THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL AIDS CONTROL PROGRAMME

COSTING OF THE THIRD HEALTH SECTOR HIV AND AIDS STRATEGIC PLAN (HSHSP III) 2013–2017

February 2015

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National AIDS Control Programme
P.O. Box 11857
Dar es Salaam
Tel: +255 22 2131213; Fax: +255 22 2138282
E-mail: info@nacp.go.tz
Website: www.nacp.go.tz

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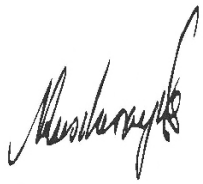
The Costing of the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017 was developed in a highly participatory manner. While the Ministry of Health and Social Welfare, through the National AIDS Control Program (NACP) took a leading role, various stakeholders—individuals and organisations—also played an important and active role.

To start with, I would like to recognise and congratulate all staff of the National AIDS Control Programme who took on this task with great courage and enthusiasm. The strong leadership and guidance of Dr. Angela A. Ramadhani, the Programme Manager was critical. I would also like to appreciate the excellent coordination and support of Dr. Robert Josiah Mwanri, without whose commitment and dedication, it would have been very difficult to effectively complete the task in time.

Secondly, I would like to thank the USAID-funded Health Policy Project (HPP) for providing financial and technical support to the process of costing the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017

The MoHSW would also like to thank the costing consultants for facilitating the costing process, creating the costing templates, collecting cost inputs, and producing this report.

It is difficult to mention specific organisations and people, hence I would like to thank all individuals, organizations, and development partners that contributed to and supported the costing of the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III).



Dr. Neema Rusibamayila

Director for Preventive Services

FOREWORD

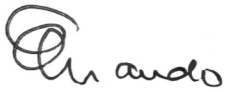
The Costing of the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017 comes at a time when the HSHSP III and its two years Operational Plan (OP) have been developed and printed. The HSHSP III costing aims to support strategic planning and evidence-based decision-making by estimating the cost of scaling up or maintaining HIV prevention and treatment interventions in the health sector. Estimating total resource needs of the HSHSP III also supports domestic and donor resource mobilization and transparent and accountable operationalization of the plan.

The development of this costing was informed by the HSHSP III and its OP which guide the national health sector response to HIV and AIDS. The focus of the HSHSP III and its OP is to achieve zero new HIV infections, zero AIDS-related deaths and zero stigma by 2017.

The Costing of the HSHSP III 2013–2017 therefore estimates the resource requirements for commodity procurement and programmatic support activities needed to achieve the goals and strategic objectives of the HSHSP III and OP. The Costing of the HSHSP III 2013–2017 also set standard unit costs agreed to each activity input. Costs for commodity procurement were based on NACP-led quantification exercises which utilized the latest epidemiological and pricing data available. All activity and commodity costs were validated by NACP program officers and other stakeholders.

It is my sincere hope that by abiding to these set costing standards, the contribution of the health sector towards the national response to HIV/AIDS will be more focused and that our common aspiration of zero new infections, zero deaths and zero stigma by 2017 will be achieved.

I therefore encourage all of our valued partners to take ownership of the document and use it as a guide as we make our contribution to the health sector response to HIV/AIDS in the next five years.



Dr. Magreth Mhando

Ag. Chief Medical Officer

ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ARV	antiretroviral
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
HPP	Health Policy Project
HSHSP III	Third Health Sector HIV and AIDS Strategic Plan
MAT	Medically Assisted Therapy
MDG	Millennium Development Goal
MoHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Program
NFM	New Funding Model
NMSF III	Third National Multisectoral Strategic Framework for HIV and AIDS
OI	Opportunistic Infections
PEP	Post-Exposure Prophylaxis
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
SBCC	Social and Behavior Change Communication
STI	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision

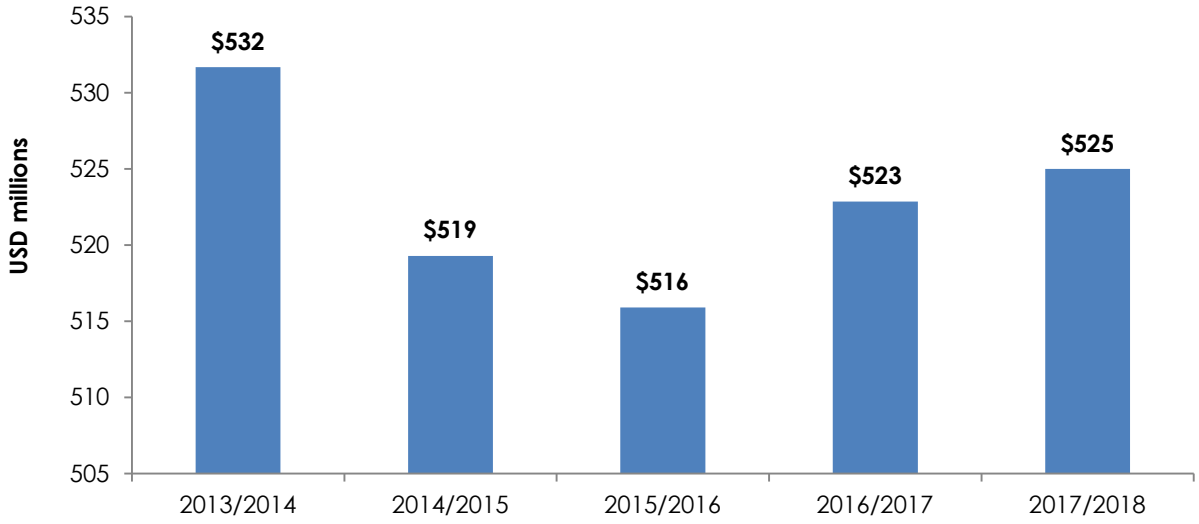
EXECUTIVE SUMMARY

The National AIDS Control Program (NACP) in the Ministry of Health and Social Welfare (MoHSW), with support from the USAID- and PEPFAR-funded Health Policy Project (HPP), engaged in a stakeholder-driven process to estimate the costs of the Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) for the fiscal years (FY) 2013/2014–2017/2018. The HSHSP III outlines the health sector contributions to the national HIV response from 2013/2014 to 2017/2018 and is aligned with the Third National Multisectoral Strategic Framework for HIV and AIDS (NMSF III).

The costing team, comprising of HPP and NACP staff, estimated the resource requirements for commodity procurement and programmatic support activities needed to achieve the goals and strategic objectives. The team helped to operationalize the HSHSP III for activity-based costing. Detailed operational planning was used to identify the specific inputs needed to carry out each activity and where and when the activity would occur. Standard unit costs agreed upon by NACP were then assigned to each activity input. Costs for commodity procurement were based on NACP-led quantification exercises which utilized the latest epidemiological and pricing data available. All activity and commodity costs were validated by NACP program officers and other stakeholders. The operationalization and costing process spanned from February 2014 to August 2014.

This report explains the HSHSP III costing process and shows the cost results by NACP unit and HSHSP III impact area and strategic objective. The total budget of the HSHSP III for all five years is estimated at *$2,615 million USD*. Figure 1 shows the total costs by year.

Figure 1: Total HSHSP III costs by year



The cost of the HSHSP III accounts for 88 percent of the total costs for implementing the NMSF III. About half (49%) of the HSHSP III costs are attributable to reducing HIV-related mortality, and nearly one-third (32%) of the total five-year HSHSP III costs is for procuring antiretrovirals (ARVs).

I. INTRODUCTION

The Third Health Sector HIV and AIDS Strategic Plan (HSHSP III), covering the period from fiscal years (FY) 2013/2014 to 2017/2018, outlines the health sector contributions to achieving zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination in Tanzania. The HSHSP III moves towards results-based planning and focuses on high-impact interventions related to issues of equity, universal access, gender and human rights, decentralization, integration, public-private partnerships, meaningful involvement of people living with HIV (PLHIV), accountability, and sustainability. Development of the HSHSP III was informed by the third National Multisectoral Strategic Framework for HIV and AIDS (NMSF III), which is a guide for the national HIV response across various sectors and levels of governance.

The National AIDS Control Program (NACP) under the Directorate of Preventive Services in the Ministry of Health and Social Welfare (MoHSW) is responsible for central coordination and technical leadership in implementing the HSHSP III. NACP, with support from the USAID- and PEPFAR-funded Health Policy Project (HPP), led a costing exercise to estimate the total resources needed to implement the HSHSP III. The HSHSP III costing team, comprised of NACP and HPP staff, initiated a stakeholder-driven costing process involving operationalizing the HSHSP III, activity-based costing to estimate programmatic support costs, and quantification exercises to estimate commodity costs.

a. Rationale for costing

The HSHSP III costing aims to support strategic planning and evidence-based decision-making by estimating the cost of scaling up or maintaining HIV prevention and treatment interventions in the health sector. Estimating total resource needs of the HSHSP III also supports domestic and donor resource mobilization and transparent and accountable operationalization of the plan.

During the costing process, costing consultants developed capacity of NACP staff in costing methodologies. In addition to routine mentoring throughout data collection and validation, the Health Policy Project (HPP) conducted a two-day training on costing methodologies and tools for HIV and AIDS programs. Capacity development was a key component of the costing process.

b. Costing approach

Costs were collected for commodity procurement and programmatic support activities. Programmatic support activities include trainings, workshops, meetings, supervision visits, monitoring and evaluation, consultancies, and equipment procurement and other capital investments. The costing captures activities conducted at the national and sub-national levels.

NACP developed a two-year operational plan containing activities for each overarching HSHSP III strategic objective. The HSHSP III costing team helped to extend the HSHSP III operational plan, collected detailed targets and information for each activity, and assigned a standard unit cost to each cost input to estimate the financial cost to the government for conducting the activity. All costs were validated by NACP staff.

It is important to note that the HSHSP III costs exclude activities conducted in the private sector and by government institutions outside the health sector. The costing also excludes any cross-cutting health system costs, such as the cost of health facilities or human resources for health carrying out the interventions.

c. Use of cost results

The final deliverables included a costed HSHSP III from 2013/2014 to 2017/2018, a training of HIV professionals on costing methodologies and tools, and a brief report summarizing the costing methods and results. NACP holds the final costing files and may update the costs at any point during planning or review stages of HSHSP III implementation.

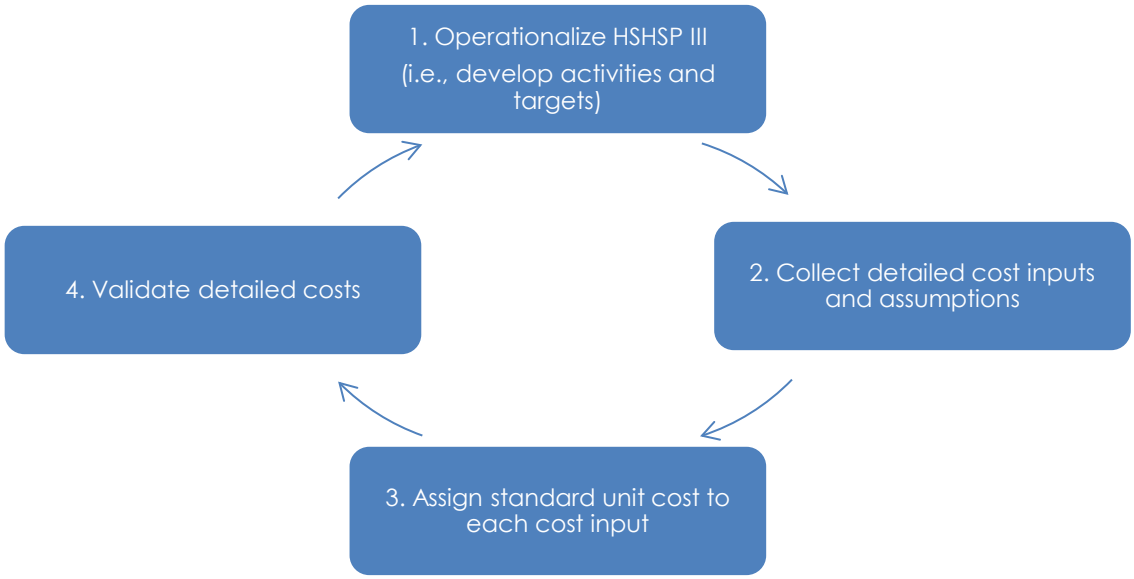
The costs of the HSHSP III were included in the overall NMSF III costing. Please see *Brief Report on Financial Resources Required for the Third National Multi-Sectoral Strategic Framework (NMSF) on HIV and AIDS 2013/2014–2017/2018* for more information on the NMSF III costing.

In October 2014, Tanzania submitted a concept note to the Global Fund under the New Funding Model (NFM). The detailed costs of the HSHSP III were used in the concept note. TACAIDS and HPP also presented the costs of the HSHSP III at the 6th Joint Biennial HIV and AIDS Sector Review held in Dar es Salaam in November 2014.

II. COSTING METHODS

Estimating the costs of the HSHSP III was a cyclical process involving several steps (see Figure 2). The first step was to operationalize the HSHSP III by identifying or extending the existing annual activities and targets. Second, the costing team collected detailed assumptions and cost inputs for each activity from program officers within each NACP unit. Third, the costing team worked with NACP to identify standard unit costs for each cost input. Fourth, the costing team validated the costs with NACP. Activities and costs were often adjusted based on technical insights and feedback from validation meetings, which resulted in repetition of steps 1 through 3.

Figure 2: HSHSP III costing process



a. Stakeholder engagement

The HSHSP III costing was a participatory process involving staff from all units within NACP and other stakeholders, such as TACAIDS. The epidemiological assumptions used in the NACP-led commodity quantifications were based on existing data and agreed upon through stakeholder consensus meetings. For instance, assumptions for the number of people needing ART each year were based on triangulation of multiple data sources and several consultative meetings with NACP, TACAIDS, UNAIDS, USAID, and other stakeholders.

b. Costs included in HSHSP III costing

Costs were collected for commodity procurement and programmatic support activities implemented at the national, regional, district, and community levels. Programmatic support activities include trainings, workshops, meetings, supervision visits, monitoring and evaluation, consultancies, and equipment procurement and other capital investments needed to achieve the HSHSP III strategic objectives and goals. Programmatic support costs were divided by NACP departments. Table 1 displays the types of costs included in the HSHSP III costing.

Table 1: Costs included in the HSHSP III costing

Programmatic support costs	Commodity costs
HIV counseling and testing (HCT)	Rapid test kits
Voluntary medical male circumcision (VMMC)	Early infant diagnosis
Sexually transmitted infections (STI)	CD4 testing reagents
Condoms	Viral load testing reagents
Social and behavior change communication (SBCC)	Hematology and chemistry testing reagents
Prevention of mother to child transmission (PMTCT)	VMMC procedure costs
Key populations	Medically assisted therapy commodities
Blood safety	STI treatment
Post-exposure prophylaxis (PEP)	Male condoms
Adult and pediatric ART	Blood safety commodities
TB/HIV collaborative activities	ARVs
Community-based activities	Opportunistic infections medicines
Stigma	Home-based care commodities
Workplace interventions (WPI)	
Monitoring and evaluation (M&E)	
Medicine and Technology, including Lab	
Quality improvement	
Program administration	

The HSHSP III costs exclude activities conducted in the private sector and by government institutions outside the health sector. The costing also excludes any cross-cutting health system costs, such as the cost of health facilities or human resources for health carrying out the interventions.

c. Operationalization of the HSHSP III and activity-based costing

The costing consultants conducted a desk review of existing documents and costs for delivering HIV and AIDS interventions in the health sector. NACP leadership provided these references, which are listed in Annex A, through initial consultations. An operational plan for the HSHSP III exists for only the first two years—2013/2014 and 2014/2015. In order to cost the entire HSHSP III, the costing consultants met with program officers at NACP to extend the operational plan by an additional two years. The key informants at NACP indicated which activities would recur each year and added new activities to be costed. Due to uncertainty in future programming, the activities occurring in 2016/2017 were assumed to occur again in 2017/2018. The key contacts consulted for the operationalization and costing are shown in Annex C.

To cost programmatic support activities, key contacts were asked to provide details about the specific resources needed to conduct each activity. For example, resources needed for a meeting may include refreshments, venue rental, per diem, and transportation. Each of these items was assigned a unit cost based on market research or recent expenditure records. The unit costs were validated by NACP staff. For a complete list of standard unit costs, see Annex D.

The costing consultants created an Excel-based template for the activity-based costing. This template requires the following inputs:

- Description of activity and costing assumptions
- Specific resources needed to conduct activity
- Quantity of each resource needed (based on standard unit of measurement)
- Unit cost of resource (from standard unit cost sheet)
- Number of days (if applicable) and frequency of occurrence per year

Key contacts from NACP were trained in how to use this template. In the template, standard unit costs are multiplied by the number of days for each activity (if applicable), the number of units needed for each activity, and the number of times the activity is estimated to occur each year. This yields a total cost for each activity per year that could be summed to find the total overall cost by NACP unit, HSHSP III strategic objective, or HSHSP III impact area by year.

d. Commodity quantifications and epidemiological assumptions

In addition to costing programmatic support activities, the HSHSP III costing team calculated costs for HIV commodity procurement in the public health sector. The costs of commodity procurement under NACP were calculated differently from program support activities explained above. NACP led quantification exercises to estimate the cost of commodities each year. The quantifications were based on the need for the specific commodity (e.g., the number of people who need a particular ARV treatment regimen), the unit cost of the commodity based on recent procurement records, and in some instances, the amount of the commodity already in stock.

Epidemiological assumptions used to estimate the need for specific commodities were based on existing data and agreed upon through a participatory process. Several rounds of meetings between NACP, UNAIDS, USAID, TACAIDS, and other stakeholders were held to reach consensus on the targeted number of adults and children receiving HIV treatment each year. HIV prevalence (5.3% of the general population) from the 2012 Tanzania HIV and Malaria Indicator Survey, HIV incidence (73,000 new HIV infections per year) from the AIDS Impact Module in Spectrum, and eligibility criteria in the national ART guidelines formed the basis for developing the assumptions regarding need for ART. The final annual targets for numbers on treatment were determined by multiplying the number of people in need of treatment by the percentage of people actually reached through the program, which is based on current program records and scale-up plans. Projections for the number of people on specific ART regimens were based on data from 88 care and treatment centers in the country.

To cost the HSHSP III, NACP also needed consensus on estimates for the size of and HIV prevalence among various key population groups, including men who have sex with men, people who use drugs, and female sex workers. Experts who work with these groups in Tanzania reached consensus on size and HIV prevalence estimates through a review of existing evidence and a Delphi consensus meeting. (For more on the methods and results of this process, please see *Consensus Estimates on Key Population Size and HIV Prevalence in Tanzania*.)

The same assumptions were used across different quantification exercises. For example, the agreed-upon number of people receiving ART each year was used in the ARV, opportunistic infections medication, and laboratory quantifications. For VMMC, NACP set regional-specific targets for the twelve priority regions (see Annex E).

e. Validation and prioritization

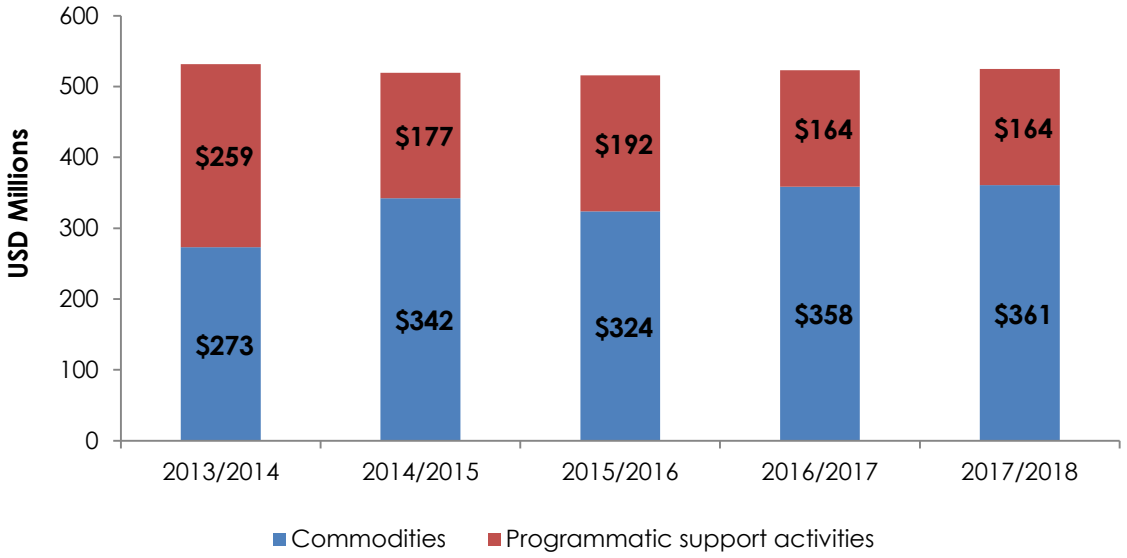
Once cost inputs were collected, the costing team held several rounds of data validation meetings with NACP staff. Validation ensured that the costing assumptions and calculations were logical, consistent, and accurate and that the overall costs aligned with the prioritized interventions. During validation meetings, the costing team reiterated all assumptions, identified cost drivers, and asked stakeholders if they would like to make any additions or revisions to the costing.

Cost validation meetings also informed planning and the prioritization process. Due to limited resources available for the HIV response, NACP staff identified which activities were the most important and where there could be cost savings. The final assumptions used to cost an activity, such as the number of healthcare workers to be trained each year, are noted in the detailed cost files.

III. HSHSP III RESOURCE REQUIREMENTS

The total cost of the HSHSP III from 2013/2014 to 2017/2018 is estimated to be *2,615 million USD*. The cost of the HSHSP III accounts for 88 percent of the NMSF III costing, which outlines the overall national HIV response. Figure 3 shows the total cost of the HSHSP III per year separating commodity and programmatic support costs. While commodity costs generally increase over time due to increases in the need for and coverage of certain HIV services, the costs for programmatic support activities steadily decline from 2013/2014 to 2017/2018. The first year of implementation has the largest programmatic support costs due to large capital investments and high administrative costs at the onset of the HSHSP III.

Figure 3: HSHSP III Costs by Year



Nearly one-third (32%) of the total five-year HSHSP III costs is for procuring antiretrovirals (ARVs). Other cost drivers include lab and diagnostic commodities (9% of total costs), STI commodities (8%), opportunistic infection medicines (7%), M&E program activities (7%), medicine and technology program activities (7%), and key population program activities (7%).

a. Cost by HSHSP III impact area

The HSHSP III contains three main impact areas: prevention of new HIV infections, reduction of HIV-related mortality, and strong and sustainable systems. The costs by impact area by year, separating routine program administration costs as a fourth category, are shown in Table 2. About half (49%) of the HSHSP III costs are attributable to reducing HIV-related mortality. Commodity costs for ARVs, OI medicines and Home-Based Care (HBC) kits are included in this impact area and account for 93% of the total cost. The ARV costing assumes that 78% of all people living with HIV eligible for treatment will be on treatment by 2017/2018. The cost of HBC kits increase over time due to the number of HBC service providers in Tanzania increasing to 18,150 by the end of the HSHSP III.

Table 2: HSHSP III Costs by Impact Area by Year (in USD millions)

Impact area	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Prevention of new HIV infections	$237.9	$170.9	$182.8	$171.4	$173.5
Reduction of HIV-related mortality	$201.9	$267.9	$253.9	$279.9	$279.9
Strong and sustainable systems	$90.1	$75.1	$77.5	$69.9	$69.9
Program administration	$1.8	$5.3	$1.7	$1.7	$1.7

The impact area for prevention of new HIV infections includes costs for several NACP departments: HTC, VMMC, STI, condoms, SBCC, blood safety, key populations, PMTCT, and PEP. The largest cost drivers in this area are VMMC programmatic support costs and VMMC, STI, and MAT commodities. The VMMC costing assumes each procedure costs on average $25.16 and over 2.7 million people will undergo the procedure from 2013/2014 to 2017/2018. The STI costing includes the cost of screening and first- and second-line treatment of all STIs in the country, including genital discharge syndrome, genital ulcerative disease, pelvic inflammatory disease, and syphilis. MAT costs are based on the assumption that 25,000 people will receive methadone daily and include the cost of naloxone for overdose management, morphine for neonatal abstinent syndrome, and urine drug screening kits.

The strong and sustainable systems impact area includes costs for M&E, quality improvement, medicine and technology, and workplace interventions. M&E (50%) and medicine and technology (45%) activities account for the vast majority of the costs. Trainings and equipment purchases, such as procurement of 300 point-of-care viral load machines, are the largest cost drivers for M&E and medicine and technology, respectively.

b. Cost by HSHSP III strategic objective

There are 27 strategic objectives identified in the HSHSP III. Table 3 shows annual costs of the top 10 highest cost strategic objectives. For the full five-year costs of all 27 strategic objectives, see Annex F.

Table 3: HSHSP III costs by year for top 10 strategic objectives (in USD millions)

Strategic objective	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018
80% of all eligible PLHIVs are put on and retained on appropriate ART regimen by 2017	$176.3	$254.9	$233.6	$262.8	$262.8
65% of councils provide access to comprehensive facility and community based health services for HIV prevention, treatment, care and support to key populations by 2017	$94.7	$48.4	$42.3	$39.9	$39.9
Prevalence of syphilis among ANC attendees and STI infection rate among men and women reporting to have an STI reduced by 50% to 2.1%, 2% and 1.5% respectively by 2017	$46.9	$42.7	$42.8	$45.3	$47.4
80% of sexually active men (10-49 years) in 12 priority regions access VMMC services by 2017	$34.5	$35.2	$43.2	$41.0	$41.0

Strategic objective	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018
Availability of accurate, complete and timely data at all levels	$25.7	$25.2	$25.5	$25.2	$25.2
80% of women and 65% of men aged 15-49 years know their serostatus (from the current 62% for women and 47% for men, respectively) and 50% are tested as couples by 2017	$19.0	$16.3	$20.7	$19.7	$19.7
Quality laboratory services for HIV and AIDS accessed by PLHIV at all levels of service delivery points countrywide	$26.1	$15.9	$24.0	$13.3	$13.3
Mother-to-child transmission of HIV reduced to below 5% by 2017	$17.5	$13.7	$13.8	$13.1	$13.1
PLHIV in all councils have access to quality comprehensive community based HIV services integrated with other services.	$12.8	$ 8.1	$ 8.7	$8.9	$8.9
Increased uptake, accessibility and quality of post-exposure prophylaxis (PEP) services for both occupational (e.g., healthcare workers) and non-occupational (e.g., rape and sexual assault) accidental exposures to blood and body fluids	$12.8	$ 8.1	$13.0	$5.5	$5.5

Due to the high cost of procuring ARVs, the strategic objective to put and retain 80% of all eligible people living with HIV on the appropriate ART regimen by the year 2017 accounts for 46% of the total HSHSP III costs. In comparison, the strategic objective with the second highest costs accounts for just 10 percent of the overall HSHSP III costs.

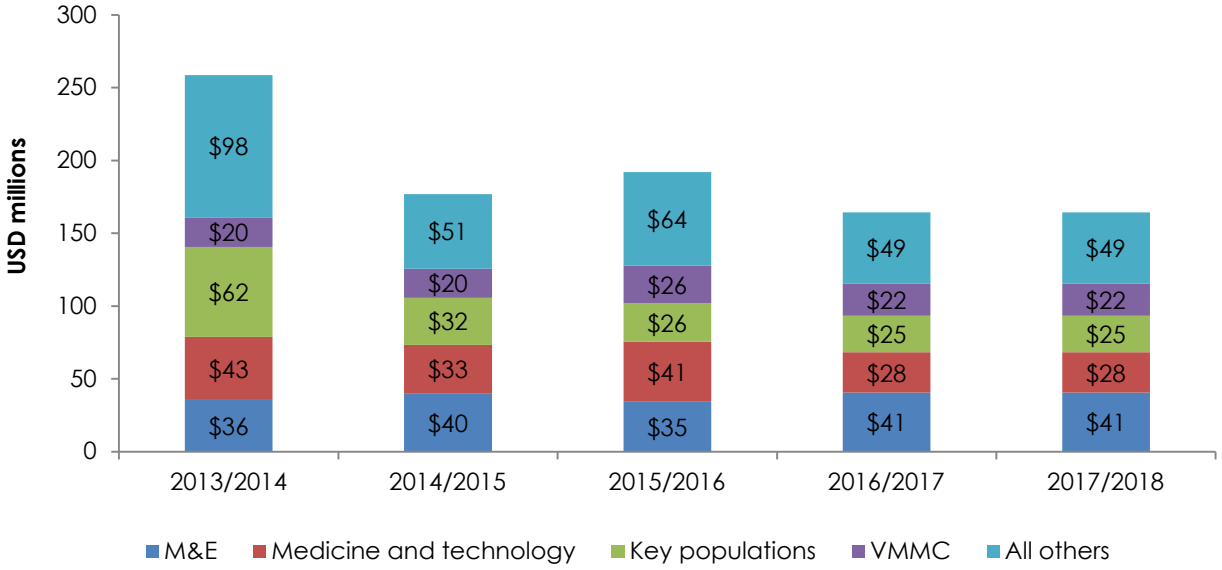
Commodity costs are the main cost drivers for the other highest-cost strategic objectives. For instance, 92% of the costs for reducing the prevalence of syphilis and other STIs are for STI treatment commodities.

c. Cost by NACP unit

There are 19 NACP units included in the HSHSP III costing. The adult ART, key populations, and STI units have the highest costs mainly due to commodity procurement. The lowest-cost NACP units account for 0.5% or less of the total HSHSP III costing. These units are program administration, condoms, SBCC, stigma, and WPI.

When looking only at programmatic support costs, four departments account for two-thirds of the total programmatic support costs: M&E (20%), medicine and technology (18%), key populations (18%), and VMMC (12%) (see Figure 4). About half of M&E programmatic support costs is for trainings to build M&E skills among health care workers. Equipment procurement accounts for significant portions of both the medicine and technology and VMMC programmatic support costs. While the medicine and technology unit is procuring new equipment for viral load testing, VMMC is procuring equipment for health facilities and mobile sites to perform male circumcisions. Approximately a quarter of the overall programmatic support costs for key populations are for renovating methadone treatment centers.

Figure 4: Programmatic support costs by NACP unit per year (in USD millions)



Across all units, trainings and workshops/meetings account for 34% and 16% of all programmatic support costs, respectively. However, the types of programmatic support activities conducted vary by NACP unit. While trainings account for 84% of PEP costs, just 5% of SBCC costs are for trainings.

d. Limitations of HSHSP III costing

The main limitation of the costing is that it does not capture the full cost of implementing HIV and AIDS interventions in the health sector due to exclusion of the private sector and cross-cutting health systems costs, such as human resources for health. The costing also assumes that costs will remain constant from 2016/2017 to 2017/2018 due to uncertainty in programming. As a result, the costing should be revisited and extended as program activities, technologies, and the HIV epidemic change.

IV. RECOMMENDATIONS

Based on the HSHSP III costing, it is recommended that NACP:

1. *Collaborate with stakeholders and development partners to develop funding strategies to mobilize resources for implementing the HSHSP III.* The national multisectoral HIV response is significantly underfunded, and it is estimated that the financial gap may be as large as $771 million USD from 2013/2014 to 2017/2018. The health sector's HIV response is the largest cost of the NMSF III, meaning that funding will likely fall short for NACP activities and procurement of essential commodities. Even if additional funds are mobilized, a large financing gap may still exist. Therefore, it is important to develop innovative and sustainable funding strategies which would decrease the financing need from traditional funders and donors.
2. *Prioritize HSHSP III interventions and activities that will yield the largest impact on HIV incidence and mortality for the lowest cost.* Due to constrained resources for the HIV response, national stakeholders, including NACP and TACAIDS, should conduct additional analyses and prioritization exercises for investments in high impact and low cost interventions. For instance, a UNAIDS investment case analysis revealed that scale-up of the most cost-effective interventions, such as ART, PMTCT, FSW programming, VMMC, and condom provisioning, could achieve 80% of the impact for 75% of the resources compared to full scale-up of all programs in Tanzania.
3. *Disseminate the costed HSHSP III to stakeholders at the national and sub-national level.* Decision-makers at the national level should be oriented on the cost results and use them to mobilize donor and domestic resources for the HIV response. Sub-national government bodies and implementing partners may use the costed HSHSP III to develop their own operational plans and budgets. The detailed operational planning and costing assumptions may be used to hold regional and district level governments accountable for implementing activities according to the HSHSP III, as well.
4. *Routinely update the costing results based on any changes in plans.* Due to unforeseen circumstances, actual program implementation may differ from the operational plan. The costing should be adjusted to reflect changes in assumptions, as any changes could have significant impact on the annual cost and funding gap estimates.
5. *Use the costing templates for HIV and AIDS for future strategic planning.* The costing templates are designed to show costs across multiple years of implementation. Users may add columns to estimate the cost of continuing activities or conducting new activities.

ANNEX A. REFERENCES

Ministry of Health and Social Welfare (MoHSW). *National Costed Plan of Action for Most Vulnerable Children (NCPA III) 2013–2017*.

National AIDS Control Program (NACP). *Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013–2017*.

Tanzania Commission for AIDS (TACAIDS). 2013. *The Second National/Multi-Sectoral Strategic Framework on HIV and AIDS (2008–2012).*

Tanzania Commission for AIDS (TACAIDS). *The Costed National Multisectoral Strategic Framework 2008-2012: Two Years Operational Plan 2008/2009–2009/2010*.

ANNEX B. COSTING TEAM

Name	Title and affiliation
Dr. Robert Josiah	Deputy Program Manager, National AIDS Control Program
Dr. Arin Dutta	Senior Economist, Health Policy Project, Futures Group
Cathy Barker	Health Scientist, Health Policy Project, Futures Group
Nena do Nascimento	Monitoring and Evaluation Advisor, Health Policy Project, Futures Group
Nicole Perales	Health Scientist, Health Policy Project, Futures Group
Xan Paxton	Global Health Policy Analyst, Health Policy Project, Futures Group
Ricardo Silva	Program Advisor, Health Policy Project, Futures Group

ANNEX C. KEY CONTACTS

Name	NACP unit
Dr. Angela A. Ramadhani	Programme Manager - NACP
Dr. Werner Maokola	NACP - TB/HIV
Dr. Patrick Mwidunda	NACP - QI
Pavel Mtango	NACP - CTU - Logistics
Dr. Anath A. Rwebembera	NACP - CTU - Pediatrics
Baraka Mpora	NACP - IEC Unit
Renatus Kisendi	NACP – CSS Unit
Bahati Mfaki	NACP - Lab Unit
Dr. Marylad Ntiro	NACP - CSSU
Peris Urassa	NACP - HIV T&C
Dr. Susan Mmbando	NACP - STI Unit
Dr. Florence Ndaturu	NACP - CTU
Dr. Daniel Nkonya	NACP - Global Fund Focal Person
Dr. Gisseng'e J. Lijja	NACP - VMMC, ARH, STI/RTI
Selestine Kato	NACP - (SCMS) Lab Advisor
Saulo Sarungi	NACP - Programme Pharmacist
Veryeh Sambu	NACP - Epidemiology Unit

ANNEX D. STANDARD UNIT COSTS

Note: Exchange rate used was 1667 Tanzanian Shillings (TZS) per 1 USD.

Item	Units	Unit Cost TZS	Source
PER DIEM			
Per diem - national level	Per person per day	80,000	Govt Circular
Per diem - regional and district level	Per person per day	65,000	Govt Circular
Per diem - driver	Per person per day	45,000	Govt Circular
International Travel Per diem	Per person per day	714,000	TACAIDS-MTEF
CONFERENCES AND MEETINGS			
Conference Registration fee (international)	Lump sum	1,700,000	NACP
Conference Registration fee	Lump sum	800,000	NACP
Conference package - City/Municipal	Per person per day	80,000	NACP
Conference package - Regional/District	Per person per day	50,000	NACP
Venue - Cities and Municipalities	Per day	250,000	NACP
Venue - Regional level	Per day	200,000	NACP
Venue - District level	Per day	150,000	NACP
Communication costs for organizing meetings	Lump sum	100,000	NACP
Airtime and internet (Communication for organizing)	Per day	30,000	NACP
Refreshments	Per person per day	25,000	NACP
TRANSPORT			
Visa	Per person	260,000	NACP
Fuel	Per liter	2,500	NACP
Transport allowance	Per person per day	20,000	MEASURE Evaluation
Ground transport	Per person roundtrip	120,000	NACP
Air Travel - International	Per person	2,956,522	TACAIDS-MTEF
Air Travel - Domestic	Per person	400,000	NACP
Taxi (to and from the airport)	Per person	120,000	NACP
Vehicle maintenance (30% of fuel)	(Fuel cost) * 0.3		NACP
PRINTING			
Stationeries/pax	Per person per day	10,000	NACP
Printing - summary report forms (e.g., Referral forms, Monthly report forms)	Per form	10,000	NACP HCT
Booklet	Per booklet	1,000	NACP SBCC

Item	Units	Unit Cost TZS	Source
Printing - posters	Per poster	800	NACP SBCC
Printing - stickers	Per sticker	400	NACP SBCC
Brochure	Per brochure	400	NACP
Registers	Per register	15,000	JHU CCP, NACP
Training Manual	Per manual	7,000	JHU CCP, NACP
Guidelines	Per guideline	20,000	NACP
Cards (e.g., Client Cards)	Per card	1,000	NACP
MISCELLANEOUS			
Consultant - International	Per person per day	850,000	TACAIDS
Consultant - National	Per person per day	480,000	NACP
Research assistant/Data collector	Per person per day	80,000	NACP M&E OP
Projector	Per projector	2,000,000	MEASURE Evaluation
Equipment hire (TV, Projector, etc.)	Per day	100,000	NACP
Hire computer (laptop)	Per computer per day	50,000	NACP M&E OP
Server	Per server	5,000,000	NACP M&E OP
Computer	Per computer	1,500,000	NACP-Procurement
Laptop	Per laptop	2,500,000	NACP-Procurement
Computer UPS	Per UPS	400,000	NACP M&E OP
Tent hire	Per tent	200,000	NACP HCT budget

ANNEX E. EPIDEMIOLOGICAL ASSUMPTIONS AND NATIONAL TARGETS

HIV testing and treatment targets for mainland Tanzania

	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Number of PLHIV (adults and children) receiving ART	513,752	597,270	714,924	825,425	825,425
Number of children receiving ART	39,317	56,113	89,401	97,018	97,018
Number of women receiving PMTCT	75,866	79,988	90,031	88,813	88,813
Number of people 15+ tested for HIV	N/A	8,000,000	8,400,000	8,900,000	8,900,000

Please note 2016/2017 and 2017/2018 use the same assumptions

Assumptions for first- vs. second-line treatment

	July 2014	July 2015	July 2016	July 2017	July 2018
Adults					
First-line regimens	96%	95%	93%	90%	90%
Second-line regimens	4%	5%	7%	10%	10%
Children					
First-line regimens	96.5%	97%	96%	95%	95%
Second-line regimens	2.5%	3%	4%	5%	5%

Key populations estimates for mainland Tanzania

	Population size	HIV prevalence
Female sex workers	155,450	26%
Men who have sex with men*	49,700	25%
People who inject drugs	30,000	36%

*Urban areas only.

VMMC Annual Regional Targets

Region	July 2014	July 2015	July 2016	July 2017	July 2018
Mbeya	75,179	78,596	88,847	99,099	99,099
Kagera	65,402	68,375	77,294	86,212	86,212
Mwanza	52,165	54,536	61,650	68,763	68,763
Tabora	46,805	48,933	55,316	61,698	61,698
Geita	46,343	48,449	54,768	61,088	61,088
Shinyanga	44,176	46,184	52,207	58,231	58,231
Simiyu	43,459	45,434	51,360	57,286	57,286
Rukwa	31,301	32,724	36,992	41,260	41,260
Iringa	19,157	20,027	22,640	25,252	25,252
Njombe	16,353	17,097	19,327	21,557	21,557
Katavi	14,527	15,187	17,168	19,149	19,149
Rorya	7,630	7,976	9,017	10,057	10,057
Totals	**462,495**	**483,518**	**546,586**	**609,653**	**609,653**

ANNEX F. TOTAL COSTS BY STRATEGIC OBJECTIVE AND NACP UNIT (IN USD MILLIONS)

Strategic objective	*NACP unit(s)*	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018
Prevention of new HIV infections						
80% of women and 65% of men aged 15-49 years know their serostatus (from the current 62% for women and 47% for men, respectively) and 50% are tested as couples by 2017	HTC	$19.0	$16.3	$20.7	$19.7	$19.7
80% of sexually active men (10-49 years) in 12 priority regions access VMMC services by 2017	VMMC	$34.5	$35.2	$43.2	$41.0	$41.0
Prevalence of syphilis among Ante Natal Clinic attendees and STI infection rate among men and women reporting to have an STI reduced by 50% to 2.1%, 2% and 1.5% respectively by 2017*	STI	$46.9	$42.7	$42.8	$45.3	$47.4
75% adolescents and youth aged 10–24 years access and utilize STI/RTI/HIV/AIDS and RH services and have access to proper information	STI	$2.7	$1.2	$1.1	$1.2	$1.2
Increased utilization of both male and female condoms during high-risk sex among women and men	Condom	$1.7	$1.6	$1.7	$1.8	$1.8
Increased adoption of safer sexual practices (reduced risk behaviours), increased healthier behaviours and increased uptake of comprehensive HIV and AIDS services (prevention, treatment, care and support)	SBCC	$1.3	$0.8	$1.1	$0.8	$0.8
Mother-to-child transmission of HIV reduced to below 5% by the year 2017**	PMTCT	$17.5	$13.7	$13.8	$13.1	$13.1
Unsafe blood transfusions eliminated in all health facilities in Tanzania mainland (from the current 35.7%) by 2017.	Blood safety	$6.9	$2.9	$3.2	$3.1	$3.1
65% of councils provide access to comprehensive facility and community based health services for HIV prevention, treatment, care and support to key populations by the year 2017^	STI and Key Populations	$94.7	$48.4	$42.3	$39.9	$39.9
Increased uptake, accessibility and quality of post-exposure prophylaxis (PEP) services for both occupational (e.g., healthcare workers) and non-occupational (e.g., rape and sexual assault) accidental exposures to blood and body fluids~	PEP	$12.8	$8.1	$13.0	$5.5	$5.5

Strategic objective	*NACP unit(s)*	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018
Reduction of HIV-related mortality						
80% of all eligible PLHIVs are put on and retained on appropriate ART regimen by the year 2017***	Adult ART	$176.3	$254.9	$233.6	$262.8	$262.8
All children under 15 years old living with HIV are put on ART and 90% are retained by the year 2017 ~*	Pediatric ART	$8.0	$2.4	$7.5	$4.7	$4.7
Morbidity and mortality of PLHIVs attributed to TB, NCDs and other co-morbidities reduced by 50% by the end of year 2015	TB-HIV	$3.7	$2.2	$3.8	$3.2	$3.2
People living with HIV in all councils have access to quality comprehensive Community Based HIV Services integrated with other services ~**	CBHS	$12.8	$8.1	$8.7	$8.9	$8.9
Equal access to health services by PLHIVs as the rest of the population (including key populations) and/or people affected by HIV and AIDS by 2017	Stigma	$1.0	$0.4	$0.3	$0.3	$0.3
Strong and sustainable systems						
Improved Coordination and Capacity for HIV M&E at all Levels	M&E	$2.2	$2.2	$2.2	$2.2	$2.2
Availability of accurate, complete and timely data at all Levels	M&E	$25.7	$25.2	$25.5	$25.2	$25.2
HIV surveillance, survey and research results are timely disseminated and used to improve formulation and delivery of effective health sector HIV and AIDS Intervention	M&E	$3.6	$10.8	$2.9	$9.6	$9.6
HIV data and information strategically demanded, disseminated and used for evidence-based decision-making by health workers, health managers and policy makers at all levels	M&E	$4.0	$1.9	$4.0	$3.7	$3.7
Increased access of comprehensive workplace interventions in the health sector focused on prevention, care, treatment and support of employees, employers and their families affected with HIV and AIDS	WPI	$0.0	$0.0	$0.0	$0.0	$0.0
Evidence in quantitative indicators of quality HIV and AIDS services demonstrated and documented in 75% of all hospitals and 50% of primary health service facilities (HC & Dispensaries)	QI	$11.2	$1.7	$1.8	$1.7	$1.7

Strategic objective	*NACP unit(s)*	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018
Continuous availability of quality HIV/STI and AIDS commodities (antiretroviral, HIV rapid test kits, laboratory reagents, medicines for opportunistic infections and related supplies) to the end user at the right quantity, time, place and cost	Medicine and Tech	$3.5	$4.1	$3.5	$3.5	$3.5
Supply Chain Management, Facility Commodity Management, Rational Use of Medicine and Pharmacovigilance (regional and District level)	Medicine and Tech	$1.8	$1.6	$1.8	$1.6	$1.6
Quality laboratory services for HIV and AIDS accessed by PLHIV at all levels of service delivery points countrywide	Medicine and Tech	$26.1	$15.9	$24.0	$13.3	$13.3
Increased "equipment uptime" (or reduced "equipment downtime") for HIV and AIDS laboratory equipment as a result of functional and reliable Plan Preventive Maintenance (PPM)	Medicine and Tech	$1.9	$1.4	$1.4	$1.4	$1.4
Laboratory Information System developed to address equipment status, logistic data usage, stock availability, Workload (testing) report and request for central level decision-making	Medicine and Tech	$7.7	$8.1	$8.3	$5.8	$5.8
Establishing a reliable and sustainable system for transporting samples to referral laboratories for testing	Medicine and Tech	$2.3	$2.3	$2.0	$2.0	$2.0
Routine program administration						
N/A	Program admin	$1.8	$5.3	$1.7	$1.7	$1.7

Notes:

*All STI commodities are under this one strategic objective.

**This strategic objective includes early infant diagnosis commodities, but excludes all other PMTCT commodities, including ARVs.

^Commodity costs for key populations only include harm reduction commodities.

~There are no PEP commodities under this strategic objective. ARVs for PEP are under Adult ARV.

***All ARV and OI costs are under this one strategic objective. All lab tests besides rapid HIV tests and early infant diagnosis are also included.

~*There are no pediatric commodity costs under this strategic objective.

~**This strategic objective includes HBC commodities.

National AIDS Control Programme
P.O. Box 11857 Dar es Salaam
Tel:-+255 22 2132313; Fax:-+255 22 2138282
Email: info@nacp.go.tz
Website: www.nacp.go.tz