50% (which is 56% of the target) of all SS of RHMTs to both regional hospitals and CHMTs in the past one year in the model regions.

Progress for Indicator 4-2

- To calculate the execution rate of mentoring to attend needs identified and documented by regional supervisors, the numerator is the number of mentoring needs attended and documented by regional mentors in response to needs identified by regional supervisors in the past one year and the denominator is the number of needs identified for mentor dispatch and documented by regional supervisors in the past one year.
- The Baseline Survey revealed the percentage of mentoring visits conducted in response to the needs identified and documented by the regional supervisors is 0% in the model regions because no mentoring needs identified and no mentors were dispatched by the RHMTs during the period of July 2010 to June 2011.
- The End Line Survey revealed that during the period of May 2013 to April 2014, Dodoma regional supervisors identified and documented three mentoring needs of two districts. Regional mentors were dispatched to the districts, but no documentation was found for the mentorship. Four mentoring needs identified by Kondoa district supervisors at two HFs were met by three regional mentors and their reports were retrievable. Five mentoring needs were documented by Pwani RHMT, but no mentors were dispatched. Therefore, the execution rate of mentoring visits in response to the needs identified is 33% (4/12) as compared to the targeted 50% (which is 66% of the target) of all needs identified and documented by regional supervisors in the past one year.

Progress for Indicator 4-3

- To calculate the retrievable documentation rate on the SS of CHMTs to their HFs in the model regions, the numerator is the number of HFs supervised on HIV/AIDS services by all CHMTs in the model regions whereby documentation was done for each specific HF and the denominator is the number of HFs covered by SS on HIV/AIDS services conducted by all CHMTs in the model regions in the past one year.
- The Baseline Survey revealed that NACP tool had not been used yet. Reports were summarized as quarterly or monthly reports covering many HFs in one report without action plans.
- The End Line Survey revealed that all councils used NACP CSS tool and most of the reports were HF specific with action plans. The number of HFs covered in the reports increased from 89 to 145. The retrievable documentation rate of SS visits on HIV/AIDS services to the HFs by all councils in the model regions has increased from 22% to 44% as compared to the targeted 25% (which is 176% of the target).

Progress for Indicator 4-4

- To calculate the execution rate of mentoring to attend needs identified and documented by council supervisors, the numerator is the number of mentoring needs attended and documented by council mentors

in response to needs identified by council supervisors in the past one year and the denominator is the number of needs identified for mentor dispatch and documented by council supervisors in the past one year.

- The Baseline Survey revealed the execution rate of mentoring was 0% in the model regions, because no mentoring needs were identified by council supervisors and no mentors were dispatched by the CHMTs to attend the needs for the past one year.
- The End Line Survey revealed that during the period of May 2013 to April 2014, the number of mentoring needs identified and documented by council supervisors were 78 in total. The number of mentoring visits conducted and documented was 50 in total. One council had records of six mentoring visits, but these were not counted because the records were not proper. The number of mentoring needs met and documented was 42, of which one of the councils accounts for 97.5%. Therefore, the increase of the execution rate needs to be looked at with caution. Nonetheless, it should be noted that nine out of 14 councils have started to identify and document mentoring needs. It is also worth noting that during the period of May to July 2014, four other councils dispatched mentors and the reports were retrievable. The execution rate of mentoring visits in response to the needs identified was increased from 0% to 53.8% (42/78) as compared to the target of 25% (which is 215% of the target) of all needs identified and documented by regional supervisors in the past one year.

Overall Assessments of Output 4

- Activities under Output 4 were designed to strengthen the CSS&M for HIV/AIDS services in the model regions, aiming to create a model CSS&M for HIV/AIDS services in the model regions. The focus of Output 4 is to strengthen the managerial foundation of CSS&M among RHMTs and CHMTs in the model regions. Using the training materials developed under Output 3, a number of trainings were conducted to facilitate the full execution of CSS&M in the model regions.
- The members of RHMTs and CHMTs in the model regions highly appreciated the trainings, orientation and reorientation for CSS&M which substantially improved their managerial capacities for CSS&M for HIV/AIDS services in the model regions.
- The project demonstrated that training alone cannot be effective enough for trainees to adopt and initiate a new desired practice. Follow-up activities such as assessment, sharing findings with stakeholders, action plan development for improvement, monitoring of the implementation of the action plan and reassessment are requisite set of activities for the adoption or initiation to happen.
- The activities of Output 4 are delayed due to the delay of activities under Output 3, particularly the development of training materials.
- **The progress and achievement level of Output 4 is satisfactory.**

The achievement level of **Output 5** is shown below.

Output 5:	Synergetic effect between M&E system and CSS&M is enhanced.
Objectively Verifiable Indicators	Achievement Level
5-1 Data feedback during supervision in the model regions will be conducted at least once a year by 2 RHMTs and 7 CHMTs.	• Data feedback during supervision in the model regions is conducted at least once a year by 2 RHMT and 8 CHMTs. • **100% for RHMTs Achieved.** • **More than 100% for CHMTs Achieved (8 CHMTs/target 7 CHMTs among 13 CHMTs).**

The progress and overall assessments of **Output 5** are shown below.

Progress for Indicator 5-1

- The Baseline Survey revealed the implementation rate of data feedback using essential indicators during supervision for HIV/AIDS services in the model regions was 0%.
- The project organized M&E review meetings to share good practices of data feedback through supervision for HIV/AIDS services in February – March 2013 and March 2014.
- The End Line Survey revealed that the data feedback during supervision in the model regions is conducted at least once a year by one RHMT as compared to the target of two RHMTs (50% of the target) and eight CHMTs as compared to the targeted seven CHMTs (114% of the target).

Overall Assessments of Output 5

- Activities under Output 5 were designed to focus on a synergy effect between M&E and CSS&M for HIV/AIDS services through facilitation of sharing good practices.
- The members of RHMTs and CHMTs in the model regions reported that they became familiar with the HIV/AIDS Scorecard Indicators for HIV/AIDS services, data feedback and data utilization.
- The members of RHMTs and CHMTs in the model regions reported that they are using HIV/AIDS Scorecard Indicators during CSS and started data feedback.
- The members of CHMTs in the model regions reported that they use figures and charts prepared in the Microsoft Excel to facilitate the discussion with the health personnel during supervision at the HFs covering HIV/AIDS services in the model regions.
- The members of RHMTs and CHMTs in the model regions reported that their capacities for data feedback and data utilization are significantly improved due to the Project activities.
- **The progress and achievement level of Output 5 is satisfactory.**

3-3 Prospect for Achieving the Project Purpose

The prospect for achieving the **Project Purpose** is shown below.

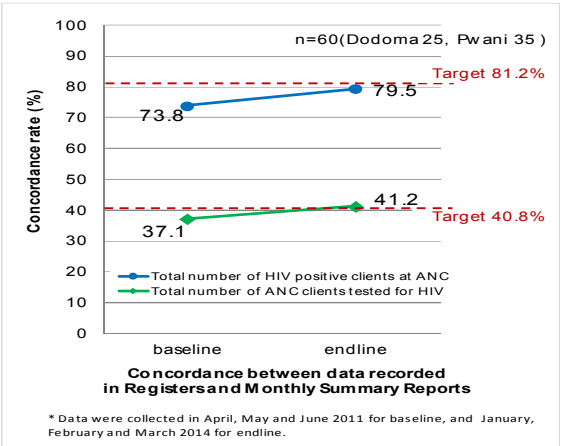
Project Purpose:	CSS&M and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up*[1].
Objectively Verifiable Indicators	Achievement Level
1 Concordance rates of the two indicators*[2] will increase by 10% in the model regions.	• Concordance rate of Indicator 1 (Total number of Ante Natal Care (ANC) clients tested for HIV) is increased by 11% and for Indictor 2 (Total number of HIV positive clients at ANC) is increased by 7.6% from the baseline survey in the model regions. • **50% Achieved (One of the two indicators has been achieved).**
2 2 RHMTs and 13 CHMTs in the model regions will be oriented on the M&E system developed by the Project.	• 2 RHMTs and 13 CHMTs in the model regions are oriented on the M&E system developed by the Project. • **100% Achieved.**
3 100% of RHMTs will be implementing CSS&M on HIV/AIDS services with the tools approved by MOHSW in the model regions*[3].	• 50% of RHMTs are implementing CSS&M on HIV/AIDS services with the tools approved by MOHSW in the model regions. • **50% Achieved.**

*1 The Project focuses on the modeling exercise for effective M&E and CSS&M in two model regions during the Project period. Expansion of the approved activities to other regions apart from the model regions will be done with the initiative of the MOHSW/NACP in collaboration with implementing partners.

*2 Rate of concordance between the numbers in the register and the monthly summary report on the following two indicators: 1) Total number of ANC clients tested for HIV, 2) Total number of HIV positive clients at ANC.

*3 Proportion of RHMTs responding that they implemented CSS&M in the last one year with the following criteria met: 1) RHMTs conducted SS to all HIV/AIDS services available at the regional hospital during the year using the CSS Tool approved by MOHSW; 2) RHMTs conducted SS to all CHMTs under their jurisdiction on HIV/AIDS component in the same year using the CSS Tool; and 3) RHMTs dispatched at least one experienced practitioner of a specific HIV/AIDS service as a mentor to a lower HF whereby the Mentoring Tool approved by MOHSW was utilized in the same year.

* 4 Improvement of data concordance is shown in the figure.



The progress and overall assessments for achieving the **Project Purpose** are shown below.

Progress for Indicator 1

- The indicator 1 of the Project purpose is set based on the hypothesis that the rate of concordance between the data in the register and the monthly summary report on the following two indicators: 1) total number of ANC clients tested for HIV and 2) total number of HIV positive clients at ANC will increase if the importance of data is understood and the sense of ownership is increased among the health care providers at the HFs covering HIV/AIDS services in the model regions, however, the Project does not have direct interventions to that level.
- The concordance rates of the above-mentioned two indicators were calculated by investigating data between the registers and the summary reports.
- The Baseline Survey revealed the concordance rate of ANC clients tested for HIV is 37.1% and the rate of HIV positive clients at ANC is 73.8%.
- The End Line Survey revealed that the concordance rate of ANC clients tested for HIV is increased from 37.1% at the baseline survey to 41.2% as compared to the targeted 40.8% and the rate of HIV positive clients at ANC is increased from 73.8% at the baseline survey to 79.5% as compared to the targeted 81.2%.
- In further analysis of improvement of data concordance, the CHMTs with doing more data feedback to the health facilities have improved data accuracy (concordance) significantly rather than the CHMTs without doing data feedback in the table below (P=0,0026). **The Project positively impacted quality improvement of data management with feedback mechanism.**

Table. The association between data feedback and changes of concordance of Indicator 1 ACP Jan–Mar 2014

Total number of ANC clients tested for HIV	improve	no change	worsen		
	n= 43 (24.2%)	n= 98 (55.1%)	n= 37 (20.1%)	chi value	p value
Data Feedback					
≧ 2 times per year (n=85)	29 (16.3%)	45 (25.3%)	11 (6.2%)	11.9	0.0026 *
< 2 times per year (n=93)	14 (7.9%)	53 (29.8%)	26 (14.6%)		

* p < 0.05

Tests

N	DF	-LogLike	RSquare (U)
178	2	5.9490048	0.0335
Test	ChiSquare	Prob>ChiSq	
Likelihood Ratio	11.898	0.0026	
Pearson	11.631	0.003	

Progress for Indicator 2

- To calculate the indicator 2, the numerator is the number of regions oriented on the M&E system for health sector HIV/AIDS services developed by the Project and the denominator is the number of all regions (two regions).
- Two RHMTs and 13 CHMTs in the model regions are oriented on the M&E system developed by the Project.

Progress for Indicator 3

- The following criteria is set to calculate the proportion of RHMTs responding that they implemented CSS&M in the last one year:
  1) RHMTs conducted SS to all HIV/AIDS services available at the Regional Hospital during the year using the CSS tool approved by the MOHSW;
  2) RHMTs conducted SS to all CHMTs under their jurisdiction on HIV/AIDS component in the same year using the CSS tool; and
  3) RHMTs dispatched at least one experienced practitioner of a specific HIV/AIDS service as a mentor to a lower HF whereby the mentoring tool approved by the MOHSW was utilized in the same year.
- To calculate the indicator 3, the numerator is the number of RHMTs having implemented CSS&M in the past one year with the above-mentioned three criteria and the denominator is number of RHMTs in the model regions (two RHMTs in two model regions).
- The Baseline Survey revealed that none of RHMTs had started CSS&M on HIV/AIDS services in the model regions.

- During the period of May 2013 to April 2014, Dodoma RHMT conducted supervision to the Regional Hospital. All seven CHMTs in Dodoma region were supervised on HIV/AIDS services twice in the past one year although only three reports for three CHMTs were retrievable. Several mentors were dispatched to three districts. Summary reports for three mentors at two HFs for one district were retrievable. Pwani RHMT conducted supervision to the Regional (Tumbi) Hospital one with NACP team. Five out of seven CHMTs were supervised with NACP tool. Two reports for Kibaha district and Rufiji district were retrievable. Other vertical SS was conducted with a special focus on ART and PMTCT. However, NACP tool was not used. No mentors were dispatched.
- The End Line Survey revealed that 50% of RHMTs as compared to the targeted 100% of RHMTs are implementing CSS&M on HIV/AIDS services with the tools approved by MOHSW in the model regions.

Overall Assessments of Project Purpose

- The members of RHMTs and CHMTs confirmed that their capacities for CSS&M and data management for M&E systems on HIV/AIDS services significantly improved by the trainings and policy guidance provided by the NACP supported by the Project..
- Despite the high achievements of the Project Purpose, there are also competency gap among RHMTs and CHMTs identified by the Evaluation Team. NACP is expected to fill the capacity gap for all CHMTs in two Regions.
- **The progress and achievement level of Project purpose is satisfactory.**

3-4 Project Implementation Process

(1) Progress of Project Activities

The Project is carrying out several activities simultaneously for its five Outputs. The progress of some Project activities has shown serious delays, particularly for Output 3 and 4. The Project started in October 2010, but the analysis of results of Baseline Survey was completed in December 2012. The delay in development of training materials seriously delayed the CSS&M activities. The PDM has been revised five times since the beginning of the Project in October 2010. In November 2011, the Project received a Mission Team from JICA to review the PDM. A Project Cycle Management (PCM) Workshop was organized for analyzing problems, revising Outputs and prioritizing and selecting activities for the Project in a participatory manner and the PDM was thoroughly revised in December 2011 with new set of indicators agreed. The second major changes were made in December 2012 after completion of the baseline data analysis. A target for each indicator was set based on the baseline and agreed in the Joint Coordinating Meeting. The third major change was made immediately after the MTR by reflecting discussion and clarifying the interpretation of some indicators. Other changes were minor. There are three major reasons for frequent revision of the PDM. 1) The first PDM included M&E Outputs that were not realistic and caused significant delay of development of M&E framework, 2) Delay in setting up concrete indicators for CSS&M in the PDM caused the delay in implementation of baseline data collection, and 3) Prolonged process in development of CSS&M training package forced the project to modify the planned activities.

The Team acknowledged the significant progress of the project achievements just after the period of MTR. The implementation of the planned activities has been accelerated. The CSS have started to be implemented in combination with mentoring and the documentation and information sharing have been significantly improved at all levels. At the NACP, CSS reports submitted and national documents published have been archived in a web-based system, from which all staff can download documents. The previous supervision reports have started to be utilized for follow-up. Data management, especially data analysis and presentation by some CHMTs has become sophisticated to the international standards. These CHMTs were strongly encouraged to present their results in domestic and international conferences to share their good practices in data analysis and feedback linking to improvement of health services. All of these achievements are beyond imagination and the CHMTs feel privileged and became confident on their entire managerial activities.

The overall status of progress of Project activities is satisfactory.

(2) Monitoring and Reporting

The progress of Project activities is continuously monitored by the JCC. It is agreed in the R/D that the JCC will meet at least once a year and when the need arises. The 1st JCC Meeting was held on 9 March 2011, 2nd on 29 December 2011, 3rd on 11December 2012, 4th on 24 April 2013; and 5th is scheduled on 17 September 2014.

There have not been any significant obstacles in the management of the Project because the JCC has kept its function of monitoring and revising the PDM and Plan of Operation (PO) as need rose during the implementation of the Project.

The monitoring system of the Project is established and it is appropriate and effective.

(3) Communication among Project Team members, with and among Counterpart members and relevant Stakeholders

The communication among the Project Team members had no difficulties and all the experts met regularly to update their activities. However, administratively, the separation of workstation of expert team fall delay in building consensus among the Project members or with NACP and stakeholders.

The communication between the Project team and implementing RHMTs and CHMTs was excellent without any arguments. The counterpart members were well encouraged daily or weekly basis by training, recognition, coaching, visitation, even mobile phone and e-mail.

The communication between the Project Team and the NACP was mainly conducted through the Chief Advisor as daily basis and through individuals by face, mobile and e-mail basis. However, the NACP expected more smooth and timely communication with Japanese experts, especially for decision making on budget and implementation period.

The communication between the NACP and the MOHSW could be improved more effectively. The Mission identified that understanding of the project achievements by MOHSW could not reached at our expectation level and it is encouraged that the ownership of the project achievements should be entitled as the entire MOHSW's efforts.

Several other development partners, particularly I-TECH, TUNAJALI, CDC and GFATM are also involved in some of similar Project activities. The Project Team is sharing Project activities with counterparts and some of the relevant development partners to avoid the duplication of activities with other development partners in a harmonized manner. The Project Team presented the Project activities at different forums, such as the National Quality Improvement Forums organized yearly and other Domestic and International Conferences.

Some of the development partners well acknowledged the Project activities. However they are willing to know much more about the details of the project activities and orientations. NACP is primarily responsible to report the Project progress and achievements to the stakeholders to avoid the duplication of activities. On behalf of NACP, it is also suggested that the Project Team could present its achievements and products in the SWAp mechanism of "Development Partners Group for Health" and "Development Partners Group for AIDS" in Tanzania. It may be good idea that NACP and the Project Team might consider arranging a presentation in such meetings for sharing Project achievements and good practices before the completion of the Project in October 2014.

The communication overall is satisfactory however NACP could share the Project achievements with MOHSW.

(4) Ownership/Participation of Tanzania Side

NACP has established QI Unit in January 2012 to coordinate with other Units of NACP to implement the cross-units CSS&M activities. The establishment of QI Unit has enabled NACP to plan, budget, implement, and report on CSS&M activities to other Units of NACP.

The provision of office space in the Regional Hospital in Dodoma has contributed for the effective and efficient implementation of Project activities in Dodoma region.

Even though the counterpart personnel are facing difficulties to allocate sufficient time to Project activities, they have **strong ownership** toward the Project activities and recognize the significance of Project activities.

NACP has already scaled-up the CSS&M mechanism to almost all regions, except for four newly developed regions, in the country. However, data management for M&E systems experienced in two target regions needs to be articulated for the strategy scaling up to all the RHMTs.

The ownership/partnership of Tanzania side is at satisfactory level.

(5) Allocation of Counterparts

The allocation of counterparts was satisfactory. In NACP, the senior managers and technical officers fully engaged in the Project activities and working closely with Japanese Expert Team with **high teamwork spirits** by delegating authorities and responsibilities among team members. Some of the members of the RHMTs and CHMTs have reported that their day-to-day duties in their respective organizations limit their involvement in the Project activities. However, most of the counterpart members are willing to be involved in any project activities to develop their managerial competencies proactively.

(6) Response to the MTR Report

The Project well acknowledged the recommendations of the MTR Report, especially for accelerating the Project activities according to the PDM and PO and timely monitoring and reviewing the indicators of PDM. The Mission Team acknowledged the dramatic progress of most of the project activities in CSS&M and data management for M&E systems. However, NACP and the Project could prepare document for strategic exit and scaling up plans in consultations with stakeholders before the completion of the Project in October 2014. This document would help MOHSW and NACP to take further actions to sustain and expand project achievements and lessons learned.

5. Evaluation by Five Criteria

5-1 Relevance

Overall relevance is good according to the following reasons:

(1) Consistency with the National Health Sector Plans and Development Policies of Tanzania

The Project purpose "CSS&M and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up" and Overall Goal of the Project "Health system is strengthened through CSS&M and effective M&E system for health sector HIV/AIDS services" are still relevant with the following national health sector plans of the GOT.

The HSHSP III (2013-2017) states that the health systems should be strengthened in order to provide high-quality HIV/AIDS services. The Plan also emphasized on establishing a comprehensive M&E system for the health sector response to HIV/AIDS.

The HSSP III (2009-2015) provides health sector reforms to strengthen the health systems for service delivery in health sector. The plan is also emphasizing on the importance of strengthening various health systems, especially the M&E system in the health sector.

The Project purpose and Overall Goal of the Project are still in consistency with the following long-term development policies of the GOT and will contribute in the achievement of objectives of these policies.

The National Strategy for Growth and Reduction of Poverty II (NSGRP II or MKUKUTA II) adopted in July 2010 specifies the achievement of the Millennium Development Goals (MDGs), including set targets for HIV/AIDS, TB and Malaria, as one of the priority dimensions for achieving the sustainable economic and social development and poverty reduction in the country.

(2) Consistency with the Japanese Policy

The Project purpose and Overall Goal of the Project are still in consistency with the following Japanese policies.

In the Yokohama Action Plan adopted in the 4th Tokyo International Conference on African Development IV (TICAD IV) in Yokohama in Japan in May 2008 and G8 Hokkaido Toyako Summit Leaders Declaration adopted in 34th G8 Summit in Toyako in Northern Island of Hokkaido in Japan in July 2008, Japan has committed its cooperation to strengthen the health systems in African countries. Japan has also committed its cooperation for the prevention and control of infectious diseases, including HIV/AIDS, in Okinawa Infectious Diseases Initiative (IDI) in 2000.

The Project is a real example for a complementarity to implement the filed activities, especially HIV/AIDS program management, supported by Global Fund and other global initiatives, which are pledged by GOJ.
"Economic growth towards poverty reduction", "Infrastructure development sustaining

economic growth and poverty reduction", and "Improvement of public services to all citizens" are the three priority areas of the Country Assistance Policy for Tanzania (June 2012) of the Government of Japan (GOJ). Under the priority area of "Improvement of public services to all citizens", the Country Assistance Policy for Tanzania stated that Japan will assist in enhancing the administrative systems in health.

(3) Appropriateness of Selection of Target Groups and Consistency with the Needs of the Target Groups

The main target groups of the Project are the staff of NACP, national supervisors and mentors, members of RHMTs and CHMTs in two model regions. The strengthening of health systems for HIV/AIDS services is the main responsibility of NACP. The capacity building for the effective and efficient delivery of HIV/AIDS services is an urgent need for the staff of NACP, national supervisors and mentors, members of RHMTs and CHMTs in the model regions. Therefore, the selection of the target group is appropriate and the Project is still in consistency with the needs of the target group.

(4) Comparative Advantage of Technical Assistance Provided by the Japanese Side

JICA has implemented numerous projects for strengthening health systems for HIV/AIDS/STIs prevention and control throughout the world, including African countries, and has necessary technical competence and experience. JICA has also implemented a former project entitled "Project for Institutional Capacity Strengthening for HIV Prevention Focusing on STIs and VCT Services" from March 2006 to July 2010 in Tanzania. The Project was built on the outcomes and experience from the former project, and is focusing on enhancement of M&E system and CSS&M for HIV/AIDS Services in the model regions.

The Project aims to achieve its Project purpose "CSS&M and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up" by using advanced technical expertise and extensive experience of the Japanese Experts, organizing trainings/workshops/study tours for the counterpart personnel, and provision of necessary equipment and materials. Thus the cooperation by Japan is very relevant to support the capacity development of counterparts for strengthening health systems for HIV/AIDS services in the model regions.

5-2 Effectiveness

Overall effectiveness is good according to the following reasons:

The five Outputs of the Project are:
1) Essential indicators for routine monitoring of HIV/AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national M&E system through the initiative of the MOHSW; 2) M&E system in model regions is strengthened; 3) CSS&M at national level is strengthened; 4) CSS&M in model regions is strengthened; and 5) Synergetic effect between M&E system and CSS&M is enhanced. These outputs are contributing to achieve the Project purpose **"CSS&M and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up".**

The logical relationship of Outputs and the Project purpose is relevant. The Project has been

on track and the Project purpose is very likely to be achieved at the completion of the Project through the combination of activities of all five Outputs.

One of the contributing factors towards the achievement of all five Outputs and Project purpose appeared to be close working relationship among the stakeholders, including NACP, MOHSW, RHMTs, CHMTs, development partners and civil societies. Especially, the Project proactively engaged and enhanced the MOHSW Technical Working Groups under the SWAp mechanism. This strategic engagement enables the NACP to develop and endorse policy guidance and implementing tools officially.

The main hampering factor during the progress of implementation of the Project is the lack of human, financial, physical, and material resources of Tanzanian stakeholders especially in model Regions/Districts, which was the one of the important assumptions of the Project purpose and Outputs in the PDM. Some members of CHMTs in both model regions reported the success to budget their fuels and administrative costs for CSS&M and M&E systems, while some argued the shortage of vehicle and fuel to hamper for not conducting quarterly supportive supervision to the HFs under their jurisdiction. The managerial gap among CHMTs could be a challenge for their uniform implementations in the new administrative policy and guidance beyond the programmatic budgetary support.

5-3 Efficiency

Overall efficiency is good according to the following reasons:

The inputs are appropriately provided from both Japanese side and Tanzania side as planned and all inputs are fully utilized to generate the intended Outputs. The quality, quantity, and timing of inputs are appropriate.

Project activities are well received by the counterpart personnel. Several kinds of trainings/workshops/study tours for counterpart personnel during the implementation of the Project are welcomed by the participants.

The Training on Data Analysis was also welcomed by the participants. Most participants are satisfied with the duration of the training, methodology of the training, and skills and expertise of the trainers from the Computing Center of University of Dar es Salaam. Most participants reported that the Training not only enhanced their capacity for data analysis, but also for data feedback and data utilization. After the training they are now able to utilize the data in analyzing the problems for the delivery and decision-making to improve HIV/AIDS services at their HFs, using the data for preparing their presentation to the community leaders and political leaders to explain the current HIV/AIDS situation in their areas as well as using data for preparing their presentation for regional, national and international forums and conferences. Some members of CHMTs and RHMTs succeeded to present their presentations at domestic and international relevant forums and conferences, which were never happened in the past.

The training for CSS&M for HIV/AIDS services is also appreciated by almost all participants. Most participants are satisfied with the duration of and methodology for the training, and skills and expertise of the trainers who were experienced supervisors and mentors invited from throughout the country. Most participants reported that the training for CSS&M for HIV/AIDS services significantly improved their capacity to conduct the supportive

supervision and mentoring.

The Head of QI Unit of NACP and District AIDS Control Coordinator of CHMT of Dodoma MC attended training in Japan at the JICA Okinawa, and District Medical Office of CHMT of Mafia attended training at the JICA Sapporo. All three participants appreciated these trainings in Japan and reported that these trainings significantly improved their capacities for conducting their jobs.

Six staff from NACP and RHMTs in the model regions attended the Study Tour to Zimbabwe from 6 – 12 July 2014, to improve their operation of supportive supervision and mentoring. The participants reported that they learnt a lot for improving operations of supportive supervision and mentoring and would like to adopt the good practices of Zimbabwe in Tanzania. Zimbabwe established the HIV/AIDS Trust Fund in which the Government of Zimbabwe allocates resources from the domestic revenues (tax revenue on luxury goods, etc.). The establishment of this trust fund in Zimbabwe reduced the dependency on external financial resources from the development partners. The participants of Study Tour were very impressed by this trust fund and strongly desired to have the same HIV/AIDS trust fund in Tanzania. The Deputy Program Manager of NACP and Head of QI Unit of NACP reported that the GOT is working to establish the HIV/AIDS trust fund and it is expected that the HIV/AIDS trust fund will be established soon in Tanzania.

Project activities are well received and enhanced by the counterpart personnel. However, the counterpart personnel sometimes faced difficulties in attending all proposed Project activities due to their engagement in their routine and programmatic assignments in their respective organizations.

5-4 Impact

Overall impact is positive according to the following reasons:

Through the various Project activities, it can be said that the so far impact on the Overall Goal of the Project is positive.

Referring to the important assumptions in the PDM, one of the key assumptions for the Project purpose is the proper allocation of human, financial, and physical resources at all levels. However, it was reported that those resources from the GOT for the strengthening of health systems for HIV/AIDS services face challenges to impact more on the Overall Goal of the Project after the completion of the Project.

Several other development partners, particularly CDC and GFATM, are also involved in some of similar Project activities and it is expected that the other development partners will continue to provide required human, financial, and physical resources for the strengthening of M&E managerial systems for HIV/AIDS services in Tanzania.

Service quality of HIV/AIDS program has been drastically improved since the overall competencies of program administration of RHMTs and CHMTs has been enhanced by the Project and NACP. More and more people come to test HIV status and compliance of ARV becomes better and better as years go by.

Uniquely, one of the members of Parliament was so impressed by the scientific presentation

of the CHMT Bahi, which is his home council, in the 17th ICASA in Cape Town, South Africa. This coincidence inspired the MP to enthusiastically support events (including financial support) for health promotion such as health forum for youth.

There is another story. The CHMT Dodoma Municipal presented their study and practice in the 20th IAC held in Melbourne, Australia. The presentations were highly appreciated by many participants from other countries in the conference. The District Executive Director, who was reported this fact, was convinced to fully support and expand Men's Health Day events in the council. The project also contributed to development of mentoring guidelines for RCH services, which could be stated as a spillover effect.

The Mbeya Referral Hospital requested the NACP to conduct CSS&M training in May 2014 to establish 4 mentoring teams at the hospital to be dispatched to Mbeya, Ruvuma, Rukwa and Katavi regions in response to needs reported by regions. This was a good initiative and will be a good model of mentoring at Zonal level. The initiative was shared in a national stakeholders meeting in which representatives from other national and zonal hospitals (MNH, the BHC and the KCMC) were participating. They are encouraged to do the same. The training was also requested by Zanzibar government as well for them to establish the same system.

No unexpected negative impact has been reported.

5-5 Sustainability

The Project completion is approaching and there is urgent need for NACP with consultation to the Project to consider the Project exit and scaling-up strategies according to the following reasons:

1. Policy Aspects

The strengthening of health systems for high-quality HIV/AIDS Services and establishing a comprehensive M&E system for health sector response to HIV/AIDS are the major priorities guided by the HSHSP III (2013-2017). The HSSP III (2009-2015) is also emphasizing on strengthening various health systems, especially the M&E system in the health sector. Operationalization of supportive supervision and mentoring at all levels in line with the NACP Manual is included as a strategy for quality improvement of HIV/AIDS services and capacity building of health service providers at all levels on data analysis, interpretation and evidence-based planning is for data demand and information use in the new strategy HSHSP III (2013-2017). The Project has supported implementation of the HSHSP II and III and the HSSP III, and devotes its continuing effort to incorporate the Project achievements into NSGRP II (2010). It is expected that the strategies and policies for strengthening health systems for HIV/AIDS services of the GOT will remain favorable for the Project effects to be sustained after the completion of the Project.

CSS&M for HIV/AIDS services could be continued by the QI Unit of NACP, which has been established under NACP in January 2012 to coordinate with other Units of NACP to implement the cross-units CSS&M activities. It is expected that the QI Unit of NACP will further play an important role to coordinate with other Units of NACP to provide quality HIV/AIDS services not only in the model regions, but also in the whole country. Same can be said for strengthening M&E system as M&E activities could be continued by the

Epidemiology Unit of NACP. It is expected that the Epidemiology Unit of NACP will further play an important role to coordinate with other Units of NACP to provide quality M&E system for HIV/AIDS services not only in the model regions, but also in the whole country. Furthermore, MOHSW is strongly expected, in close collaboration with NACP, to nurture the achievements from the Project and utilize in the health services in other several areas than HIV/AIDS.

2. Organizational Aspects

The roles and responsibilities of counterparts for the Project implementation were clearly defined and shared among the concerned organizations. The staff of counterparts reported that their institutional capacity for the M&E system and CSS&M for HIV/AIDS services has been drastically strengthened by the Project activities. The Project also fostered the relationship between NACP, RHMTs and CHMTs in the model regions. It is expected that the counterparts could pursue relevant activities to keep Project effects after the completion of the Project.

3. Financial Aspects

In order to keep continuing the Project activities after the completion of the Project, NACP has to make serious efforts to secure proper funding from the MOHSW. Therefore, financial aspects are a matter of concerns for the sustainability of Project effects after the Project.

Several other development partners, particularly CDC, are also involved in some of similar Project activities (strengthening of RHMT in Pwani region) and it is expected that the other development partners will continue to provide required human, financial, and physical resources for the strengthening of health systems for HIV/AIDS services in Tanzania. It is expected that most of activities related to CSS&M will be continued with the financial assistance of other development partners as other development partners are already providing financial assistance for CSS&M related activities in other regions. Two of the RHMTs and most of the CHMTs in the model regions have incorporated the budget for supervision and mentoring covering HIV and AIDS services in their CCHP for 2014/15. However, the interest of development partners in prevention and control of HIV/AIDS in Tanzania is declining as SIDA and DANIDA have terminated HIV/AIDS prevention and control activities in Tanzania. DFATD (former CIDA) is terminating its activities in 2016 and CDC has no concrete future planning after 2016.

In addition, the GOT is considering establishment of HIV/AIDS Trust Fund in which the GOT will allocate resources from the domestic revenues (tax revenue on luxury goods, etc.). It is expected that the establishment of this Trust Fund will reduce dependency on external financial resources, particularly from the development partners. If the GOT could establish this Trust Fund, it would be a great step to pursue the sustainable HIV/AIDS services and of course for the sustainability of Project effects after the Project.

4. Technical Aspects

To ensure the technical sustainability of the Project, it would be necessary for domestic resources to continue the technical assistance, particularly implementation of trainings, provided by the Project for the staff of counterparts.

The counterparts have deepened their understanding for the Outputs and Project purpose through various Project activities. Most of staff of the counterparts expressed that the technical transfer has been conducted very effectively and efficiently through various Project activities.

It is worth noting that the Dodoma RHMT has initiated a meeting to share good data utilization practices among all stakeholders including implementing partners and an academic institution that is a potential TA partner. Encouraging and strengthening this kind of local initiative and collaboration could be one of the ways for sustainability.

However, it is urgently demanded that the NACP and MOHSW could elaborate strategic direction for technical backstopping to enhance quality managerial capacities in RHMTs and CHMTs proactively.

6. Conclusion

Overall Project performance is GOOD according to the five criteria of Relevance, Effectiveness, Efficiency, Impact, and Sustainability.

(1) Relevance: Good

The Project is still in consistency with the National Health Sector Plans and Development Policies of the GOT, the Japan's Country Assistance Policy for Tanzania, and with the needs of the target groups.

The selection of target groups is appropriate, project approach is adequate, and cooperation by Japan is relevant.

(2) Effectiveness: Good

The Project purpose is likely to be achieved at the completion of the Project in October 2014.

(3) Efficiency: Good

Timing, quantity, and quality of inputs are appropriate and all inputs are fully utilized to generate intended Outputs.

(4) Impact: Positive

So far impact on the Overall Goal of the Project is positive.
No unexpected negative impact has been reported.

(5) Sustainability: Expected

The sustainability of the Project is expected to be assured in terms of policy, organizational, financial, and technical aspects, IF appropriate human, financial, physical and material resources from the counterparts could be attained to continue the Project effects after the completion of the Project.

Based on review of relevant documents of the Project, such as Minutes of Meetings (M/M), Detailed Design Report, R/D, PDM, PO, MTR Report, Project Progress Reports, etc.; questionnaire to relevant stakeholders; a series of meetings and discussions with counterparts, other development partners, and Japanese Experts; site visits as well as results of discussion among members of Evaluation Team, the Team concluded that the so far Project performance is satisfactory.

Evaluation Team confirmed that the Project successfully positioned its role in the efforts for strengthening health systems for HIV/AIDS services, while several other development partners have been providing financial and technical support for the HIV/AIDS services in Tanzania.

Thus, it is encouraged that the counterparts, particularly NACP, have to review the Project achievements and to elaborate future strategies to sustain the Project impact in a self-reliant manner.

6. Recommendations and Lessons Learned

6-1 Recommendations

To NACP and the Project Team

(1) The Project achievement on **effective M&E framework and implementation mechanism** including data management and supportive supervision and mentoring is vital to enhance governance of health systems and to be accountable for all managerial practices. NACP and the Project Team are expected to influence these achievements to other programmatic areas such as TB, malaria, reproductive health and immunization as cross-cutting issues.

(2) It is observed that there are **more and better managerial practices** at the CHMTs and RHMTs levels and, therefore, it is strongly recommended to document and share these good practices not only with NACP, but also with the MOHSW, PMORALG and other relevant development partners.

(3) The members of CHMTs and RHMTs in the model regions, staff of NACP and MOHSW, representatives of development partners highly appreciated the "Training on Data Analysis", CSS&M training, and several products, such as the CSS&M Manual and Tools and training package and, therefore, it is strongly recommended to advise NACP with consultation to the Project to consider **regular updating mechanism and implementation of refresher trainings** in light of new gained experiences as well as in light of development of new policies and approaches.

(4) To enhance sustainability and scaling out of the project achievements, it may be a good idea to consider arranging **individual dialogue or group meetings** with all relevant departments of MOHSW and development partners for sharing Project achievements and good practices to articulate financial, physical and technical sustainability. Towards the end of the Project period, NACP with the Project should host a dissemination forum to share experiences, achievements and lessons learned and demonstrate managerial guidelines, manuals and tools with other departments and programs in MOHSW and relevant stakeholders.

(5) It is recommendable that NACP in conjunction with the Project could draw **the exit and scaling up strategies** for the project achievements and lessons to influence the counterparts and stakeholders to understand clear roadmap for capacity development in strengthening health systems.

To CHMTs and RHMTs in the Model Regions

(1) Promote **regular horizontal learning mechanism between and among RHMTs and CHMTs and CHMTs to HFs** in the model regions as well as in other regions for sharing knowledge and skills obtained through the Project activities and good practices, such as data analysis, data feedback and data utilization and documentation of SS reports even after the completion of the Project.

(2) After the completion of the Project, the RHMT/CHMT is highly encouraged to establish effective and efficient **consultative mechanisms** with MOHSW/NACP and

other relevant development partners to consider operationalizing the M&E system and CSS&M for HIV/AIDS services at a nationwide scale.

(3) **Document and publish the good practices** cherished by the Project activities to international conference and other opportunities to draw attention and interest from potential partners.

To MOHSW

(1) MOHSW with consultation to NACP should enhance training needs for M&E management into **institutional arrangement for pre-service modules and in-service training courses** for further managerial integrations and innovations. The Project has already capacitated managerial training programs at several potential institutions such as University Computing Center, University of Dodoma and other Zonal Health Resource Centers.

(2) After the completion of the Project, the MOHSW is encouraged to review **the internal roles and responsibilities** with NACP for essential functions and operation procedures for M&E system and CSS&M for HIV/AIDS services under the auspices of revision of organigram to implement HSSP III in order to build more accountable and effective health systems in Tanzania.

(3) MOHSW/NACP is positioned in the **leadership role for strengthening health systems** for HIV/AIDS services nationwide that will surely contribute for the social and economic development of Tanzania. The Project is just a catalyst to foster the country ownership with technical and financial assistance from JICA for strengthening the health systems for HIV/AIDS services in two model regions. While JICA supported the country for a long period for strengthening health systems for HIV/AIDS services, it is right time for MOHSW/NACP, PMO-RALG and other concerned authorities/health facilities to further strengthen health systems for HIV/AIDS services at their own resources for providing better HIV/AIDS services to the people who are suffering most.

To JICA

(1) JICA could enhance project achievements and lessons into **future formulation and implementation of new health sector support program**, especially paying attention to supervision mechanism with mentoring support and data management with epidemiological knowledge (EKIGAKU) to enhance effective M&E systems under the Information and Accountability Framework for strengthening heath systems in Tanzania.

6-2 Lessons Learned

(1). The Project showed that the **governance mechanism for information and accountability framework** can be realized and strengthened by **overall M&E systems in a harmonization between data management and supportive supervision.** The progress of HIV/AIDS services becomes more evident and accountable to the public. Introduction of scorecard indicators and mentoring support to enhance effective programmatic management can be duplicated to other programmatic areas such as TB, malaria, reproductive health and immunization to strengthen governance mechanism of entire health systems.

(2). The Project demonstrated to foster **critical thinking among health managers** during supervision by equipping EKIGAKU skills on data analysis, interpretation and utilization to improve health service management. Once the health managers develops strong desire to understand facing challenges profoundly, supervision mechanism mobilizes human network to tackle specific issues and link with appropriate health interventions. This is a real synergy between supervision and data management in the M&E systems, while it might not happen in top-down approach, which can hinder self-thinking process and critical conscious.

(3). The Project could leverage effective health management **with major differences by minor innovations** in the field. The Project introduced epidemiological skills on data management (EKIGAKU) to members of RHMTs and CHMTs to enhance competencies on evidence-based health planning and quality management both on administrative and on clinical aspects. However managerial training alone cannot be effective to make difference for desired practices. Follow-up activities such as OJT, assessment, feedback to stakeholders, action plan development for improvement, monitoring of the implementation of the action plan are requisite set of activities to initiate transformation.

(4). The Project utilized **the coordination mechanism such as Technical Working Groups and relevant harmonization mechanisms** effectively to develop policy and guidelines of managerial tools introduced by the Project and exercised by the field managers. Any other projects had better to enhance the SWAp arrangement for their health policy management and to influence effective scaling up beyond the project scope of work.

(5). To avoid frequent revisions of PDM, the Detailed Design (D/D) of the Project formulation should develop **realistic implementing scenario and setting achievable indicators** under the full consensus and mutual agreement with the counterpart organizations. Addition to that, it is always favorable that Baseline Survey should be conducted at the initial stage of the project, which could facilitate amendments of project design as early as possible.

Annexes

Annex 1: Schedule of the Terminal Evaluation

Date/ Day	Time	Dr. BUBEDA	Dr. SUGISHITA	Ms. SHIRIMA	Mr. AMATSU	Mr. ABE	Dr. KHAN	Item/ Itinerary	Place of Stay
31 Aug. 2014 (Sun.)	13:20						X	• Arrival at Dar Es Salaam by QR 1347	
1 Sep. 2014 (Mon.)	08:10 – 09:10			X		X	X	• Meeting with JICA Tanzania Office	
	10:00 – 11:00	X		X		X	X	• Meeting of Evaluation Team	
	14:00 – 16:30						X	• Meeting with the Japanese Experts	
2 Sep. 2014 (Tue.)	08:15 – 08:30	X		X		X	X	• Courtesy visit to MOHSW	
	08:40 – 09:40	X					X	• Meeting with National Coordinator PMTCT, Reproductive Child Health (RCH) Section, MOHSW	
	09:50 – 10:50	X					X	• Meeting with Acting Assistant Director, Health Services Inspectorate and Quality Assurance Section, MOHSW	
	15:45 – 16:30	X					X	• Meeting with UNAIDS	
	17:00 – 17:45						X	• Meeting with Chief Advisor of JICA's Human Resources for Health Development Project	
3 Sep. 2014 (Wed.)	10:30 – 12:00	X					X	• Meeting with I-TECH	
	14:45 – 15:45	X					X	• Meeting with TUNAJALI	
	16:45 – 17:45						X	• Meeting with Experts of JICA's Regional Health Management Project Phase 2	
4 Sep. 2014 (Thu.)	07:00 – 08:30	X		X			X	• Travel from Dar Es Salaam to Dodoma	Dodoma
	08:45 – 10:30	X		X			X	• Travel from Dodoma to Kongwa	
	10:30 – 12:00	X		X			X	• Focus Group Discussion with CHMT of Kongwa District and Observations	
5 Sep. 2014 (Fri)	08:00 – 09:30	X		X			X	• Focus Group Discussion with RHMT of Dodoma and Observations	
	09:45 – 10:45	X		X			X	• Focus Group Discussion with Regional Referral Hospital Management Team (RRHMT) of Dodoma and Observations	
	13:00 – 14:00	X		X			X	• Focus Group Discussion with CHMT of Dodoma MC and Observations	
6 Sep.	09:30 – 11:00	X		X			X	• Departure from Dodoma to Dar Es Salaam	

Date/ Day	Time	Dr. BUBEDA	Dr. SUGISHITA	Ms. SHIRIMA	Mr. AMATSU	Mr. ABE	Dr. KHAN	Item/ Itinerary	Place of Stay
2014 (Sat.)	12:30 – 14:00	X		X			X	• Meeting with Head of QI Unit of NACP	Dar Es Salaam
7 Sep. 2014 (Sun.)								• Preparation of Joint Report of Terminal Evaluation	
8 Sep. 2014 (Mon.)	09:00 – 10:00	X					X	• Meeting with MOHSW	
	11:00 – 12:00	X					X	• Meeting with CDC	
9 Sep. 2014 (Tue.)	09:00 – 09:30						X	• Meeting with GIZ	
	10:40 – 11:50			X		X	X	• Travel from Dar Es Salaam to Mkuranga	
	12:10 – 13:10			X		X	X	• Meeting with CHMT of Mkuranga District and Observations	
	13:30 – 15:00			X		X	X	• Travel from Mkuranga to Dar Es Salaam	
	15:15		X					• Arrival at Dar Es Salaam by EK 725	
10 Sep. 2014 (Wed.)	08:00 – 08:45		X			X	X	• Meeting of Evaluation Team at JICA Tanzania Office	
	08:45 – 10:30		X			X	X	• Meeting with the Chief Advisor of the Project	
	11:10 – 12:30	X	X	X		X	X	• Meeting with USAID	
11 Sep. 2014 (Thu.)	06:30 – 08:20	X	X	X		X	X	• Travel from Dar Es Salaam to Kibaha	
	08:30 – 10:00	X	X	X		X	X	• Focus Group Discussion with RHMT of Pwani and Observations	
	10:00 – 10:30	X	X	X		X	X	• Travel from Kibaha to Mlandizi	
	11:00 – 12:10	X	X	X		X	X	• Focus Group Discussion with CHMT of Kibaha and Observations	
	12:10 – 13:45							• Travel from Mlandizi to Dar Es Salaam	
12 Sep. 2014 (Fri.)	06:30 – 08:30	X	X	X		X	X	• Travel from Dar Es Salaam to Bagamoyo	
	08:45 – 09:35	X	X	X		X	X	• Meeting with Deputy Program Manager of NACP	
	09:40 – 10:10	X	X	X		X	X	• Meeting with Head of M&E Unit of NACP	
	10:35 – 11:05							• Meeting with WHO	
	13:30 – 15:00							• Travel from Bagamoyo to Dar Es Salaam	
13 Sep. 2014 (Sat.)								• Preparation of Joint Report of Terminal Evaluation	

Date/ Day	Time	Dr. BUBEDA	Dr. SUGISHITA	Ms. SHIRIMA	Mr. AMATSU	Mr. ABE	Dr. KHAN	Item/ Itinerary	Place of Stay
14 Sep. 2014 (Sun.)								• Preparation of Joint Report of Terminal Evaluation	
15 Sep. 2014 (Mon.)	07:30 – 07:45		X			X	X	• Meeting of Evaluation Team at JICA Tanzania Office	
	08:00 – 09:00	X	X	X		X	X	• Meeting with MOHSW	
	09:00 – 10:00	X	X	X		X	X	• Meeting of Evaluation Team at MOHSW	
16 Sep. 2014 (Tue.)	08:30 – 10:00	X	X					• Debriefing of Joint Report of Terminal Evaluation to NACP	
	10:00 – 12:00							• Debriefing of Joint Report of Terminal Evaluation to the Country Representative of JICA Tanzania Office	
	15:00 – 17:00		X			X	X	• Finalization of Joint Report of Terminal Evaluation	
17 Sep. 2014 (Wed.)	08:30 – 12:30	X	X	X		X	X	• JCC Meeting	
18 Sep. 2014 (Thu.)	16:45		X					• Departure from Dar Es Salaam to Tokyo by EK 726	
19 Sep. 2014 (Fri.)	14:00 – 15:00			X	X	X	X	• Report from Evaluation Analyst to JICA Tanzania Office	
20 Sep. 2014 (Sat.)	18:20						X	• Departure from Dar Es Salaam to Osaka by QR 1348	

Annex 2: List of Persons Interviewed

Date/ Day/ Time	Name	Position	Organization
2 Sep. 2014/ Tuesday/ 08:40 – 09:40	Dr. M.D. Kajoka	National Coordinator, PMTCT, RCH Section	MOHSW
09:50 – 10:50	Dr. Eliudi Eliakimu	Acting Assistant Director, Health Services Inspectorate and Quality Assurance Section	
15:45 – 16:30	Mr. Emmanuel Baingana	SI Advisor	UNAIDS
	Mr. Fredrick Macha	National Program Officer	
17:00 – 17:45	Mr. Hisahiro ISHIJIMA	Chief Advisor, JICA's Human Resources for Health Development Project	JICA
3 Sep. 2014/ Wednesday/ 11:00 – 12:00	Dr. Fatma Kabole	Country Director	I-TECH
	Dr. Flavian Magari	Expert (Retired)	
	Ms. Hilda Missano	Institutional Capacity Building, Project Lead	
	Ms. Violet Rugangila	HTC Project Lead	
14:45 – 15:45	Dr. Joseph Ngweshemi	Director of Field Operations	TUNAJALI
	Dr. Anthony M. Leonard	Senior Technical Officer Care & Treatment	
	Dr. Erema Sambua	Regional Program Manager	
16:45 – 17:45	Ms. Natsue MIYATA	Capacity Development Specialist JICA's Regional Health Management Project Phase 2	JICA
	Mr. Masaaki HAMADA	Coordinator/Training Planning Specialist JICA's Regional Health Management Project Phase 2	
4 Sep. 2014/ Thursday/ 10:30 – 12:00	Dr. Didad Malale	District AIDS Control Coordinator (DAAC) and Member of CHMT of Kongwa District	Kongwa District Hospital
5 Sep. 2014/ Friday/ 08:00 – 09:30	Dr. Jacob Chemibele	Regional Dental Officer	RHMT of Dodoma
	Dr. Mohammad Iyuliu	Regional AIDS Control Coordinator	
	Dr. Zainab Chaula	Physician	
	Dr. Ezekiel Mpwja	Regional Medical Officer	
	Mr. Raphael Mlumba	Regional Laboratory Technician	
	Mr. Gerald Manesseh	Environmental Health Officer	
	Mr. Ally Nyanze	Regional Vector Control Officer	
	Ms. Mary Kongola	Regional Home-Based Care Coordinator	
	Ms. Alphancina M. Mahano	Regional Mental Health Coordinator	
	Ms. Margreth T. Kiyabo	Zonal Reproductive & Child Health Coordinator	

Date/ Day/ Time	Name	Position	Organization
	Ms. Mwanaharusi Kabika	Regional Health Management Information System Coordinator	
	Ms. Mwanaisha Hajjan	Regional Health Secretary	
	Ms. Jane Nillo	Regional Health Promotion and Systems Strengthening	
09:45 – 10:45	Dr. Zainab Chaula	Physician	RRHMT of Dodoma
13:00 – 14:00	Dr. Festo R. Mapunda	Acting Municipal Officer of Health	CHMT of Dodoma MC
	Dr. Nahumo Nassari	District AIDS Control Coordinator	
6 Sep. 2014/ Saturday/ 12:30 – 14:00	Dr. Patrick Mwidunda	Head of QI Unit of NACP	NACP
8 Sep. 2014/ Monday/ 09:00 – 10:00	Mr. Claud John Kumalija	Acting Assistant Director for M&E	MOHSW
11:00 – 12:00	Dr. Michalle Roland	Country Director	CDC
	Dr. Sajida Kimambo	Deputy Branch Chief, Care and Treatment	
	Mr. Sri Perera	HIS Advisor	
	Ms. Angela Makot	Chief of Human Institutional Capacity Building Branch	
9 Sep. 2014/ Tuesday/ 09:00 – 09:30	Dr. Christian Pfleiderer	Deutsche Gesellschaft fur Internationale Zusammenarbeit (GIZ) Health Program, Social Health Protection	GIZ
12:10 – 13:10	Dr. Joseph Mganga	District AIDS Control Coordinator	CHMT of Mkuranga
10 Sep. 2014/ Wednesday/ 11:10 – 12:30	Ms. Susna De	HSS Team Lead	USAID
	Ms. Shannon Young	HRH Advisor	
	Ms. Jacqueline Kalimunda		
11 Sep. 2014/ Thursday/ 08:30 – 10:00	Dr. Aden Mpangue	Acting RMO	RHMT of Pwani
	Dr. Romilus Kahwili	RDO	
	Mr. Simon P. Malulu	RHO	
	Mr. William Nelson	Regional AIDS Control Coordinator	
	Mr. Ally Bakari	Data Clerk	
	Ms. Grace Chuwa	RRCHCO	
	Ms. Jehovaness John Mollel	RMEO/RNOO	
11:00 – 12:10	Dr. Simon Malcomera	District AIDS Control Coordinator	CHMT of Kibaha
	Mr. Japhal E. Mwamafupa	DHMIS & M&E	
	Mr. Bonza Mshana	Acting DMO	
	Ms. Maria Kahema	DRCHCO	

Date/ Day/ Time	Name	Position	Organization
12 Sep. 2014/ Friday/ 08:45 – 09:35	Dr. Robert Josiah	Deputy Program Manager, NACP	NACP
09:40 – 10:10	Dr. Bonita Kilama	Acting Head of Epidemiology Unit of NACP	
10:35 – 11:05	Dr. Richard Bamla	Medical Officer HIV/AIDS	WHO
15 Sep. 2014/ Monday/ 08:00 – 09:00	Dr. Donan W. Mmbando	Chief Medical Officer, MOHSW	MOHSW
16 Sep. 2014/ Tuesday/	Debriefing to NACP	NACP Experts and Counterparts	NACP
08:30 – 10:00 **11:00-15:00** **17:00-18:00**	Finalizing Report Debriefing to JICA CR	Evaluation members Chief Representative	JICA JICA
17 Sep. 2014/ Wednesday/ 08:30 – 12:30 PM	JCC Meeting Consultant Follow-up Survey	JCC members Dr. Khan	CEEM
18 Sep. 2014/ Thur.AM 16:45	Consultant Follow-up Survey Dr. Sugishita's Departure	Dr. Khan Dr. Sugishita	
19 Sep. 2014/ Friday/ AM PM	Consultant Follow-up Survey Report of Follow-up Survey	Dr. Khan	
20 Sep.2014 Sat. 18:20	Consultant's Departure	Dr. Khan	

Annex 3: Project Design Matrix (PDM) Version 4.1 dated 14 March 2014 for the Terminal Evaluation

Project Title: Health Systems Strengthening for HIV/AIDS Services Project
Project Duration: October 2010 – October 2014
Target Area: Tanzania (Model Regions: Pwani and Dodoma)
Target Group: NACP, National supervisors and mentors, and RHMTs and CHMTs in model regions
Beneficiary: RHMTs, CHMTs, Health Facilities and Households

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Health system is strengthened through comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV/AIDS services.	Proportion of regions implementing supervision and mentoring using data feedback will be 50% in Tanzania.	- Supervision Reports - Mentoring Reports - Surveys	
Project Purpose			
Comprehensive supportive supervision, mentoring and effective M&E system for health sector HIV/AIDS services is developed and demonstrated for scale-up*[1].	1. Concordance rates of the two indicators*[2] will increase by 10% in the model regions. 2. 2 RHMTs and 13 CHMTs in the model regions will be oriented on the M&E system developed by the project. 3. 100% of RHMTs will be implementing CSS&M on HIV/AIDS services with the tools approved by MOHSW in the model regions*[3].	- Situation Analysis Data and Survey - Project Reports - Supervision Reports - Mentoring Reports	HIV/AIDS remains as national priority. Human, financial and physical resources are maintained at all levels.
Outputs			
1. Essential indicators for routine monitoring of HIV/AIDS health services are selected and endorsed by the MOHSW/NACP and integrated into the national M&E system through the initiative of the MOHSW.	1-1 Endorsed essential indicators will be in place. 1-2 Essential indicators will be integrated into the National HIV/AIDS Scorecard Indicators.	- List of the Essential Indicators - List of the Scorecard Indicators	Human, financial and physical resources are maintained at all levels.
2. M&E system in model regions is strengthened.	2-1 By the end of the project, data feedback will be given twice a year from 2 RHMTs to CHMTs and from at least 7 out of 13 CHMTs to health facilities in the model regions. 2-2 By the end of the project, 90% of members of RHMTs and CHMTs in the model regions will have started utilizing the data.	- Situation Analysis Data and Survey - Reports of Data Feedback - Reports of Data Utilization	
3. Comprehensive supportive supervision and mentoring at national level is strengthened.	3-1 One coordinated schedule will be in place at the national level. 3-2 By the end of the project, retrievable documentation rate	- CSS&M Coordinated Schedule - CSS and Mentoring	

	will be 70% of all supervision conducted by NACP in the past one year.	Reports	
	3-3 By the end of the project, execution rate of mentoring visits in response to the needs identified will be 50% of all needs identified and documented by national supervisors in the past one year.		
4. Comprehensive supportive supervision and mentoring in model regions is strengthened.	4-1 By the end of the project, retrievable documentation rate will be 50% of all SS to both regional hospitals and CHMTs covering HIV/AIDS services in the past one year in the model regions.	- Survey - CSS and Mentoring Reports	
	4-2 By the end of the project, execution rate of mentoring visits in response to the needs identified will be 50% of all needs identified and documented by regional supervisors in the past one year.		
	4-3 By the end of the project, retrievable documentation (health facility specific) rate of SS visits on HIV/AIDS to health facilities by all councils in the model regions will be 25%.		
	4-4 Execution rate of mentoring visits in response to the needs identified will be 25% of all needs identified and documented by regional supervisors in the past one year.		
5. Synergetic effect between M&E system and CSS&M is enhanced.	5-1 Data feedback during supervision in the model regions will be conducted at least once a year by 2 RHMTs and 7 CHMTs.	- Supervision Reports	

Activities	**Inputs**		**Pre-conditions**
	Japan	**Tanzania**	
0-1 Conduct baseline data collection, midterm evaluation, end line data collection and final evaluation 0-2 Conduct Joint Coordinating Committee (JCC) Meetings 0-3 Conduct a Mind-set Change and Leadership Workshop 0-4 Participate in International Conferences 1-0 Plan M&E activities 1-1 Select essential indicators at national level 1-2 Orient RHMTs and CHMTs in model regions on the essential indicators	1) Dispatch of Japanese Experts Chief Advisor Epidemiology specialist Project Coordinator/Training specialist Other short-term experts 2) Equipment Photocopy and fax machine IT equipment for data analysis in model regions, etc. 3) Operational cost	1) Assignment of the personnel 2) Facilities and equipment 3) Office space 4) Operational cost	Significant proportion of trained personnel remains as implementers of tasks assigned by the Project. Structure, roles and responsibilities of national, regional and district administration for M&E and supportive supervision

2-1 Assess IT situation for data analysis at regional and council levels 2-2 Procure and install hard and software based on the assessment 2-3 Collect and store the data set of the essential indicators by RHMTs and CHMTs 2-4 Build the skills and knowledge of data analysis and interpretation 2-5 Establish and implement data feedback system from RHMTs to CHMTs and from CHMTs to HFs 2-6 Facilitate data utilization for health services by RHMTs and CHMTs 3-1 Develop and print CSS&M training package 3-2 Conduct National Training of Trainers (TOT) 3-3 Train national supervisors and mentors 3-4 Develop biannual plan and budget for national supervisors and mentors 3-5 Strengthen CSS&M through operationalization of the biannual plan 3-6 Conduct national synergy meetings between supervisors and mentors 3-7 Conduct stakeholders meetings to share experiences/lessons 3-8 Review and print CSS&M manual and tools 4-1 Orient RHMTs and CHMTs on CSS&M for HIV/AIDS services 4-2 Select and train regional and district supervisors and mentors 4-3 Strengthen CSS&M through integration into general supportive supervision and operationalization of mentoring 4-4 Conduct regional and district synergy meetings between supervisors and mentors 4-5 Conduct stakeholders meetings to share experiences/lessons 4-6 Integrate CSS&M into Regional Annual Health			are maintained. Human, financial and physical resources are maintained at all levels.

	Plans and CCHPs			
5-1	Incorporate data feedback in supervision			
5-2	Share their experiences and good practices in the model regions			
5-3	Conduct study tour for improving supervision and mentoring			

*1 The project focuses on the modeling exercise for effective M&E and CSS&M in the two regions during the project period. Expansion of the approved activities to other regions apart from the model regions will be done with the initiative of the MOHSW/NACP in collaboration with implementing partners.

*2 Rate of concordance between the numbers in the register and the monthly summary report on the following two indicators: 1) Total number of ANC clients tested for HIV and 2) Total number of HIV positive clients at ANC.

*3 Proportion of RHMTs responding that they implemented CSS&M in the last one year with the following criteria met: 1) RHMTs conducted supportive supervision to all HIV/AIDS services (VCT, PITC, STI, PMTCT, C&T, TB/HIV, HBC, Laboratory and Pharmaceutical services) available at the regional hospital during the year using the CSS Tool approved by MOHSW; 2) RHMTs conducted supportive supervision to all CHMTs under their jurisdiction on HIV/AIDS component in the same year using the CSS Tool; and 3) RHMTs dispatched at least one experienced practitioner of a specific HIV/AIDS service as a mentor to a lower health facility whereby the Mentoring Tool approved by MOHSW was utilized in the same year.

Annex 4: List of Inputs

Annex 4-1: List of Counterparts for the Project

NACP
Program Manager and Heads of All Units

Model Regions
(1) Pwani Region
Kibaha Town Council
Kibaha District Council
Kisarawe District Council
Bagamoyo District Council
Mkuranga District Council
Refiji District Council
Mafia District Council

(2) Dodoma Region
Dodoma Municipal Council
Bahi District Council
Chamwino District Council
Kongwa District Council
Mowapwa District Council

RHMTs and CHMTs
Regional and District Medical Officers
AIDS Control Officers
Health Statistics Officers

Annex 4-2: List of Japanese Experts

Long-Term Japanese Experts

No.	Name	Position	Period
1	Mr. Nobuhiro KADOI	Chief Advisor	1) 26/10/2010 – 25/10/2012 2) 25/11/2013 – 06/04/2014 3) 22/04/2014 – 26/10/2014
2	Dr. Ayuko TANAKA	Epidemiology Specialist/M&E	1) 22/06/2012 – 21/06/2014 2) 21/06/2014 – 27/10/2014
3	Ms. Asuka HASEGAWA	Project Coordinator/Training Specialist	1) 10/01/2011 – 09/01/2013 2) 10/01/2013 – 27/10/2014

Annex 4-3: List of Trainings/Workshops for the Counterpart Personnel

No.	Training	Component	Period	Venue	Participants
1	CSS&M Training (Pre-test of Training Materials #1)	CSS&M	21 – 27 Feb 2011	VETA Morogoro	17
2	CSS&M Training (Pre-test of Training Materials #2)	CSS&M	21 – 26 Mar 2011	KCC Kibaha	15
3	CSS&M Facilitators' Skill Training #1	CSS&M	20 Jun – 2 Jul 2011	VETA Tanga	28
4	CSS&M Training (National, Regional & Partners)	CSS&M	27 Jun – 2 Jul 2011	VETA Tanga	31
5	Finalization Workshop for the Training Package of CSS&M of HIV/AIDS Services	CSS&M	28 Jul – 5 Aug 2011	Peace Inn, Morogoro	8
6	CSS&M Training (National, Regional levels)	CSS&M	12 – 17 Dec 2011	VETA Morogoro	26
7	CSS&M Training (Region & Council - Dodoma)	CSS&M	23 – 28 Jan 2012	VETA Dodoma	33
8	CSS&M Training (Region & Council - Pwani)	CSS&M	30 Jan – 4 Feb 2012	ADEM Bagamoyo	35
9	CSS&M Training (Region & Council - Dodoma)	CSS&M	5 – 10 Mar 2012	VETA Dodoma	32
10	CSS&M Training (Region & Council - Pwani)	CSS&M	12 – 17 Mar 2012	ADEM Bagamoyo	35
11	CSS&M Facilitators' Skill Training #2	CSS&M	13 – 18 Aug 2012	VETA Dodoma	22
12	CSS&M Training (National, Regional levels)	CSS&M	3 – 8 Sep 2012	VETA Dodoma	26
13	Orientation Workshop on Documentation and Information Flow in CSS&M of HIV/AIDS Services for Pwani Region	CSS&M	11 Jan 2013	KCC Kibaha	31
14	Orientation Workshop on Documentation and Information Flow in CSS&M of HIV/AIDS Services for Dodoma Region	CSS&M	8 Feb 2013	VETA Dodoma	24
15	Mindset Change in Health Leadership and Management Training	Leadership/Management	2 – 5 Mar 2013	Oasis Hotel Morogoro	12
16	Workshop to review the tools of CSS&M	CSS&M	2 – 5 Dec 2013	Oasis Hotel Morogoro	29
17	Workshop to incorporate comments for the review of the tools for CSS&M	CSS&M	16 – 19 Dec 2013	Oasis Hotel Morogoro	22
18	Orientation on the revised CSS tool to NACP staff	CSS&M	6 Feb 2014	NACP	17
19	Orientation on the revised CSS tool to the R/CHMTs in the model regions	CSS&M	10 Mar 2014	Oasis Hotel Morogoro	69
20	CSS&M Training (Mbeya Referral Hospital) (Funded by DoD)	CSS&M	19 – 23 May 2014	Mbeya Referral Hospital	32
1	PCM Workshop on M&E in HIV/AIDS Health Services	M&E	8 – 9 Nov 2011	Njuweni Kibaha	43
2	PCM Workshop on M&E in HIV/AIDS Health Services	M&E	3 – 4 Nov 2011	VETA Dodoma	38
3	Orientation of Score Card Indicators	M&E	24 Aug 2012	Ceemi,	44

No.	Training	Component	Period	Venue	Participants
				Dar Es Salaam	
4	Data Analysis Training (Basic Course)	M&E	17 – 21 September 2012	University of Computing Centre, Arusha	13
5	Data Analysis Training (Intermediate Course)	M&E	24 – 28 September 2012	University of Computing Centre, Arusha	18
6	On-the-Job Training Review Meeting, Dodoma – Data Analysis	M&E	11 – 12 Feb 2013	Maktaba ya Mkoa, Dodoma	25
7	On-the-Job Training Review Meeting, Pwani – Data Analysis	M&E	14 – 15 Mar 2013	ADEM, Bagamoyo	28
8	PMTCT PCM Workshop in Dodoma Municipality	M&E	10 October 2013	Maktaba ya Mkoa, Dodoma	16
9	Workshop: How to make a presentation for National Quality Improvement Forum and International Conference on AIDS and STIs in Africa	M&E	9 November 2013	VETA Dodoma	8
10	Meeting for sharing results of PMTCT PCM Workshop and finding way forward in Dodoma Municipality	M&E	13 November 2013	Municipal Hall, Dodoma	98
11	Data Feedback Meeting for Traditional Healers, Mkuranga	M&E	20 November 2013	Parapanda Hall, Mkurnaga	42
12	Workshop: Presentation Rehearsal for National Quality Improvement Forum and International Conference on AIDS and STIs in Africa	M&E	25 November 2013	Ceemi, DSM	4
13	Data Feedback Meeting for Peer Educators, Mkurnaga	M&E	10 January 2014	Campsite Hall, Mkurnaga	51
14	Training for Trainers on Measurement and Physical Exercises	M&E	1 March 2014	CHMT Office, Dodoma Municipal Council	5
15	Workshop: Presentation Rehearsal for M&E Review Meeting	M&E	23 March 2014	Oasis hotel, Morogoro	13
16	M&E Review Meeting	M&E	24 March 2014	Oasis hotel, Morogoro	26
17	Data Feedback Meeting for Home Based Care Providers, Mkuranga	M&E	26 March 2014	Campsite Hall, Mkurnaga	82
18	Workshop: How to make a poster for International Aids Conference	M&E	3 May 2014	CHMT office, Dodoma Municipal Council	4
19	Workshop: How to make a poster for International Aids Conference	M&E	10 May 2014	CHMT office, Mkuranga	2
20	Workshop: How to make a presentation and presentation rehearsal for Muhimbili University of Health and Allied Sciences Scientific	M&E	13 May 2014	Kunduchi Beach hotel, DSM	7

No.	Training	Component	Period	Venue	Participants
	Conference				
21	On-the-Job Training to refine data feedback materials (DFM)	M&E	November 2012 – Present 1-2 times OJT per DFM x 53 DFM submitted	RHMT or CHMT offices in model regions	1-4 per team per OJT

Overseas Study Tour and Trainings

Study Tour to Zimbabwe to improve operation of SS and Mentoring from 6 – 12 July 2014

Participants	Position/Organization
Dr. Angela Ramadhani	Program Manager, NACP, MOHSW
Dr. Patrick Mwidunda	Head of QI Unit, NACP, MOHSW
Ms. Peris Urasa	HIV Testing and Counselling Program Officer, NACP, MOHSW
Dr. Mohamed Iyullu	Regional AIDS Control Coordinator, Regional Administrative Secretariat (RAS) Dodoma
Dr. Paul Luvanda	Regional AIDS Control Coordinator, RAS Iringa
Mr. William Nelson	Regional AIDS Control Coordinator, RAS Pwani

Trainee Name	Position/Organization	Training	Period	Venue
Patrick Evariste Mwidunda	Head of QI Unit, NACP	Evidence Based Public Health Planning	2013/09/14 – 2013/09/18	JICA Okinawa
Nahum Obed Nassari	District AIDS Control Coordinator, CHMT Dodoma MC	Strengthening of Community Health System for Infectious Diseases	2014/01/15 – 2014/03/08	JICA Okinawa
Credianus Kilian Mgimba	District Medical Officer, CHMT Mafia	Health Systems Management for Regional and District Management	2014/06/24 – 2014/08/09	JICA Sapporo

Annex 4-4: List of Equipment and Materials Provided by the Project

Project Ledger Folio No.	Item	Specifications	Price		Delivery Date	Delivered to
			USD	TSH		
NACPJICA2/ME/01/01	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/24	RHMT Pwani
NACPJICA2/ME/01/02	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/12	RHMT Pwani
NACPJICA2/ME/01/03	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/23	CHMT Kibaha TC
NACPJICA2/ME/01/04	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/23	CHMT Kibaha DC
NACPJICA2/ME/01/05	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/02	CHMT Kisarawe
NACPJICA2/ME/01/06	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/25	CHMT Rufiji
NACPJICA2/ME/01/07	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/04/30	CHMT Bagamoyo
NACPJICA2/ME/01/08	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/05/18	CHMT Manispaa
NACPJICA2/ME/01/09	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/05/12	CHMTBahi
NACPJICA2/ME/01/10	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/05/16	CHMT Chamwino
NACPJICA2/ME/01/11	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/05/17	CHMT Kongwa
NACPJICA2/ME/01/12	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2012/06/15	CHMT Mpwapwa
NACPJICA2/ME/01/13	Desk Top Computer	Dell OptiPlex 990 Mini tower	1,156		2013/05/09	CHMT Mafia
NACPJICA2/ME/02/01	Software	MS office 2010 Professional	339		2012/04/24	RHMT Pwani
NACPJICA2/ME/02/02	Software	MS office 2010 Professional	339		2012/04/12	RHMT Pwani
NACPJICA2/ME/02/03	Software	MS office 2010 Professional	339		2012/04/23	CHMT Kibaha TC
NACPJICA2/ME/02/04	Software	MS office 2010 Professional	339		2012/04/23	CHMT Kibaha DC
NACPJICA2/ME/02/05	Software	MS office 2010 Professional	339		2012/04/02	CHMT Kisarawe
NACPJICA2/ME/02/06	Software	MS office 2010 Professional	339		2012/04/25	CHMT Rufiji
NACPJICA2/ME/02/07	Software	MS office 2010 Professional	339		2012/04/30	CHMT Bagamoyo
NACPJICA2/ME/02/08	Software	MS office 2010 Professional	339		2012/05/18	CHMT Manispaa
NACPJICA2/ME/02/09	Software	MS office 2010 Professional	339		2012/05/12	CHMTBahi
NACPJICA2/ME/02/10	Software	MS office 2010 Professional	339		2012/05/16	CHMT Chamwino
NACPJICA2/ME/02/11	Software	MS office 2010 Professional	339		2012/05/17	CHMT Kongwa
NACPJICA2/ME/02/12	Software	MS office 2010 Professional	339		2012/06/15	CHMT Mpwapwa
NACPJICA2/ME/02/13	Software	MS office 2010 Professional	339		2013/05/09	CHMT Mafia
NACPJICA2/ME/03/01	Software	Kaspersky Antivirus (single user)	20		2012/04/24	RHMT Pwani
NACPJICA2/ME/03/02	Software	Kaspersky Antivirus (single user)	20		2012/04/24	RHMT Pwani
NACPJICA2/ME/03/03	Software	Kaspersky Antivirus (single user)	20		2012/04/23	CHMT Kibaha TC
NACPJICA2/ME/03/04	Software	Kaspersky Antivirus (single user)	20		2012/04/23	CHMT Kibaha DC
NACPJICA2/ME/03/05	Software	Kaspersky Antivirus (single user)	20		2012/04/02	CHMT Kisarawe
NACPJICA2/ME/03/06	Software	Kaspersky Antivirus (single user)	20		2012/04/25	CHMT Rufiji
NACPJICA2/ME/03/07	Software	Kaspersky Antivirus (single user)	20		2012/04/30	CHMT Bagamoyo

Project Ledger Folio No.	Item	Specifications	Price		Delivery Date	Delivered to
			USD	TSH		
NACPJICA2/ME/03/08	Software	Kaspersky Antivirus (single user)	20		2012/05/18	CHMT Manispaa
NACPJICA2/ME/03/09	Software	Kaspersky Antivirus (single user)	20		2012/05/12	CHMTBahi
NACPJICA2/ME/03/10	Software	Kaspersky Antivirus (single user)	20		2012/05/16	CHMT Chamwino
NACPJICA2/ME/03/11	Software	Kaspersky Antivirus (single user)	20		2012/05/17	CHMT Kongwa
NACPJICA2/ME/03/12	Software	Kaspersky Antivirus (single user)	20		2012/06/15	CHMT Mpwapwa
NACPJICA2/ME/03/13	Software	Kaspersky Antivirus (single user)	20		2013/05/09	CHMT Mafia
NACPJICA2/ME/04/01	UPS	APC Backup 650VA	82		2012/04/24	RHMT Pwani
NACPJICA2/ME/04/02	UPS	APC Backup 650VA	82		2012/04/12	RHMT Pwani
NACPJICA2/ME/04/03	UPS	APC Backup 650VA	82		2012/04/23	CHMT Kibaha TC
NACPJICA2/ME/04/04	UPS	APC Backup 650VA	82		2012/04/23	CHMT Kibaha DC
NACPJICA2/ME/04/05	UPS	APC Backup 650VA	82		2012/04/02	CHMT Kisarawe
NACPJICA2/ME/04/06	UPS	APC Backup 650VA	82		2012/04/25	CHMT Rufiji
NACPJICA2/ME/04/07	UPS	APC Backup 650VA	82		2012/04/30	CHMT Bagamoyo
NACPJICA2/ME/04/08	UPS	APC Backup 650VA	82		2012/05/18	CHMT Manispaa
NACPJICA2/ME/04/09	UPS	APC Backup 650VA	82		2012/05/12	CHMTBahi
NACPJICA2/ME/04/10	UPS	APC Backup 650VA	82		2012/05/16	CHMT Chamwino
NACPJICA2/ME/04/11	UPS	APC Backup 650VA	82		2012/05/17	CHMT Kongwa
NACPJICA2/ME/04/12	UPS	APC Backup 650VA	82		2012/06/15	CHMT Mpwapwa
NACPJICA2/ME/04/13	UPS	APC Backup 650VA	82		2013/05/09	CHMT Mafia
NACPJICA2/ME/05/01	Surge Protector	APC	21		2012/04/24	RHMT Pwani
NACPJICA2/ME/05/02	Surge Protector	APC	21		2012/04/12	RHMT Pwani
NACPJICA2/ME/05/03	Surge Protector	APC	21		2012/04/23	CHMT Kibaha TC
NACPJICA2/ME/05/04	Surge Protector	APC	21		2012/04/23	CHMT Kibaha DC
NACPJICA2/ME/05/05	Surge Protector	APC	21		2012/04/02	CHMT Kisarawe
NACPJICA2/ME/05/06	Surge Protector	APC	21		2012/04/25	CHMT Rufiji
NACPJICA2/ME/05/07	Surge Protector	APC	21		2012/04/30	CHMT Bagamoyo
NACPJICA2/ME/05/08	Surge Protector	APC	21		2012/05/18	CHMT Manispaa
NACPJICA2/ME/05/09	Surge Protector	APC	21		2012/05/12	CHMTBahi
NACPJICA2/ME/05/10	Surge Protector	APC	21		2012/05/16	CHMT Chamwino
NACPJICA2/ME/05/11	Surge Protector	APC	21		2012/05/17	CHMT Kongwa
NACPJICA2/ME/05/12	Surge Protector	APC	21		2012/06/15	CHMT Mpwapwa
NACPJICA2/ME/05/13	Surge Protector	APC	21		2013/05/09	CHMT Mafia
NACPJICA2/ME/06/01	USB key	SanDisk 4GB		31,260	2012/08/24	RHMT Pwani
NACPJICA2/ME/06/02	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Kibaha TC
NACPJICA2/ME/06/03	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Kibaha DC

Project Ledger Folio No.	Item	Specifications	Price		Delivery Date	Delivered to
			USD	TSH		
NACPJICA2/ME/06/04	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Kisarawe
NACPJICA2/ME/06/05	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Mkuranga
NACPJICA2/ME/06/06	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Rufiji
NACPJICA2/ME/06/07	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Bagamoyo
NACPJICA2/ME/06/08	USB key	SanDisk 4GB		31,260	2012/08/24	CHMT Mafia
NACPJICA2/ME/06/09	USB key	Sony 4GB		31,260	2012/08/24	RHMT Dodoma
NACPJICA2/ME/06/10	USB key	Sony 4GB		31,260	2012/08/24	CHMT Manispaa
NACPJICA2/ME/06/11	USB key	Sony 4GB		31,260	2012/08/24	CHMT Bahi
NACPJICA2/ME/06/12	USB key	Sony 4GB		31,260	2012/08/24	CHMT Chamwino
NACPJICA2/ME/06/13	USB key	Sony 4GB		31,260	2012/08/24	CHMT Kongwa
NACPJICA2/ME/06/14	USB key	Sony 4GB		31,260	2012/08/24	CHMT Kondoa
NACPJICA2/ME/06/15	USB key	Sony 4GB		31,260	2012/08/24	CHMT Mpwapwa
NACPJICA2/ME/07/01	Color Printer	HP Laser Jet CP1515N		416,000	2012/12/07	RHMT Pwani
NACPJICA2/ME/07/02	Color Printer	HP Laser Jet CP1515N		416,000	2013/01/22	CHMT Kibaha TC
NACPJICA2/ME/07/03	Color Printer	HP Laser Jet CP1515N		416,000	2013/01/04	CHMT Kibaha DC
NACPJICA2/ME/07/04	Color Printer	HP Laser Jet CP1515N		416,000	2013/03/25	CHMT Kisarawe
NACPJICA2/ME/07/05	Color Printer	HP Laser Jet CP1515N		416,000	2012/12/05	CHMT Mkuranga
NACPJICA2/ME/07/06	Color Printer	HP Laser Jet CP1515N		416,000	2012/12/14	CHMT Rufiji
NACPJICA2/ME/07/07	Color Printer	HP Laser Jet CP1515N		416,000	2013/01/03	CHMT Bagamoyo
NACPJICA2/ME/07/08	Color Printer	HP Laser Jet CP1515N		416,000	2012/11/07	CHMT Mafia
NACPJICA2/ME/07/09	Color Printer	HP Ink Jet 1663		70,000	2012/12/19	RHMT Dodoma
NACPJICA2/ME/07/10	Color Printer	HP Laser Jet CP1515N		416,000	2012/11/13	CHMT Manispaa
NACPJICA2/ME/07/11	Color Printer	HP Laser Jet CP1515N		416,000	2012/11/09	CHMT Bahi
NACPJICA2/ME/07/12	Color Printer	HP Laser Jet CP1515N		416,000	2012/12/19	CHMT Chamwino
NACPJICA2/ME/07/13	Color Printer	HP Laser Jet CP1515N		416,000	2014/02/21	CHMT Kongwa
NACPJICA2/ME/07/14	Color Printer	HP Laser Jet CP1515N		416,000	2013/03/07	CHMT Kondoa
NACPJICA2/ME/07/15	Color Printer	HP Laser Jet CP1515N		416,000	2012/03/08	CHMT Mpwapwa
NACPJICA2/ME/08/01	Projector	Acer X 112	525		2014/01/30	CHMT Mkuranga
NACPJICA2/ME/09/01	Hard Disk	Transcend 320 GB Red		140,000	2014/05/28	RHSM Pwani
NACPJICA2/ME/09/02	Hard Disk	Transcend 320 GB Red		140,000	2014/05/28	CHMT Kibaha TC
NACPJICA2/ME/09/03	Hard Disk	Transcend 320 GB Red		140,000	2014/05/29	CHMT Kibaha DC
NACPJICA2/ME/09/04	Hard Disk	Transcend 320 GB Red		140,000	2014/06/06	CHMT Kisarawe
NACPJICA2/ME/09/05	Hard Disk	Transcend 320 GB Red		140,000	2014/05/10	CHMT Mkuranga
NACPJICA2/ME/09/06	Hard Disk	Transcend 320 GB Red		140,000	2014/06/16	CHMT Rufiji
NACPJICA2/ME/09/07	Hard Disk	Transcend 320 GB Red		140,000	2014/05/26	CHMT Bagamoyo

Project Ledger Folio No.	Item	Specifications	Price		Delivery Date	Delivered to
			USD	TSH		
NACPJICA2/ME/09/08	Hard Disk	Transcend 320 GB Red		140,000	2014/06/04	CHMT Mafia
NACPJICA2/ME/09/09	Hard Disk	Transcend 320 GB Red		140,000	2014/05/03	CHMT Dodoma MC
NACPJICA2/ME/09/10	Hard Disk	Transcend 320 GB Red		140,000	2014/05/01	CHMT Bahi
NACPJICA2/ME/09/11	Hard Disk	Transcend 320 GB Red		140,000	2014/05/02	CHMT Kongwa
NACPJICA2/ME/09/12	Hard Disk	Transcend 320 GB Red		140,000	2014/05/08	CHMT Kondoa
NACPJICA2/ME/10/01	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/10/02	CHMT Kibaha DC
NACPJICA2/ME/10/02	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/11/07	CHMT Kisarawe
NACPJICA2/ME/10/03	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/11/07	CHMT Mkuranga
NACPJICA2/ME/10/04	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/07/22	CHMT Bagamoyo
NACPJICA2/ME/10/05	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/07/21	CHMT Mafia
NACPJICA2/ME/10/06	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2013/10/08	CHMT Dodoma MC
NACPJICA2/ME/10/07	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2013/10/08	CHMT Bahi
NACPJICA2/ME/10/08	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2013/10/08	CHMT Chamwino
NACPJICA2/ME/10/09	Cartridge for Color Printer	HP 300 Black and Color x 5		500,000	2014/08/11	RHMT Dodoma
NACPJICA2/ME/10/10	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/02/21	CHMT Kongwa
NACPJICA2/ME/10/11	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/04/10	CHMT Kondoa
NACPJICA2/ME/10/12	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/07/14	CHMT Mpwapwa
NACPJICA2/ME/10/13	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/08/12	CHMT Pwani
NACPJICA2/ME/10/14	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/08/12	CHMT Kibaha TC
NACPJICA2/ME/10/15	Cartridge for Color Printer	CB 540, 541, 543 x 3		1,800,000	2014/08/13	CHMT Rufiji
NACPJICA2/ME/12/01	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/02	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/03	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/04	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/05	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/06	BP Machine	Geratherm Easy Med		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/07	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/08	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/09	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/10	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/11	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/12	Weight Machine	Omron Body Fat Monitor with Scale BF400		240,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/13	Mega Phone	Hand Speaker		70,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/14	Mega Phone	Hand Speaker		70,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/15	Waist Measure Tape	60 Inch/150cm x 6 Items		3,000	2013/11/16	CHMT Dodoma MC

Project Ledger Folio No.	Item	Specifications	Price		Delivery Date	Delivered to
			USD	TSH		
NACPJICA2/ME/12/16	BMI Chart	A0 Size Hard Board x 10 Items		80,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/17	OPD Notebook	36 Pages / Notebook x 200 Items		40,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/18	Stamp Set	2 Stamps, Stamp Stand, Sheet and Ink		150,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/19	T-Shirt	Siku ya afya ya mwanaume		3,800,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/20	Pen	Siku ya afya ya mwanaume		100,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/12/21	ANC Invitation Card	Uchunguzsi wa afya ya mwanaume		100,000	2013/11/16	CHMT Dodoma MC
NACPJICA2/ME/13/01	Digital Camera	Sony Cyber Shot W730		235,000	2014/05/01	CHMT Bahi
NACPJICA2/ME/13/02	Digital Camera	Sony Cyber Shot W730		235,000	2014/05/02	CHMT Kongwa
NACPJICA2/ME/13/03	Digital Camera	Sony Cyber Shot W730		235,000	2014/05/05	CHMT Dodoma MC
NACPJICA2/ME/13/04	Digital Camera	Sony Cyber Shot W730		235,000	2014/05/08	CHMT Kondoa
NACPJICA2/ME/13/05	Digital Camera	Sony Cyber Shot W730		235,000	2014/05/10	CHMT Mkuranga

Annex 4-5: Operational Expenses

Japanese Side **Unit: Tanzania Shelling (TSH)**

Item	Fiscal Year (FY)					Total
	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014 (First Quarter)	
Air Tickets	890,900	14,659,920	9,524,600	21,297,832	58,344,920	98,914,272
Travelling	27,790,400	182,362,100	130,128,874	133,679,712	46,733,316	465,896,010
Contracts with Local Consultants	45,957,500	55,500,276	14,340,000	0	0	115,797,776
Contracts with Local NGOs	0	0	0	0	0	0
Contracts	0	0	0	0	0	0
Lecturers Honorariums	6,067,900	22,028,600	14,521,500	12,398,750	2,633,000	52,423,250
Venue for Lectures	0	0	216,000	0	0	216,000
Overall Administration	73,029,095	186,369,157	99,530,447	128,587,340	14,497,766	461,268,790
Total (TSH)	**153,735,795**	**460,920,053**	**268,261,421**	**295,963,634**	**122,209,002**	**1,194,516,098**
Total (JPY) with the rate of 0.06 TSH/Yen	**9,224,148**	**27,655,203**	**16,095,685**	**17,757,818**	**7,332,540**	**71,670,966**