

**THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE
TANZANIA MAINLAND**



**HEALTH SECTOR HIV AND AIDS STRATEGIC
PLAN -II
(HSHSP) 2008-2012**

December, 2009

LIST OF ABBREVIATIONS AND ACRONYMS

| Acronym/ Abbreviation | Meaning |
|--------------------------|---|
| ADDO | <i>Accredited Drug Dispensing Outlets</i> |
| ADR | <i>Adverse Drug Reaction</i> |
| AIDS | <i>Acquired Immunodeficiency Syndrome</i> |
| ANC | <i>Antenatal Clinic</i> |
| ART | <i>Anti retroviral therapy</i> |
| ARVs | <i>Anti retroviral drugs</i> |
| ASRH | <i>Adolescent Sexual Reproductive Health</i> |
| BCC | <i>Behaviour Change Communication</i> |
| BP | <i>Best Practice</i> |
| CCHPs | <i>Comprehensive Council Health Plans</i> |
| CHMT | <i>Council Health Management</i> |
| CMACs | <i>Council Multisectoral AIDS Councils</i> |
| CMO | <i>Chief Medical Officer</i> |
| COSTECH | <i>Commission for Science and Technology</i> |
| CP | <i>Couple Prevention</i> |
| CSOs | <i>Civil Society Organisations</i> |
| CTC | <i>Care and Treatment Clinic</i> |
| DACC | <i>District AIDS Control Coordinator</i> |
| DDH | <i>Designated District Hospital</i> |
| DED | <i>District Executive Director</i> |
| DHBs | <i>District Health Boards</i> |
| DMO | <i>District Medical Officer</i> |
| DNA PCR | <i>DNA polymerase chain reaction</i> |
| DP | <i>Development Partner</i> |
| DPG | <i>Donor Partner Group</i> |
| EQA | <i>External Quality Assurance</i> |
| ESRF | <i>Economic and Social Research Foundation</i> |
| FBO | <i>Faith Based Organization</i> |
| FY | <i>Financial Year</i> |
| GDP | <i>Gross Domestic Product</i> |
| GLP | <i>Good Laboratory Practice</i> |
| GoT | <i>Government of Tanzania</i> |
| GPA | <i>Global Program on AIDS</i> |
| GTZ | <i>Deutsche Gesellschaft für Technische Zusammenarbeit (German Technical Cooperation)</i> |
| HAART | <i>Highly active Anti retroviral therapy</i> |
| HBC | <i>Home based Care</i> |
| HBCT | <i>Home based Counselling and Testing</i> |
| HBV | <i>Hepatitis B Virus</i> |

| Acronym/ Abbreviation | Meaning |
|----------------------------------|--|
| HCV | <i>Hepatitis C virus</i> |
| HCW | <i>Health Care worker</i> |
| HIV | <i>Human Immunodeficiency Virus</i> |
| HIVDR | <i>HIV Drug Resistance</i> |
| HRH | <i>Human Resource for Health</i> |
| HSHSP | <i>Health Sector HIV/AIDS Strategic Plan</i> |
| HSS | <i>Health System Strengthening</i> |
| HSSP | <i>Health Sector Strategic Plan</i> |
| HTC | <i>HIV Testing Counselling</i> |
| IDU | <i>Injecting Drug Users</i> |
| IEC | <i>Information Education and Communication</i> |
| IHI (formerly IHRDC) | <i>Ifakara Health Institute</i> |
| IMCI | <i>Intergrated Management Of Childhood Illnesses</i> |
| IP | <i>Implementing Partner</i> |
| IPC | <i>Infection and Prevention Control</i> |
| JAR | <i>Joint Annual Reviews</i> |
| KAP | <i>Knowledge Attitude Practice</i> |
| L&D | <i>Labour and Delivery</i> |
| M & E | <i>Monitoring and Evaluation</i> |
| MARPs | <i>Most at risk populations</i> |
| MDG | <i>Millenium Development Goals</i> |
| MIPA | <i>Meaning Involvement of People living with AIDS</i> |
| MKUKUTA | <i>Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania</i> |
| MoEVT | <i>Ministry of Education and Vocational Training</i> |
| MOHSW | <i>Ministry of Health and Social Welfare</i> |
| MSD | <i>Medical Stores Department</i> |
| MSM | <i>Men having Sex with Men</i> |
| MTCT | <i>Mother to Child Transmission</i> |
| MTEF | <i>Mid term Expenditure Framework</i> |
| MTPs | <i>Mid Term Plans</i> |
| MTR | <i>Mid term review</i> |
| MUHAS | <i>Muhimbili University for Health and Allied Sciences</i> |
| NACOPHA | <i>National Council of People living with HIV/AIDS</i> |
| NACP | <i>National AIDS Control Programme</i> |
| NBS | <i>National Bureau of Statistics</i> |
| NBTS | <i>National Blood Transfusion Services</i> |
| NCTP | <i>National Care and Treatment Plan</i> |
| NEMLIT | <i>National Essential Medicine List</i> |
| NGO | <i>Non Governmental Organization</i> |

| Acronym/ Abbreviation | Meaning |
|----------------------------------|---|
| NHIF | <i>National Health Insurance Fund</i> |
| NIMR | <i>National Institute for Medical Research</i> |
| NMSF | <i>National Multi Sectoral Framework</i> |
| NQIC | <i>National Quality Improvement Committee</i> |
| NVP | <i>Nevirapine</i> |
| OIs | <i>Opportunistic Infections</i> |
| PEP | <i>Post Exposure Prophylaxis</i> |
| PER | <i>Public Expenditure Review</i> |
| PITC | <i>Provider Initiated Testing and Counselling</i> |
| PLHIV | <i>People living with HIV</i> |
| PMORALG | <i>Prime Minister Office Regional Administration and Local Government</i> |
| PMTCT | <i>Prevention of Mother to Child Transmission</i> |
| POPSM | <i>Presidents' Office Public Service Management</i> |
| QA | <i>Quality Assurance</i> |
| RAS | <i>Regional Administrative Secretary</i> |
| RCHS | <i>Reproductive and Child Health Services</i> |
| RHMT | <i>Regional Health Management Team</i> |
| RPR | <i>Rapid Plasma Reagin</i> |
| RTIs | <i>Reproductive Tract Infections</i> |
| SDV | <i>Single Dose Nevirapine</i> |
| SMI | <i>Safe Motherhood Initiative</i> |
| SOP | <i>Standard Operating Procedures</i> |
| STIs | <i>Sexually Transmitted Infections</i> |
| STP | <i>Short Term Plan</i> |
| SW | <i>Social Welfare</i> |
| TACAIDS | <i>Tanzania Commission for AIDS</i> |
| TDHS | <i>Tanzania Demographic Health Survey</i> |
| TFDA | <i>Tanzania Food and Drug Authority</i> |
| THIS | <i>Tanzania HIV Indicator Survey</i> |
| TTIs | <i>Transfusion Transmissible infections</i> |
| UDSM | <i>University of Dar es Salaam</i> |
| UNGASS | <i>UN General Assembly Special Session for AIDS</i> |
| VCT | <i>Voluntary Counselling and Testing</i> |
| VMACs | <i>Village Multisectoral Committees</i> |
| WHO | <i>World Health Organization</i> |

TABLE OF CONTENT

Abbreviations and Acronyms

Foreword

Acknowledgement

Executive Summary

SECTION ONE: STRATEGY FRAMEWORK

1.1. COUNTRY BACKGROUND AND HISTORY

- 1.1.1 Introduction
- 1.1.2 The Planning Process
- 1.1.3 Geographic and administrative
- 1.1.4 Demographic and socio economic
- 1.1.5 General health and nutrition situation in the country
- 1.1.6 HIV and AIDS:
 - 1.1.6.1 Burden of disease
 - 1.1.6.2. Gender and HIV and AIDS
 - 1.1.6.3. Impact of HIV and AIDS on health services

1.2 THE HEALTH SECTOR RESPONSE TO HIV AND AIDS

- 1.2.1. National Health System response and capacity
- 1.2.2. HIV and AIDS Control Strategies
- 1.2.3. Programmatic and Financial gaps

1.3. VISION, MISSION, GOALS AND STRATEGIC OBJECTIVES

- 1.3.1. Vision 2025
- 1.3.2. Mission
- 1.3.3. Goals
- 1.3.4. Key Principles
- 1.3.5. Main Assumptions
- 1.3.6. National HIV and AIDS Priorities

2.0. SECTION TWO: NARRATIVE AND JUSTIFICATION OF THE MATRICES

- 2.1. Thematic area 1: Prevention
- 2.2. Thematic Area 2: Treatment, Care and Support
- 2.3. Thematic Area 3: Cross-Cutting issues
- 2.4. Thematic Area 4: Health Systems Strengthening

3.0. SECTION THREE: THE IMPLEMENTATION FRAMEWORK

- 3.1. Implementation Arrangements
- 3.2. Priority Activities for Operationalization of the Strategy
- 3.3. Coordination Framework
- 3.4. Financing the Response
 - 3.4.1. The Costs of Health Sector Response to HIV and AIDS
 - 3.4.2. Resource management

3.5. Monitoring and Evaluation of the Plan

- 3.5.1. Objectives
- 3.5.2. M & E Components
- 3.5.2. M&E roles and responsibilities
- 3.5.3. Documentation of lesson learnt

4.0. SECTION FOUR: ANNEXES

Annex 1: Selected Unit Costs “From MKUKUTA Based MDGs Costings For The Health Sub-Sector”

Annex 2: Framework for Target Setting of Selected Impact and Outcome Indicators

Annex 3: Organogram for Ministry of Health and Social Welfare (MOHSW)

Annex 4: Matrices

- 4.1. Thematic Area I: Prevention
- 4.2. Thematic Area II: Treatment, Care and Support
- 4.3. Thematic Area III: Cross-Cutting Issues
- 4.4. Thematic Area IV: Health Systems Strengthening

Annex 5: References and Notes

103

112

FOREWORD

During the past twenty five years, Tanzania has seen the evolution of the HIV and AIDS epidemic from a rare and unknown disease to a familiar condition that today is known to most households. In 1983, the initial AIDS cases were reported in the Kagera region in North Western Tanzania. In 1986, three years later, all regions of Tanzania Mainland had reported AIDS patients. By 2004, about 7 per cent of the Tanzanian population aged 15 and 49 years were estimated to be infected with Human Immunodeficiency virus (HIV).

In response to this epidemic, a number of actions have been implemented by the Government and other stakeholders aiming to roll back the epidemic and mitigate its impacts. These actions which constitute the national response to HIV/AIDS, have grown over time from the initial health sector response between 1985 and 2000 to a broad stakeholder response that has received a special multisectoral emphasis in recent years following the formation of the Tanzania Commission for AIDS in the year 2000.

Despite these efforts, availability of core HIV and AIDS interventions is far from becoming universally accessible to all. Most interventions for HIV and AIDS prevention, care and support are delivered through the health care system and their coverage is yet to reach most primary health care facilities. Further more, the fact that most interventions are delivered in health facilities, their uptake by certain population groups which are most vulnerable to HIV and which play a major role in the spread of the epidemic, is limited. These groups include among others, men who have sex with men, commercial sex workers, injection drug users as well as women and youth in general. During the past twenty five years of the national response, the health sector has played a very critical role in creating public awareness on HIV and AIDS as well as providing most services for prevention, care, treatment and support. In order to strengthen the already established interventions as well make further expansion of these services, which are part of the national multisectoral response to HIV and AIDS, the health sector has developed a Health Sector HIV and AIDS Strategy which will provide guidance to the operations of the sectoral response in the next five years. This strategy which is a successor to the previous strategy of 2003-2006 will be known as Health Sector HIV and AIDS Strategy II. 2008-2012(HSHSP-II). The HSHSP-II shall strive to add a new critical phase to the national multisectoral efforts against HIV and AIDS. In this phase, the core health sector based HIV and AIDS interventions will be made universally accessible to all Tanzanians in need. Furthermore, during the lifetime of HSSHSP-II, the core services will be brought closer to the communities and made friendlier to the beneficiaries. The selection of interventions contained in the HSHSP II is based on the comparative advantages of the health sector. In that connection, most services are those that are delivered through the health services delivery system. The strategy will not scale up the availability of services but will also strengthen the capacity of the health system to deliver quality services at national, regional, district and community levels. The envisioned strengthening will avoid creating vertical HIV AND AIDS services by integrating all interventions in the routine health services. Through the strengthened and scale up health sector response to HIV and AIDS, it is expected that new infections will be prevented and those affected by HIV and AIDS will be accorded appropriate care, treatment and support services.

I wish to call upon the health sector stakeholders to make use of this strategy as their guidance in making their contribution to the national response to HIV and AIDS.

Blandina S. J. Nyoni
PERMANENT SECRETARY
MINISTRY OF HEALTH AND SOCIAL WELFARE
December, 2009

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The development of Health Sector HIV Strategic Plan (HSHSP II) 2008-2012 is a result of extensive work involving broad consultations and collaborative efforts of various stakeholders including a numbers of individuals, several institution, organizations, development partners and interested groups.

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The formulation of the HSHSP II 2008-12 could not be achieved without the contribution of Health Care Workers and beneficiaries of health services whose perspective and ideas played a major role in shaping the content and focus of this strategy. We thank them all.

Last but not least I wish to acknowledge the outstanding performance of the National AIDS Control Programme (NACP) secretariat in designing the formulation process of this strategy, for their technical inputs, final editing and on coordination of the whole process. Your work is highly appreciated.

Dr. Deo Mtasiwa
Chief Medical Officer
Ministry of Health Social Welfare

December, 2009.

EXECUTIVE SUMMARY

Introduction

This Health Sector HIV and AIDS Strategic Plan (HSHSP-2008-2012) is the contribution of the Health sector to the overall National Multisectoral Strategic Framework (NMSF-2008-2012). The theme of the HSHSP is “*universal access to preventive, care, treatment and support services*”

The plan has been prepared at the time when the country and, in particular, the health sector, is facing significant challenges such as serious human resource crisis, inadequate funds to immediately deal with the health problems and geographical imbalances in the distribution of the available resources within the country.

Background

Health Sector Performance and Disease Burden

Over the past five years, the overall performance of the health sector has shown some improvements and there is government commitment to allocate more resources. The country has recorded successes in key HIV and AIDS interventions, such as: increased coverage for PMTCT, introduction and expanded care and treatment, increased availability of condoms, increased counseling and testing services, expansion of services to communities and household levels. Lastly measures to monitor the epidemic are in place.

Despite these improvements, the biggest challenge is that the epidemic is far from being contained. Currently, the majority of people in need of services cannot access them especially the vulnerable groups and rural areas. The challenges of assuring quality of services being provided remains an area of great concern. Although resources are being allocated to the epidemic by the government, sustainability still remains a formidable task.

In order to successfully implement this strategic plan, the following assumptions are made:

- Continued peace and political stability in the country;
- There will be adequate numbers of appropriately trained and well motivated health workers;
- Macroeconomic stability and sustainable economic growth will continue;
- Increased Government prioritisation and funding to the health sector;
- Increased Partners support to other programmes within the health sector; and
- Timely and appropriate attention to implementation of all health priority areas.

Vision, Mission, Goals and Key Principles

| | |
|-----------------------|---|
| Vision: | “Tanzania united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus.” |
| Mission | Working in partnership with other public sectors, private sector, civil society and communities to play a leading role in the prevention of further spread of HIV AND AIDS and mitigate its impacts by providing essential interventions and quality care. |
| Goals: | <ul style="list-style-type: none">• To scale up the health sector response to HIV and AIDS and strengthen the health system capacity to support HI and AIDS interventions,• To promote access and utilization of affordable and essential interventions and commodities for HIV and AIDS, and• To improve the quality of HIV and AIDS interventions to the general public, PLHIV, health care providers and other vulnerable populations. |
| Key Principles | Equity of access, Ethical conduct and human rights, Quality, Accountability, Partnerships Decentralisation, Leadership: Gender |

National HIV and AIDS Priority Interventions

Though the lesson of prioritization in terms of focusing on few interventions has been acknowledged, this strategic plan has included some illustrative activities to serve as a menu that accommodates the interests of various stakeholders involved in the health sector response.

There are four themes including the health system strengthening. The health system interventions represent support services which facilitate the efficient and effective management of the health sector HIV and AIDS response, and without which implementation of the HIV and AIDS priorities would be seriously compromised.

| Thematic area | Key Challenges | Strategic objective | Targets |
|---|---|---|---|
| 1. Prevention | | | |
| 1.1. PMTCT | <p>34% of HIV positive pregnant women are receiving ARV prophylaxis</p> <p>30% of exposed babies received ARV prophylaxis</p> <p>Only 1347 health facilities out of a total of 4871 providing RCH services are also providing PMTCT services.</p> | <p>Increase the percentage of HIV positive pregnant women who receive ARVs from 34% in 2007 to 80% by 2012 to reduce the transmission of HIV from mothers to their children, during pregnancy, birth and/or breast-feeding and ensure access to care and treatment for mothers and babies</p> | <p>-At least 80% of all pregnant women get access to standard Package of PMTCT (provided with information to prevent HIV transmission, tested for HIV and counselled, receive family planning services, infant feeding counselling and support)</p> <p>-At least 80% of pregnant women living with HIV and their babies receive ARV prophylaxis for MTCT prevention</p> <p>-At least 80% of infants born to women living with HIV receive co-trimoxazole prophylaxis.</p> <p>-At least 50% of male partners of women tested for HIV through PMTCT are screened and counseled for HIV.</p> <p>-At least 50% of infants born to women living with HIV are tested for HIV . (using Antibody Test /DNA PCR).</p> <p>-At least 50% male partner of women tested for HIV through PMTCT are screened and counselled</p> |
| <p>1.2. Prevention of sexual transmission of HIV</p> <p>a) STI</p> | <p>Inadequate screening for syphilis in RCH services</p> <p>Few youth friendly reproductive health services</p> <p>STI services addressing high risk population groups are limited.</p> <p>Weak monitoring of aetiologies and antimicrobial susceptibility patterns of STI pathogens</p> <p>Poor contact tracing (21-35%)</p> | <p>To expand quality STI services and enhance appropriate utilization of services</p> | <p>Increase the percentage of STI patients attending health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines from 67% in 2005 to 80% by 2012.</p> <p>Number of STI cases treated annually 2008 – 1,210,674 2009 – 1,249,346 2010 – 1,288,065 2011 – 1,327,022 2022 – 1,366,235</p> <p>Increase the percentage of health facilities providing STI case management by syndromic approach from (3000)66% to (4000)85% by 2012.</p> <p>Increase the percentage of first visit ANC attendees who receive routine antenatal syphilis screening services from 40% in 2006 to 75% in 2012.</p> <p>Increase the percentage of STI patients attending health care facilities who received appropriate advice on condoms use, partner notification and who are referred for HIV testing from 9.3% (2003) to 50% by 2012.</p> <p>Increase percentage of individuals served by health care facilities that have supply of essential STI drugs and</p> |

| Thematic area | Key Challenges | Strategic objective | Targets |
|---|--|--|---|
| | | | that have reported no stock outs lasting longer than one week in the proceeding twelve month from 39.7 (2003) to 60% by 2012. |
| b) Male circumcision | Male circumcision has not been integrated in HIV prevention services currently in the country | To promote medically safe accepted male circumcision for health benefits and as a preventive measure against HIV transmission | Strategic framework for male circumcision in place by end of 2009 |
| 1.3. Prevention of HIV in Health care settings a) Safe blood | Limited numbers of blood donors Weak distribution of donated blood and blood products by Zonal centers to regional distribution points | To increase supply of safe blood from 15% to 50% of the blood transfusing hospitals by 2012. | Increase low risk blood donations from baseline to 70% in public and private hospitals |
| b) Workplace programmes | Inadequate functioning of National Quality Improvement Committee (NQIC) on infection control Low rate of implementation of PEP. Inadequate coverage of HIV work place interventions in health facilities | To implement comprehensive workplace interventions in the health sector focused on the prevention, care, treatment and support of employees and their families | Health Sector Workplace HIV intervention strengthened and promoted at all levels |
| 1.4. Prevention of HIV transmission in vulnerable groups a) Youth | Adolescent sexual and reproductive health (ASRH) not mainstreamed into HIV and AIDS at all levels | Strengthen promotion, availability, accessibility and use of condoms | All regions mobilized to provide ASRH friendly services Percent of unmarried young women and men aged 15-19 who had never had sex increased by 10% from the current 54% and 46% respectively by 2012. |
| b) CSW, MSM, IDU | Inadequate data on the characteristics, risk taking behaviours, magnitude, social-economic- situation of vulnerable populations Lack of policy guideline for the Vulnerable populations | To prevent transmission of HIV among MARPs. | Availability of favourable policy guideline for MARPs by 2010 Establish magnitude of HIV AND AIDS among MARPs and determinants of HIV transmission by 2009 A package for HIV prevention for MARPs developed by 2010 Public -private partnership for MARPs intervention established at all levels by 2011 |
| 1.5. Positive prevention | Inadequate meaningful engagement and involvement of PLHIV for Positive Prevention Several PHLA groups are poorly organized and weak | To reduce the risk of PLHIV getting re-infection or infecting others with HIV | National guidelines for meaningful involvement of PLHIV (MIPA) developed Increase the number of couple who are counselled and tested |
| 2. Treatment, Care and Support | | | |
| 2.1. Facility based services a) ART | Only 19.4% and 12.8% of adults and children in need of ART receive this treatment Limited number of days for | To strengthen and scale up implementation of comprehensive care and treatment services in public and private facilities so as to provide | A comprehensive package of care and treatment available throughout the Health system according to the level of a facility 90% of all eligible persons put on ART by 2012 |

| Thematic area | Key Challenges | Strategic objective | Targets |
|---|--|---|---|
| | <p>offering ART services</p> <p>Lack of integration of CTC clinics into routine care</p> | ART services to 90% of all PLHIV in need of ART of which 18% will be children by 2012 | <p>18% of patients on treatment are children by 2012 (from the current 8%)</p> <p>All health facilities have at least 2 HCWs trained in HIV and AIDS care and treatment</p> <p>Policy on task shifting is in place</p> |
| b) TB/HIV collaborative | <p>Poor absorptive capacity of VCT centers to scale up TB activities</p> <p>Inadequate linkage of CTC clinics into TB interventions</p> | To improve the quality of care for both PLHIV as well as TB patients by strengthening the collaboration between TB and HIV programmes at all levels. | <p>All CTCs screening PLHIV for TB</p> <p>All TB clinics screening patients for HIV co-infection</p> <p>All TB clinics at all levels of health services providing HIV care and treatment.</p> |
| c) Quality of facility based services | Low capacity at National and Regional level to monitor and supervise ART care and treatment interventions | <p>To provide quality HIV and AIDS care and treatment to PLHIV and improve the quality of life by 2012.</p> <p>Targets</p> <p>All HIV care and treatment health facilities to provide essential package of care</p> <p>All Health Care facilities to have at least two Health Care Workers trained to provide care and treatment services</p> <p>All facilities providing care and treatment are supervised at least twice a year.</p> | <p>Targets</p> <p>All HIV care and treatment health facilities to provide essential package of care</p> <p>All Health Care facilities to have at least two Health Care Workers trained to provide care and treatment services</p> <p>All facilities providing care and treatment are supervised at least twice a year.</p> |
| <p>2.2. Community based services</p> <p>a) HBC</p> | <p>Only 50,000 are receiving HBC services out of 320,000 who are in need</p> <p>Erratic supply of HBC kits resulting in inadequate use of effective pain management medicines including oral morphine.</p> | <p>To strengthen and scale up the implementation of comprehensive care and treatment services</p> <p>To strengthen and scale up the implementation of standard package of home based care services for HIV and AIDS in all districts.</p> <p>To strengthen effective linkages and referrals between community based and clinical service to ensure the provision of comprehensive services across a continuum of care for PLHIV</p> | <p>All districts implement standard package of HBC and support services</p> <p>Review the national package for HBC services</p> <p>Policy guideline on use of oral morphine for home use formulated by 2010</p> <p>Partners providing HBC, their package and their locality identified and documented in each district.</p> <p>At least two health care workers per facility trained on standard package of HBC care.</p> <p>At least two community HBC providers per village trained on standard package of HBC care.</p> <p>All HBC patients effectively linked to CTC and other support services.</p> <p>Reach 495,300 adults and children living with HIV who receive care and support services outside facilities by 2012.</p> |
| 3. Cross-cutting Issues | | | |

| Thematic area | Key Challenges | Strategic objective | Targets |
|--|---|--|--|
| 3.1. Laboratory services | <p>No high containment laboratory (P3) for virus isolation and characterization.</p> <p>Inadequate supply of laboratory reagents and other consumables,</p> <p>No capacity to monitor drug resistance (ARVs and antimicrobial agents-STI, TB)</p> <p>Different specifications of laboratory equipment so difficulties in maintaining them</p> <p>Irregular maintenance of laboratory equipment</p> | Strengthen laboratory system at all levels to support prevention, care, treatment and other interventions for STI, HIV and AIDS. | <p>Establish quality assurance systems in all public and private hospital laboratories by 2012.</p> <p>Establish Infant HIV diagnosis capacity in three regional hospitals and ensure equitable services by 2012.</p> <p>Establish capacity for HIV drug resistance testing in one laboratory at one of the referral hospital by 2012 .</p> <p>Establish a functional and sustainable equipment maintenance mechanism by 2009.</p> <p>Establish logistic management system to ensure uninterrupted supply of test kits and laboratory reagents</p> |
| 3.2. HIV Testing & Counselling | <p>10.5% of people aged 15 to 49 in urban areas had been tested in the past year against 3.4% in rural areas</p> <p>VCT being a part time activity and hospital-based, lack of recognition as a career path (counsellor is not a cadre in the health system)</p> <p>A weak referral and networking system</p> <p>Inadequate supervision and support to counsellors,</p> <p>Existence of different HTC standards</p> | To improve access to and use of quality HIV testing and counselling (HTC). | <p>Annual number of people who received HIV testing and counselling services and received their test results reaches 4,933,450 by 2012.</p> <p>Proportions of women and men aged 15-49 years who receive HTC services and receive their test result increase from 37% and 27% of women and men respectively to 60% and 40% by 2012.</p> <p>More than 20% of dispensaries throughout the country provide VCT services by 2012.</p> <p>PITC services are established in all hospitals and health centres and at least 10% of the dispensaries by 2012.</p> <p>Five hundred (500) VCT counsellors are trained to meet the needs of special groups such as auditory and visually impaired individuals, children and MARPs by 2012.</p> <p>Fifty percent (50%) of VCT sites are assessed by 2012.</p> <p>Comprehensive HTC guidelines, standard operating procedures (SOPs) and cue cards are distributed to all HTC service sites by 2011.</p> <p>Annual coordination and quarterly subcommittee meetings at the national level are organised.</p> |
| 3.3. IEC and BCC and Stigma reduction | <p>BCC</p> <p>Non inclusion of BCC programming in HIV and AIDS interventions</p> <p>Current messages are not contextualised to local settings</p> <p>No monitoring tools are</p> | Improve provision of BCC interventions for HIV and AIDS using the contextual approach | <p>Four focused KAP studies conducted by 2010 to address key knowledge gaps on the determinant of the epidemics in Tanzania</p> <p>Health sector HIV and AIDS Communication Strategy developed by 2009</p> <p>Mechanisms to link various BCC stakeholders established by 2010</p> <p>IEC materials for universal access to</p> |

| Thematic area | Key Challenges | Strategic objective | Targets |
|--|--|---|---|
| | <p>available to establish effectiveness of the BCC programs</p> <p>IEC Centralized and inadequate production of IEC materials.</p> <p>Regional media and other communication channels are rarely used</p> <p>No evaluation done on impact of different types media used for channelling messages to the public</p> <p>Regional media and other communication channels are rarely used</p> <p>Stigma No clear law to minimize stigma and promote respect for Human Rights of persons living with HIV and AIDS</p> | <p>Improve the provision of HIV and AIDS information through innovative approaches based on available evidence.</p> <p>Ensure stigma reduction interventions at all levels of health system..</p> | <p>prevention, Care, treatment and support are available in rural areas Coordinate production of major IEC materials. NACP website fully developed by 2010 NACP library strengthened</p> <p>Stigma reduction interventions developed, integrated and implemented at all levels of health system by 2012. Incorporate stigma and discrimination reduction modules in various health training materials by 2012</p> |
| 3.4. Condom programming | <p>Condom outlets are limited in number and variety (health facilities, shops, youth clubs).</p> <p>54.2% of male condoms are free, 45.8% are sold through social marketing (2006 NACP) @ TZS. 100 for a pack of 3. Female condoms are relatively expensive @ TZS. 350 each (PSI)</p> <p>Condoms stock outs in rural areas and for vulnerable groups</p> | Strengthen promotion, availability, accessibility and use of condoms | <p>At least 60% of youth aged 15-24 years use condoms in all risk sexual exposure Condom use promoted using ten different innovative approaches through private- public partnership at all levels by 2012 Develop training materials on dual protection of condoms for HIV and STIs prevention and family planning Identify five additional partners for condom distribution by 2012 Conduct four operational research on condom promotion and distribution by 2010</p> |
| 4. Health System Strengthening | | | |
| 4.1. National Planning and Programme management | <p>NACP directly implementing some HIV and AIDS interventions at lower levels.</p> <p>The creation of vertical structures that drain the limited resources within the health care delivery system</p> <p>Poor linkage of vertical programs leading to inefficiency and at times artificial shortages of drugs and other commodities</p> <p>Poor coordination between HIV and AIDS programmes</p> | Strengthen managerial capacity for planning, resource allocation, utilization, implementation and monitoring of all, HIV and AIDS interventions at all levels. | <p>Improve management capacity for planning, resource allocation and coordination in 20% of district levels by 2012.</p> <p>Quality improvement in implementation of all HIV and AIDS interventions institutionalised by 2012</p> |

| Thematic area | Key Challenges | Strategic objective | Targets |
|---|---|---|--|
| | <p>and actors</p> <p>Inadequate documentation and dissemination of best practices at all levels</p> | | |
| 4.2. Procurement, supply management | <p>Two competing systems (Push and Pull) for acquisition of supplies</p> <p>Erratic supplies</p> <p>Improper utilization of maximum-minimum so adhoc order placement.</p> <p>Inefficient fall back opportunities at facility level to use alternative methods of acquiring supplies when MSD has stock outs.</p> <p>No central tool for commodity forecasting for HIV and AIDS commodities</p> <p>No regular consumption feedback of HIV and AIDS commodities from end users</p> <p>There is gross under reporting of ADR.</p> | Strengthen procurement, supply management and pharmacovigilance systems for STI, HIV and AIDS medicines, diagnostics and other commodities | <p>Medical Stores Department able to respond to the needs and requirements of supplies for HIV and AIDS services by 2012.</p> <p>Annual revision of NEMLIT Pharmacovigilance reports compiled and disseminated annually.</p> |
| 4.3. Human resources for health | <p>Recruitment and hiring-establishment</p> <p>The tendency of recruitment of staff by projects and secondment practices</p> <p>In service training</p> <p>Different schedules of in service training practices by various HIV and AIDS interventions or programmes</p> <p>Task shift policy.</p> <ul style="list-style-type: none"> -No standardized programme for training and certification that guarantees essential standards of care. -No regulatory framework -Unclear incentive package for implementing task shift plan (policy). | Establish a system to build and sustain human resource. | <p>Functions and skills required for comprehensive HIV and AIDS responses at all levels established.</p> <p>Human resource capacity required for managing the HIV and AIDS responses strengthened.</p> |
| 4.4. Strategic information a) M&E | <p>Unclear flow of data and inefficient reporting – incomplete, under reporting</p> <p>Doubtful use of data at all levels –</p> <p>Lack of integrated supervision and adequate feedback at the facilities</p> | Strengthen monitoring and evaluation system to provide relevant comprehensive information in a timely manner for programme management and planning. | <p>Comprehensive monitoring and evaluation system for HSHSP II operational by December 2009.</p> <p>M & E to feature in the national comprehensive supervision manual by December 2009.</p> <p>The national comprehensive supervision manual fully operational by 2012.</p> <p>Develop and disseminate</p> |

| Thematic area | Key Challenges | Strategic objective | Targets |
|---|--|---|---|
| | <p>level to ensure improved quality of services.</p> <p>Lack of harmonized M & E system (each program with a database and M & E)</p> <p>Lack of information or documentation on best practices</p> | | <p>comprehensive HIV and AIDS Strategic Information report annually effective 2008.</p> <p>All facilities submit timely, accurate and complete reports on HIV and AIDS interventions by 2010</p> |
| b) Biological and behavioural surveillance on STI, HIV and AIDS | <p>Inadequate biological and behavioural surveillance on STI and HIV</p> <p>No surveillance activities targeting the most-at-risk sub populations (MARPS)</p> <p>Absence of testing facilities or infrastructure for diagnosis of HIV in children ;</p> <p>Use of RPR test in STI surveillance poses difficulties in remote areas due to the cold chain requirement</p> | Strengthen surveillance activities to monitor the dynamics of the epidemic and the impact of STI, HIV and AIDS interventions. | <p>Biennial surveillance reports produced and disseminated timely.</p> <p>Surveillance activities for at least one MARPs population established by December 2009.</p> <p>Adoption of alternative and user friendly kit for syphilis testing performed by 2010.</p> <p>PMTCT and HTC HIV prevalence data validated by 2010</p> |
| c) HIV, STI and TB drugs resistance and drug side effects | <p>Inadequate surveillance activities concerning drugs resistance monitoring (for STI and ARV).</p> <p>Insufficient capacity to carry out STI drug susceptibility monitoring</p> <p>Insufficient capacity to correctly identify and report on side effects of HIV drugs (ADR)</p> | Strengthen surveillance of ARVs and STI drug resistance as well as pharmacovigilance of ARVs, STI drugs and OI medication | <p>Four laboratories to perform STI drug susceptibility monitoring by 2011.</p> <p>HIV drug resistance early warning indicators monitored in 30 HIV care and treatment facilities by 2012.</p> <p>Effective implementation of pharmacovigilance for ARVs, STI and OIs drugs in 100 facilities by 2012</p> <p>Implement ten rounds of HIVDR Threshold surveys by 2012.</p> |
| 4.5. Priority STI, HIV and AIDS, Research | <p>Limited understanding of the nature and driving forces of the HIV epidemic at the sub-national level and among sub-populations</p> <p>Lack of research policy on HIV and AIDS and Weak research coordination</p> <p>Inadequate dissemination of the results of research locally, to policy makers , programmes managers and the beneficiaries</p> <p>Very little has been done in the area of Paediatrics HIV/AIDS.</p> | Strengthen the health sector capacity to contribute to national HIV and AIDS and STI related research and development | <p>Review and disseminate STI, HIV and AIDS research priorities by December 2009.</p> <p>Allocate enough funds for five research projects which are within HIV and AIDS research agenda annually.</p> <p>Build capacity of seventy districts to conduct operational research by 2012.</p> |

Financing the Health sector response for HIV and AIDS

The Health Sector Strategy for HIV and AIDS 2008-2012 is estimated to cost between **US\$2,078 million** and **US\$2,287 million**. The projected resources to be mobilized during the same period range from **US\$1,470 million** to **US\$2,301 million**. Therefore, the plan will be operated under a deficit budget of between **US\$311 million** and **US\$320 million**. The gaps in meeting the demands of HIV interventions in the next five years will increase with time.

Implementation Framework

Implementation

The duration of the HSHSP is five years, from 1 July 2008 to 31 June 2013. The HSHSP is closely linked with the NMSF 2008-12 and the Medium Term Expenditure Framework (MTEF). The HSHSP will be operationalised through MTEF plans and annual action plans and budgets.

The HSHSP will be implemented and coordinated through the existing health sector organisational and management structures at national, regional and district levels, including public, private, faith based and traditional healers involved in providing health care services.

MoHSW will ensure that effective and adequate financial and administrative management systems and control procedures are in place to ensure that all GoT and DP resources are disbursed and accounted for as planned. MOHSW will also establish mechanisms to provide adequate capacity, linked to performance, for successful program implementation, in consultation with the development partners (DPs).

Decentralisation will remain as one of the key principles for the organisation and management of the health sector to HIV and AIDS.

Monitoring and Evaluation

Monitoring and evaluation of the implementation of the HSHSP will be conducted through appropriate systems, procedures and mechanisms. The Monitoring and Evaluation (M&E) Sub-Committee of MoHSW will be responsible for providing advice on all matters concerning M&E.

The Health Management Information System (HMIS), Financial Administrative Management System (FAMS) and other routine systems will be the major tools for data collection. Depending on the type and relevance of the indicators, routine monitoring will be undertaken, on a monthly, quarterly, bi-annual and annual basis. The MOHSW and other agencies will primarily use this data and its analyses for decision making. MOHSW will produce quarterly activity and financial reports for all levels of the health system for consideration at decision making levels. It will also produce an Annual Performance Review Report, on the performance of the sector against annual plans and output targets.

MOHSW will be responsible for sector performance monitoring and review. It will plan and lead the Joint Annual Reviews (JAR), with appropriate involvement and support of the DP, other Government ministries and other key stakeholders. The findings of the JAR will be presented at the first DPG meeting of each year.

There will be two evaluations during the duration of this plan. These will consist of a mid-term assessment after the first 3 years of implementation and a comprehensive final evaluation in 2011. All stakeholders will agree on the timing, terms of reference and composition of these two review missions. All costs will be included in the Health Sector Budget.

SECTION ONE

1.1. COUNTRY BACKGROUND AND HISTORY

1.1.1 Introduction

The Health Sector for HIV and AIDS Strategy - II 2008-2012 has been developed taking into account the following developments in Tanzania:

- Firstly, Tanzania AIDS Commission (TACAIDS) who has the accountability for developing and adjusting the national multi sector HIV and AIDS strategy has developed a National HIV and AIDS Multi-sectoral Strategic Framework (NMSF 2008-2012). This framework lays out clearly the areas for concentration for the various sectors and provides guidance on the formulation of the sectoral plans for HIV and AIDS according to their comparative advantage: By addressing HIV and AIDS in a comprehensive and multi sectoral manner, the NMSF contributes to MDGs, universal access to HIV services, overall national development, poverty reduction and thus to the attainment of the aspiration laid out in the Vision 2025.
- Secondly, the Ministry of Health and Social Welfare (MOHSW) has the overall Health Sector Strategic Plan (HSSP-2008). The development of a new health sector strategy will include the HIV and AIDS.
- Thirdly, this new Health Sector Strategy on HIV and AIDS, spearheaded by MOHSW through the National AIDS Control Programme (NACP), is a continuation of the previous strategy which concluded at end of 2006.

Therefore, this HSHSP 2008-2012 is a systematic approach of contributing to the:

- Operationalization of the TACAIDS NMSF 2008-2012.
- Operationalization of the current Ministry of Health Strategic Plan (HSSP-2008) and serve as an input into the anticipated new overall health sector strategy.
- Guidance of various implementers of Health Sector Strategy for HIV and AIDS at different levels.

The management intent of the HSHSP 2008-2012 is not to replace the need for Partners, Regions and Districts to have their own plans, but rather to:

- Support coordinated, prioritised and knowledge-based scale up of the response.
- Facilitate broad ownership of the response by all partners and practical partnerships for the implementation of the response.
- Represent joint strategic direction of all Partners, Sectors, Regions and Districts.
- Enable the involvement of key sectors and decentralised levels in all stages of the process.
- Guide resource management at the strategic level.

1.1.2. The Strategic Planning Process and Structure

The HSHSP 2008-2012 has been built on the process of joint annual reviews of the progress with the current 2003-2006 Health Sector Strategic Plan for HIV and AIDS and a broad consultative process with the Partners, Sectors, Regions and districts. The approach used included data collection, review of literature, thematic group works, stakeholders' consensus building workshops, field visits to Regions and districts and consolidation of the plan. The draft HSHSP was also presented and discussed at the stakeholder meetings of MOHSW and other fora.

1.1.3. Geographic and Administrative Profile

As of November 2007, Tanzania Mainland had 21 regions and about 124 districts. Each district is divided into divisions, which in turn are composed, of 3-4 wards (5-7 villages form a ward). The district is the most important administrative and implementation unit for public services. For this reason the Ministry of Health and Social Welfare (MOHSW) in collaboration with the Prime Minister's Office Regional Administration and Local Government (PMORALG) through the Health Sector and Local Government reforms are currently strengthening the district health services, making the districts the focus for health development.

1.1.4. Demographic and Socio-economic

The Tanzania Mainland has an estimated 2007 population of 38,291,219 projected from the 2002 population Census. It has an annual population growth rate of 3.1%. Crude birth rate is 41.6 per 1,000 populations and life expectancy at birth is 52 years for men and 55 years for women. Twenty five percent (25%) of the population resides in urban areas whereas the majority (75%) of population is rural dwellers.

Table1. Demographic and Socioeconomic Parameters

| Parameter | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|--------------------|------------|------------|------------|------------|------------|------------|------------|
| Total population | 37,133,156 | 38,291,219 | 39,474,667 | 40,683,291 | 41,914,311 | 43,169,305 | 44,439,683 |
| Growth rate | 3.20 | 3.10 | 3.10 | 3.10 | 3.00 | 3.00 | 2.90 |
| Population <1 | 1,495,830 | 1,529,901 | 1,562,570 | 1,596,426 | 1,628,587 | 1,663,322 | 1,690,929 |
| Population 5+ | 30,520,545 | 31,260,142 | 32,252,496 | 33,284,186 | 34,346,707 | 35,432,468 | 36,540,089 |
| Population 15+ | 20,634,300 | 21,281,097 | 21,943,610 | 22,618,638 | 23,304,925 | 24,001,428 | 24,705,812 |
| Population 15 - 49 | 17,170,784 | 17,756,846 | 18,343,552 | 18,929,495 | 19,516,143 | 20,106,402 | 20,700,532 |
| CBAW (15 - 49) | 8,913,923 | 9,200,145 | 9,486,086 | 9,770,578 | 10,054,385 | 10,339,107 | 10,624,871 |
| Crude birth rate | 42.4 | 41.6 | 40.8 | 40.0 | 39.3 | 38.4 | 37.6 |

Source: National Bureau of Statistics, Tanzania National projections Volume XII (2006)

1.1.5. General Health and Nutrition Status

According to TDHS 2004-2005 report, the current infant mortality and under five-year are 68 and 112 per 1,000 live births respectively whilst the maternal mortality is estimated at 578 deaths per 100,000 live births. The nutritional status shows a slight improvement, for instance stunting changed from 44% (2000) to 38% (2004/5) while wasting changed from 5% to 3% over the same period. The underweight improved from 29% to 22%.

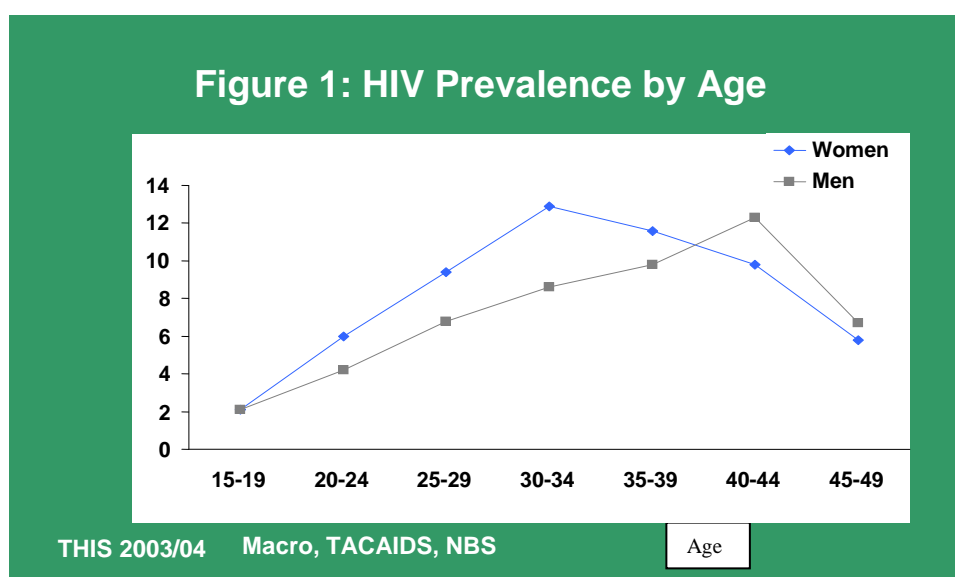
1.1.6. HIV and AIDS

1.1.6.1. Burden of disease

The Tanzania HIV AND AIDS Indicator Survey (THIS) of 2003/4 shows that the predominant mode of transmission has remained heterosexual contact, constituting about 80% of all new infections. Mother to child transmission is estimated to account for about 18% of new infections. About 1.8% of young persons aged 15 to 24 who reported that they never had sex were found to be HIV positive. This suggests that they were infected through blood transfusion, unsafe injections or traditional practices, including male circumcision or female genital cuttingⁱ.

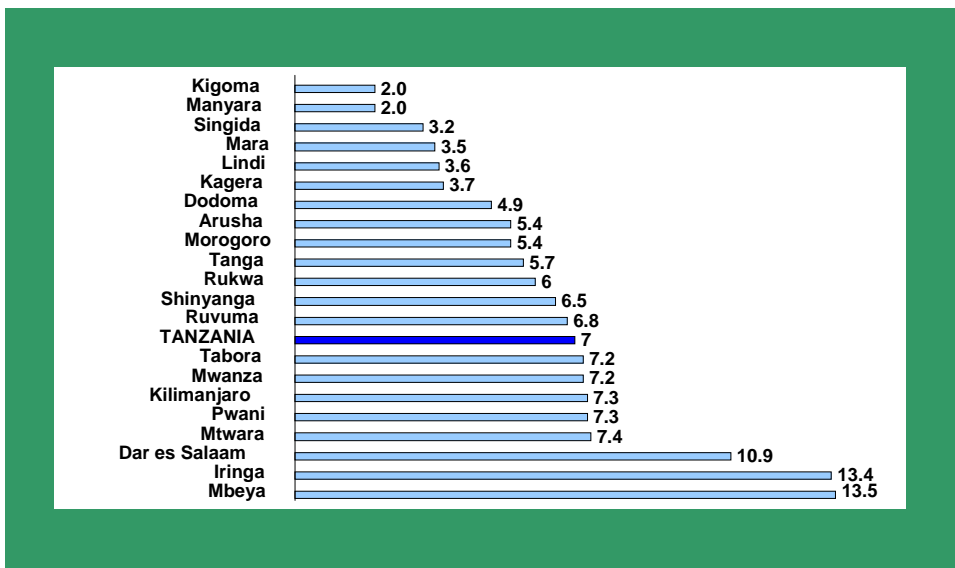
Recent studies indicate that in some parts of the country, transmission through anal sexual intercourse (heterosexual or among men who have sex with men) as well as HIV infection through drug abuse are occurring and may be important factors for the further spread of HIV.

Tanzania is facing a ‘generalizedⁱⁱ’ epidemic of HIV. The overall prevalence in the sexually active population (age 15 to 49) is 7.0%, with women being more affected than men (7.7% versus 6.3%). This results in a female/male ratio of 1.2 to 1.

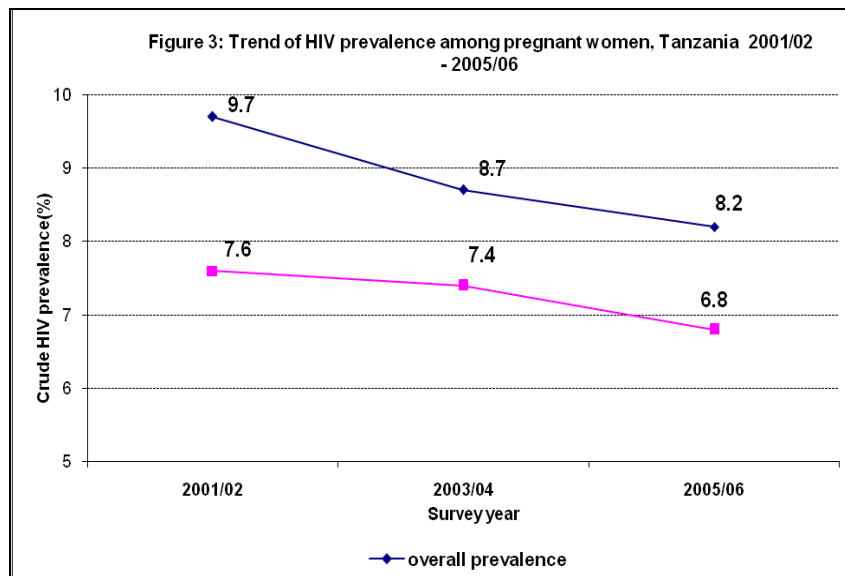


The distribution of the infection across the regions shows that there are 3 regions with adult prevalence above 10% (Mbeya, Iringa and Dar es Salaam), 7 regions with prevalence below 5% (Manyara, Kigoma,

Singida, Mara, Lindi, Kagera and Dodoma) while the remaining 11 regions have a prevalence between 5 and 8%.



As depicted in Figure 2 above, there is no single HIV epidemic in the country but probably several dozen of localised HIV epidemics which sometimes have a regional, sometimes only a district dimension. There are signs that the overall national figures are stabilizing and even going down slightly in the last five yearsⁱⁱⁱ.



1.1.6.2. Gender and HIV and AIDS

It is estimated that there are about 840,000 women aged 15 to 49 years living with HIV representing 56% of the total HIV infected population. Additionally, women in this age group account for 60% of the new infections.

While young men and women are equally infected in the age group 15 to 19 (2.1%), women aged 20 to 24 are 1.4 times more likely than men of the same age group to be infected (6.0% women and 4.2% men are HIV+). The prevalence in women peaks in the age group of 30 to 34 years, while it is highest for men in the age group 40 to 45. Adult prevalence in urban areas is 10.9% (12.0% for women and 9.6% for men), and the prevalence in rural areas is less than half at 5.3% (5.8% for women and 4.8% for men).

The HIV epidemic is largely driven by unsafe sexual behaviour by males, on one hand, and by female subordination and lack of economic independence, on the other. For example, more than 70% of sexually active out-of-school girls reported granting sexual favors for basic daily needs, having relationships with older men^{iv}.

The THIS report showed that, HIV prevalence is related to marital status in that, prevalence is lowest (1.9%) among respondents who had never been in a union and never had sex and highest (18.4%) among those who were formerly married. Discordance rate was at a magnitude of 8% among cohabitating couples, with more discordance in older couples and in urban compared to rural areas.

Therefore, the most vulnerable group in Tanzania, as elsewhere in Africa, has been shown to be married women who are least likely to use or have protected sex. They are also most likely to be exposed to infection through concurrent sexual partners that either they or their husbands have.

Since men assume more assertive and directive roles in sexual decision-making, they need to be addressed not only as beneficiaries but also as central in the fight against HIV and AIDS.

1.1.6.3. Impact of the AIDS Epidemic on health services

The concrete impact of HIV and AIDS on the health sectors in term of additional morbidity and mortality (days and years lost) is not known. Anecdotal evidence suggests that the rate of HIV infection among employees of health is at least as high as that of the adult population as a whole.

The already over-stretched health sector has suffered multiple effects due to HIV and AIDS: increased number of patients due to opportunistic infections, increased demand and sometimes reallocation of resources from other equally important health problems, and decreased number of health workers. Therefore there is serious impact on the health services in terms of quality of care as a result of increased service demand coupled with attrition of the workforce and stigma attached to HIV and AIDS.

The average HIV+ adult in Tanzania has an average of 17 illness episodes before death, leading to healthcare costs per patient which can be twice the Tanzanian GDP of US\$478 per capita.

1.2 HEALTH SECTOR RESPONSE TO HIV AND AIDS

1.2.1. National Health System Response and Capacity

The health system in Tanzania has two major components; the public and the private sector. The public share is 56%, the private share is 44% (which includes Faith Based Organizations (FBOs) 30% and private for profit 14 %). The system works at four levels; the community, the ward where we have a dispensary and a health centre at the division level. As we move further we have the district and regional hospitals at district and regional levels. At the zonal and national level are the consultant/ referral hospitals.

Table 2: Levels of Health Service Delivery

| Level | Type of health facility | Service population | Remarks |
|----------|-------------------------|--------------------|---|
| Country | National Hospital | 36 million | There is only one national hospital, serves 36 million because offers some specialized services not generally available in other consultant hospitals |
| Zone | Consultant Hospital | 8 million | Serve as the referral centre for the hospitals in the surrounding regions in the zone. There are four consultant hospitals in total including the national hospital. |
| Region | Regional Hospital | 1-1.5 million | 17 regional hospitals. |
| District | District Hospital | 250-500,000 | A number of FBO hospitals function as designated district hospitals (DDH). More than 1 hospital may be available in each district, usually run by FBOs (219 hospitals). |
| Division | Health centre | 50-100,000 | 481 health centres. |
| Ward | Dispensary | 5-10,000 | More than 1 dispensary may be available in a ward (4679). |
| Village | Health post, ADDO | 2-5,000 | |

Currently in Tanzania there are a total of 5,379 health facilities geographically distributed so that 70% of the population is within 5 km of a facility and 90% is within 10 km as at the end of 2005.^v

Administratively, the health system is largely decentralized. The MoHSW has direct responsibility for the referral and regional hospitals, and regulatory power over all health facilities. To accomplish this responsibility, the Ministry's functions are divided into six directorates which include: Hospital Services, Preventive Services, Human Resource Development, Policy and Planning, Social Welfare, Administration and Personnel. These departments are further divided into sections for a more effective implementation as

reflected in the organogram. The organisation and management of HIV and AIDS services is undertaken within the parameters of the Preventive Services of MoHSW mandate through NACP.

The district facilities are independently run by the PMORALG.

Human resource

The country is facing a serious human resource crisis. Between 1994 and 2005 the human resource has declined by 35.4%. The shortages are best shown in Table 3.

Table 3: Human resources national requirements

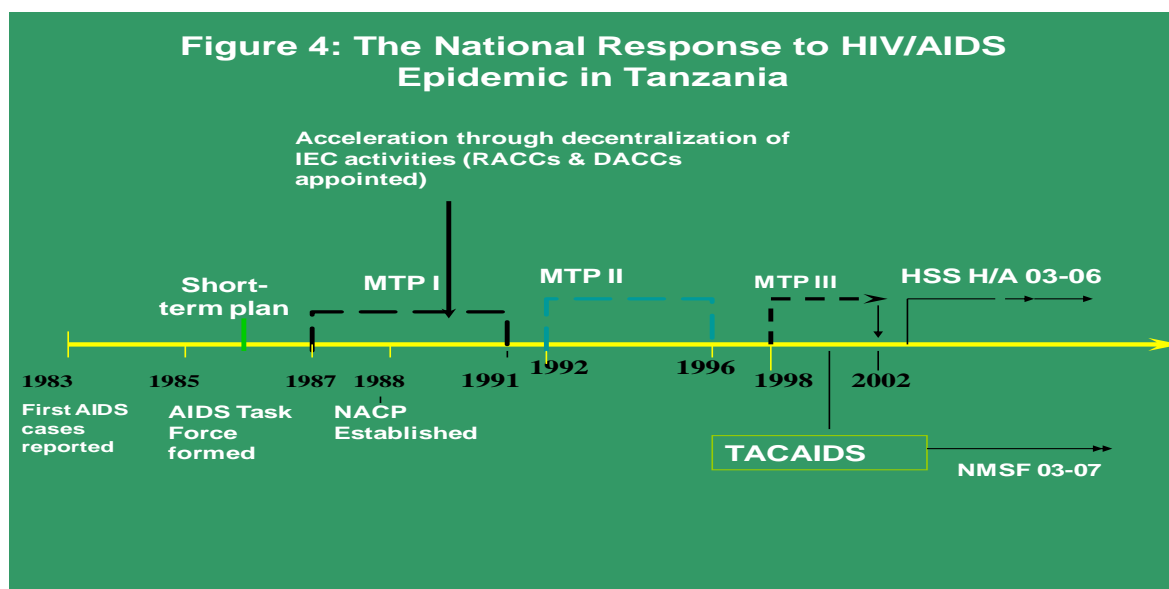
| | Total required | Current staffing level | Shortage | Shortage % of requirement |
|-------------------------|----------------|------------------------|---------------|---------------------------|
| Specialists | 171 | 96 | 75 | 43.9 |
| Doctors | 2,057 | 1,483 | 574 | 27.9 |
| Trained nurses | 14,743 | 9,093 | 5,650 | 38.3 |
| Pharmacists/chemists | 328 | 87 | 241 | 73.5 |
| Technicians | 1,506 | 741 | 765 | 50.8 |
| Other medical staff | 7,780 | 6,478 | 1,302 | 16.7 |
| Support staff | 16,737 | 13,778 | 2,959 | 17.7 |
| Administrators/managers | 547 | 196 | 351 | 64.2 |
| Total | 43,869 | 31,952 | 11,917 | 27.2 |

SOURCE: "Assessment of the Human and Financial Resources for the Revised HIV and AIDS National Multi-sectoral Strategic Framework" 2007

There are also serious imbalances in existing human resources between rural and urban areas.

1.2.2. HIV and AIDS Control Strategies

The National Response to HIV in Tanzania has evolved since 1985. Under the responsibility of the MOHSW and its National AIDS Control Programme (NACP) supported by World Health Organisations' (WHO) Global Programme on AIDS (GPA) several Short-term (STP) and Medium-Term Plans (MTPs) have been developed and implemented between 1985 and 1991. (See Figure 4)



During the implementation of the STPs and MTPs a number of achievements were realised including the strengthening of the health sector services to ensure safe blood transfusions, management of STIs, care of the infected and affected, as well as rising public awareness about the disease to over 95%. Despite these efforts, HIV infection rates continued to increase in the country, reaching its peak in the mid 90s.

Starting with the MTP II (1992 - 1996) efforts were undertaken, to work towards a broader national response involving sectors like education, labour, and agriculture for the first time, as well as collaborating more intensively with NGOs and bilateral and international agencies. From 2000 the responsibility of coordinating the national response was shifted to the Prime Minister's Office under TACAIDS.

In 2002, the Health Sector Strategy for HIV and AIDS (2003-2006) was developed, followed in 2004 with the first National HIV and AIDS Care and Treatment Plan (NCTP) which ushered in large-scale antiretroviral treatment for PLHIV in the country.

1.2.3. Programmatic and financial gaps

1.2.3.1 Programmatic gaps

The major programmatic gaps include coverage and quality of services and the weak referral and coordination system between institutions. Some key programmes are indicated in the Table 4 below. Efforts have been made to date to design, build support for and implement effective referral networks that respect confidentiality and patient choice while creating a continuity of care and support.

| Table 4: Programmatic Gap Analysis of selected interventions | | | | | | | | |
|--|-------------------------------|-------------------------------|-------------------------------|------------|------------|------------|------------|--|
| | Actual | | Anticipated | | Estimated | | | Comments |
| | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 | |
| A. People in NEED of Key Services | | | | | | | | |
| VCT | 17,170,784 | 17,756,846 | 18,343,552 | 18,929,495 | 19,516,143 | 20,106,402 | 20,700,532 | Population aged 15 - 49 (National Projection Vol XII) |
| PITC | 7,541,000 | 7,333,000 | 8,000,000 | 8,667,000 | 9,333,000 | 10,000,000 | 10,667,000 | Outpatients aged 5 and above projected (1/3 of OPD cases) |
| PMTCT | 1,400,000 | 1,509,000 | 1,560,000 | 1,611,870 | 1,665,300 | 1,695,720 | 1,727,700 | Calculations are based on women who get pregnant each year |
| Anti Retro Viral (ARVs) | 150,000 | 200,000 | 250,000 | 300,000 | 350,000 | 400,000 | 440,000 | 10% of persons on treatment will have died in the first year, 20% in the second year etc. Half of eligible persons will die without treatment within the first year |
| | (75,000 + 80% of pop in need) | (100,000 +90% of pop in need) | (220,000+ 64% of pop in need) | | | | | |
| | | | | | | | | |
| B. People CURRENTLY RECEIVING or ANTICIPATED TO RECEIVE (TARGET) Key Services : | | | | | | | | |
| VCT | | 5,836,598 | 1,200,000 | 1,200,000 | 1,200,000 | 1,200,000 | 1,200,000 | Proportions of women and men aged 15-49 who have ever tested for HIV and received their results increase from 37% and 27% of women and men respectively to 60% and 40% |
| (Cumulative) | | 5,836,598 | 7,036,598 | 8,236,598 | 9,436,598 | 10,636,598 | 11,836,598 | |
| PITC | - | - | 196,000 | 866,700 | 1,866,600 | 3,000,000 | 3,733,450 | |
| PMTCT | 377,913 | 750,000 | 900,000 | 1,200,000 | 1,300,000 | 1,400,000 | 1,500,000 | |
| ARVs | 58,671 | 79,181 (By May 07) | 202,000 by Dec 08 | 250,000 | 300,000 | 350,000 | 400,000 | |
| | | 150,000 | | | | | | |
| C. UNMET NEED OR GAP in terms of people in need of Key Services (A¹ – B¹ = C¹, A² – B² = C² etc.) | | | | | | | | |
| VCT | | 11,920,248 | 11,306,954 | 10,692,897 | 10,079,545 | 9,469,804 | 8,863,934 | |

| | | | | | | | | |
|-------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|--|
| PITC | | 7,333,000 | 7,804,000 | 7,800,300 | 7,466,400 | 7,000,000 | 6,933,550 | |
| PMTCT | 1,033,887 | 759,300 | 660,000 | 411,000 | 365,300 | 295,720 | 227,000 | |
| ARVs | 219,344 | | 123,750 | | 70,000 | | | |

SOURCE: REPORTS ON UNIVERSAL ACCESS AND TARGET SETTING

1.2.3.2. Financial Contributions to National Response and gaps

The total need is calculated based on HIV and AIDS interventions, Human resource for health and health facilities from the report “**MKUKUTA Based MDGs Costings for the Health Sub-sector**” done in 2006. The financial resource requirement and projections are based on the report “**Assessment of the Human and Financial Resources for the Revised HIV and AIDS National Multi-sectoral Strategic Framework**” done in 2007.

Table 5: Current and Projected Financial Gap Analysis

| | Million US\$ | Million US\$ | Million US\$ | Million US\$ | Million US\$ | Million US\$ |
|--|--------------|--------------|--------------|--------------|--------------|----------------|
| Domestic (A) | | | | | | |
| Best case scenario | 46.6 | 55.4 | 64.2 | 73 | 81.9 | 321.1 |
| Middle case scenario | 37.4 | 40.1 | 45.5 | 51 | 56.4 | 230.4 |
| Worst case scenario | 22.6 | 23.6 | 24.5 | 25.5 | 26.4 | 122.6 |
| | | | | | | |
| Total External (B) | | | | | | |
| Best case scenario | 318.1 | 351.2 | 382.4 | 413.5 | 444.6 | 1,909.8 |
| Middle case scenario | 288.1 | 307.2 | 326.6 | 345.9 | 365.4 | 1,633.2 |
| Worst case scenario | 241.6 | 255.5 | 269.5 | 283.4 | 297.4 | 1,347.4 |
| | | | | | | |
| Total resources available (A+B) | | | | | | |
| Best case scenario | 364.7 | 406.6 | 446.6 | 486.5 | 526.5 | 2,230.9 |
| Middle case scenario | 325.3 | 347.3 | 372.1 | 396.9 | 421.8 | 1,863.4 |
| Worst case scenario | 264.2 | 279.1 | 294 | 308.9 | 323.8 | 1,470 |
| | | | | | | |
| Total need (C) | | | | | | |
| Best & Expensive case scenario | 381.8 | 429.8 | 483.8 | 354.2 | 636.9 | 2,286.5 |
| Middle case scenario | 364 | 401.9 | 443.9 | 300.6 | 567.6 | 2,078 |
| Worst case scenario | 364 | 401.9 | 443.9 | 300.6 | 567.6 | 2,078 |
| | | | | | | |
| Unmet need (C)-(A+B) | | | | | | |
| Best & expensive case scenario | 17.1 | 23.2 | 37.2 | 132.3 | 110.4 | 320.2 |
| Middle case scenario | 38.7 | 54.6 | 71.8 | 96.3 | 145.8 | 310.9 |
| Worst case scenario | 38.7 | 54.6 | 71.8 | 8.3 | 145.8 | 310.9 |
| | | | | | | |
| | | | | | | |

SOURCES: Developed For the Plan From- “MKUKUTA Based MDGs Costings for the Health Sub-Sector, 2006” and “Assessment of the Human and Financial Resources for the Revised HIV and AIDS National Multi-sectoral Strategic Framework, 2007”.

Table 5 shows that there are gaps in meeting the demands of HIV interventions in the next five years and these gaps increase over time.

1.3. VISION, MISSION, GOALS AND KEY PRINCIPLES

1.3.1. Vision 2025

The long term vision for Tanzania's development is reflected in "Vision 2025". The key focus of the vision is reflected in the main objective of the MKUKUTA which is "To reduce the incidence of absolute poverty to 10% and relative poverty to 30% of the total population by the year 2017".

The Health Sector HIV and AIDS Strategy is a major contributor to the attainment of the vision of the overall multi-sectoral response expressed in the National Multi-sectoral Strategic Framework for HIV and AIDS i.e.

"Tanzania united in its efforts to reduce the spread of HIV and to provide the best available care for those infected and affected by the virus."

1.3.2. Mission

The Mission of the Health Sector in contributing to the National Vision is

Working in partnership with other public sectors, private sector, civil society and communities to play a leading role in the prevention of further spread of HIV and AIDS and mitigate its impacts by providing essential interventions and quality care.

1.3.3. Goals

In this connection, the Health Sector has defined the following goals for its response to HIV and AIDS:

- To scale up the health sector response to HIV and AIDS and strengthen the health system capacity to support HIV and AIDS interventions,
- To promote access and utilization of affordable and essential interventions and commodities for HIV and AIDS, and
- To improve the quality of HIV and AIDS interventions to the general public, PLHIV, health care providers and other vulnerable populations.

The three goals of the health sector response will be attained through objectives, strategies, interventions and activities in four main Thematic Areas: Prevention, Treatment, Care and Support, Cross-cutting Issues and Health System Strengthening.

1.3.4. Key principles

A number of principles will guide the implementation of this strategy. These include concern for quality, ethical conduct, human rights, gender and equity.

| | |
|---|---|
| Equity of access: | Equity considerations constitute the basis for the interventions identified in this strategy and how they have to be scaled up. This is particularly the case with ART, which need to be a component of a continuum of care. |
| Ethical conduct and human rights | People should be allowed to make informed decisions. There are major ethical and human rights issues involved not only in medical interventions but also in other health interventions such as Communication and Education. |
| Quality | Although the ultimate goal will be to scale-up HIV services and interventions, due recognition will be given to quality. Concern for quality will precede quantity consideration. Existing services and interventions have to be consolidated prior to expansion. Thus quality training will precede interventions, materials have to be in place before services or interventions are promoted. Similarly assessment and reviews are to be undertaken before a given intervention is recommended for scaling up. |
| Accountability: | Accountability for the resources utilised, services provided and to the communities served at all levels of health service delivery. |
| Partnerships: | Partnership with all the stakeholders, taking full advantages of the synergies provided by each stakeholder group. |
| Decentralisation: | Devolution of key responsibilities, including planning, organization, coordination and control of healthcare delivery, and resources from the centre to the districts and hospitals, where health services are provided. |
| Leadership: | Appropriate, efficient and effective leadership in the implementation of the strategic plan, at all stages of the healthcare delivery system. |
| Gender | Gender imbalances underlie the pattern of response to illness and health care seeking behaviour. They also affect how care and other forms of support are provided. |

1.3.5. Main Assumptions

The main assumptions for the successful implementation of this plan are:

- Continued peace and political stability in the country;
- Availability of adequate numbers of appropriately trained and well motivated health workers;
- Macroeconomic stability and sustainable economic growth;
- Increased Government prioritisation and funding to the health sector;
- Increased Partners support to other programmes within the health sector; and
- Timely and appropriate attention to implementation of all health priority areas.

1.3.6. National HIV and AIDS Priority Areas

The lesson learnt from implementation of the 2003-2006 plan is that it is critical for the new Health Sector Strategy for HIV and AIDS to identify and concentrate on a limited number of national HIV priority areas, rather than attempt to include “everything that needs to be done” in the strategic plan. Failure or lack of prioritisation in the plan would not provide for the degree of focus and concentration of efforts and resources required to deal with the critical areas requiring such attention.

Though the lesson is acknowledged and the fact that a strategic plan usually addresses only strategies without going deep into activities, this plan has included activities which are part of the matrices in the Annex for the following reasons:

- Firstly, the set of activities will serve as a menu that accommodates the interests of various stakeholders involved in the health sector response. This means that different activities or interventions may be important for different stakeholders.
- Secondly, carrying out the prioritization exercise is better done at activities level. A possible tool that can be used to assess the feasibility of interventions by each sector or organization as they develop their operational or annual plans is suggested below:

Table 6: Tool for assessing feasibility of interventions

| <i>Intervention</i> | <i>Availability of resources</i> | <i>Affordability to catchments area</i> | <i>Acceptability to target population</i> | <i>Direct or short term effect</i> | <i>Indirect or long term effect</i> | <i>Total score</i> |
|---------------------|--|--|---|------------------------------------|-------------------------------------|--|
| <i>1</i> | <i>Not available=0</i> | <i>Not affordable (high cost)=0</i> | <i>Not=1</i> | <i>No=0</i> | <i>No=0</i> | <i>Highest score indicates that the intervention is easily implementable. It is a priority</i> |
| | <i>Poorly =1</i> | <i>Low=1</i> | <i>Weakly=1</i> | <i>Yes=1</i> | <i>Yes=1</i> | |
| | <i>Highly available in quantity or quality=2</i> | <i>Readily available (very low cost)=2</i> | <i>Highly=2</i> | | | |

SECTION TWO

NARRATIVE AND JUSTIFICATION OF THE MATRICES

2.1. THEMATIC AREA I: PREVENTION

2.1.1 Introduction

The HIV epidemic in Tanzania is the result of a complex interplay between biological, socio-cultural and socio-economic factors. The strategies outlined here aim to decrease the risk of infection among the general population, with special attention to young people, both through enhancing knowledge and skills and through making relevant health services more accessible and youth friendly. The health sector at the community level will contribute towards a dialogue about sexuality, gender roles and cultural practices in order to initiate critical reflection and action to reduce local factors that increase vulnerability to HIV.

Availability of relevant health services, such as management of Sexually Transmitted Infections, HIV Testing and Counselling (HTC), Prevention of Mother to Child Transmission (PMTCT) and safe blood will be further expanded while safeguarding the quality and ensuring gender sensitivity. Condoms, both male and female, will be made available in all health facilities. Further more, additional innovative outlets and channels will be established to increase availability and accessibility of condoms to the general population.

The available evidence shows that financial resources allocated to broad prevention programmes have a range of positive effects on public health in general. A comprehensive review of literature concludes that *“broad primary prevention programmes are at least 28 times more cost-effective than HAART, and that broad primary prevention has a range of positive spin-off effects on public health and disease control in general and no known side-effects.”* Therefore an intensified and comprehensive prevention programme is very critical.

2.1.2 Intervention Area 1: Prevention of Mother to Child Transmission of HIV

2.1.2.1 Preamble

Prevention of Mother to Child Transmission of HIV (PMTCT) has become a crucial intervention in the global fight against the epidemic. In Tanzania about 1.4 million women become pregnant each year. Data from ANC HIV sentinel surveillance sites in Tanzania (2005) indicate that the overall HIV prevalence among pregnant women attending antenatal clinics is 8.2%. When effectively and appropriately implemented, PMTCT services have the potential to prevent infection in babies who would otherwise be born HIV-positive or contract the infection during delivery and breast feeding.

Prevention of mother-to-child transmission of HIV core interventions include:

- Information on testing and counselling on preventing HIV transmission (Primary prevention).
- Access to family planning services for women living with HIV and AIDS and their partners. (Prevent unintended pregnancies).
- Use of antiretroviral drugs to prevent HIV transmission from mother to child.
- Access to HIV treatment, care and support for infected mothers, infants and other family members.

In order to provide the above PMTCT intervention will be:

- Implemented through multi-sectoral and multidisciplinary approaches necessitating effective coordination and partnerships of all actors under government leadership, and involving all stakeholders in the public, private and NGO sectors, civil society and PLWHA in the planning, implementation and monitoring of programmes.
- Delivered as part of comprehensive RCH and HIV and AIDS packages and will therefore be integrated with other relevant RCH services (ANC, delivery, PNC, EPI, IMCI, FP) and HIV and AIDS services (prevention including client and provider-initiated counselling and testing, care, support and HIV and AIDS treatment including OI and ART).
- Based on scientifically and ethically sound approaches.
- Of high quality and provided at all levels of health system.

2.1.2.2 Situation Analysis

For the year 2007:

- A total of 1347 health facilities were providing PMTCT services.
- A total of 713,506 (48%) new ANC attendees received PMTCT services
- About 91.6% (713,506 of 778,619) of these new ANC attendees were tested for HIV.
- Of those tested, 9.9% (70,710 of 713,506) were found to be HIV positive, which is slightly higher than 8.2% HIV prevalence from the 2005 ANC sentinel surveillance results.
- About 60% (42,595 of 70,710) of those found to be HIV positive through the programme received nevirapine prophylaxis (at ANC and L&D),
- HIV exposed babies who received nevirapine syrup prophylaxis were 30% (21,358/ 70,710)
- Despite this progress in specific programmatic terms, at the end of 2007, only 34% (42,595/ 123,738) of HIV positive pregnant women in the country received antiretroviral prophylaxis to reduce MTCT

2.1.2.2.1 Achievements

A lot of progress has been made to in the rolling out of PMTCT interventions in the country.

- The number of health facilities providing PMTCT Services has increased from 5 pilot sites in September 2000 to 1347 by December 2007.
- Key programmatic documents have been developed and disseminated including:
 - PMTCT Guidelines (2004, Revised 2007)
 - PMTCT Training Materials (2004, Revised 2007)
 - PMTCT Monitoring Tools (2004, Revised 2007)
 - PMTCT Managers Orientation Guide (2006)
 - Draft advocacy package for PMTCT interventions (2007)
- The programme has trained 254 TOTs at regional and district levels to support training of HCWs.
- The programme together with PMTCT implementing partners has trained 3,856 health care workers in the existing PMTCT sites.

2.1.2.2.2 Challenges/gaps/emerging issues

| Aspects | Challenges for PMTCT |
|------------------|--|
| Availability | <ul style="list-style-type: none"> • Only 1347 health facilities out of a total of 4871 RCH clinics are also providing PMTCT services. • Only 34% of HIV positive pregnant women are receiving ARV prophylaxis. • Only 30% of exposed babies received ARV prophylaxis. |
| Equitable access | <ul style="list-style-type: none"> • Weak referral system within and outside the health facilities, <ul style="list-style-type: none"> - Patient ART eligibility assessment is only conducted in the CTC centres thus requiring all HIV positive pregnant women to be referred to the nearest CTC centre. • Only 6.3% of rural women aged 15 to 49 who were pregnant in the past 2 year were offered and accepted HIV test during antenatal clinics. (THIS, 2004). |

2.1.2.3 Equity, gender and sustainability considerations

- Women confront a number of gender-based obstacles in accessing PMTCT services such as, using ARV prophylaxis or engaging in alternative infant feeding practices.
- The role of men in facilitating and supporting women in preventing HIV, fighting stigma and discrimination at home and at the community level is of crucial importance and needs to be addressed.
- Limited resources to accelerate PMTCT efforts from Government, Partners and the community.

2.1.2.4 Strategic Objectives

Increase the percentage of HIV positive pregnant women who receive ARVs from 34% in 2007 to 80% by 2012 to reduce the transmission of HIV from mothers to their children, during pregnancy, birth and/or breast-feeding and ensure access to care and treatment for mothers and babies.

1. Advocate for and increase awareness and commitment to addressing PMTCT and paediatric HIV prevention care, treatment and support among key stakeholders, including partners, policy makers and leaders at all levels.

2. Strengthen the provision of quality PMTCT and paediatric HIV prevention care, treatment and support integrated into maternal new born and child health services to all health facility levels.
3. Improve delivery of community PMTCT and paediatric HIV prevention care, treatment and support and referral of HIV-infected women, their children and families.

2.1.2.5 Targets:

1. At least 90% of all reproductive and child health services provide comprehensive PMTCT services by 2012.
2. At least 80% of all pregnant women get access to standard Package of PMTCT (provided with information to prevent HIV transmission, tested for HIV and counselled, receive family planning services, infant feeding counselling and support)
3. At least 80% of pregnant women living with HIV and their babies receive ARV prophylaxis for MTCT prevention
4. At least 80% of infants born to women living with HIV receive co-trimoxazole prophylaxis.
5. At least 50% of male partners of women tested for HIV through PMTCT are counselled and tested for HIV.
6. At least 80% of children born to women living with HIV are tested for HIV using either Antibody Test or DNA PCR).

2.1.2.6 Indicators:

1. Number of health facilities offering PMTCT services
2. % of HIV infected women receiving ARV to reduce the risk of MTCT (stratified by single dose Nevirapine SDV) vs more efficacious regimens)
3. % of identified exposed babies receiving ARV prophylaxis
4. %/number infants born to HIV infected women started on Cotrimoxazole prophylaxis at 12 months of age
5. % of male partners of women tested for HIV through PMTCT who are tested for HIV.
6. %/number of children born to HIV infected women who received an HIV test within the past 12 month (by Antibody Test/DNA PCR)

2.1.2.7 Key Implementers:

MoHSW, TACAIDS, NACOPHA, Public, Private and FBO Hospitals, Regional and District Councils, Health Management Teams, Partners, PMORALG

2.1.3 Intervention Area 2a: Prevention of Sexual Transmission of HIV: STI Prevention and Management

2.1.3.1 Preamble

Adequate treatment of patients with STIs and their partners can reduce the rate of transmission of HIV in the population, as has been demonstrated in a community based STI intervention study done in Mwanza, Tanzania in 1995. Furthermore, it reduces the reproductive – tract and obstetric complications associated with STIs. Interventions for STIs have therefore been considered essential in HIV prevention programmes. However, the public in general, particularly young people, tend to be ill-informed about STIs. According to Demographic and Health Survey (DHS) 2004-2005, about 11% of the sexual population contact STIs annually while it is assumed that, only 60% utilise the existing STIs services.

The Surveillance of HIV and Syphilis Infection among Antenatal Mothers in the RCH, 2005/2006 indicates the overall syphilis sero-prevalence of 6.9% (Surveillance of HIV and Syphilis Infections among antenatal clinic attendees 2005/2006).

2.1.3.2 Situation analysis

The following achievements and challenges were encountered during the implementation of 2003-2006 strategic plan:

2.1.3.2.1 Achievements

- All public hospitals including Referral, Regional, District and District Designated Hospitals, Health Centres and 66% of the dispensaries provide STI syndromic case management services.
- To achieve the goal of the STI control programme, the NACP in the period 2003-2006 continued to work in collaboration with the government structures, communities and a number of non-governmental agencies.
- Some FBOs and NGOs including private health facilities also provided STIs services.
- A total of 8,378 Health care providers have been trained in STI syndromic case management.
- Developed National Guidelines for the Management of STI/Reproductive Tract Infections
- Over 564 Health Care Workers from Antenatal Clinics trained in management of syphilis in pregnancy under NACP coordination.
- Developed, produced and distributed a variety of educational materials (posters, leaflets and video tapes) on STI prevention and control
- About 67.2% of service providers made correct choice of drugs, dosage and duration of treatment for their clients (NACP survey 2005)

2.1.3.2.2 Challenges

| Aspects | Challenges in STI prevention and management |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • Inadequate screening for syphilis in RCH services • Inadequate condom promotion and distribution • Poor coordination of STI control activities at all levels • Inadequate STI drugs, syphilis screening tests and other related medical supplies • STI drugs are used for management of other illnesses that require antibiotics |
| Equitable access | <ul style="list-style-type: none"> • Quality assurance for STI control is low especially in remote areas and in private facilities • Few youth friendly reproductive health services • STI services addressing high risk population groups are limited. |
| Quality | <ul style="list-style-type: none"> • Poor reporting system • STI commodities ordering system (indent) not adhered to in some districts hence irregular distribution, delays, stock outs has been reported at health facility level • Weak monitoring of aetiologies and antimicrobial susceptibility patterns of STI pathogens • Self medication leading to inappropriate management and complications • Poor contact tracing (21-35%) |

2.1.3.2.3 Emerging issues

- There appears to be a shift of interest among partners in supporting STI programme, very few are willing to support the programme.
- Shortage of HCWs at the facility level coupled with increased HIV interventions has resulted into displacement of previously trained HCWs from the STI clinics to other HIV services such as PMTCT, Care and Treatment and VCT
- Sexual violence and abuse especially for young girls and boys remains a problem
- Emerging new syphilis screening tests to reduce the challenges of cold storage in rural setting but will imply retraining of the health care workers

2.1.3.3 Equity, gender and Sustainability Considerations

STIs like gonorrhoea are acute and symptomatic in most males, but may be asymptomatic (up to 60%) in many women. Other STIs like Trichomoniasis have symptoms in women, but remain often asymptomatic in males indicating the need of specific attention of HCWs in dealing with STIs and sex differences. HIV, Syphilis and gonorrhoea can also be transmitted by the pregnant woman to her new born baby. HCWs will need to increasingly seek laboratory confirmations in cases where symptoms do not exist but circumstantial evidence of infection exists. It is also important to differentiate between RTIs which may not be sexually transmitted when managing female clients. Labelling such clients as having STIs may be stigmatizing and cause marital disharmony.

STI prevention and education, efforts must be undertaken to empower girls and women to decide on the sexual relations they want and to resist pressure by men and also measures must be found to empower young boys to resist pressure from older women.

2.1.3.4 Strategic Objective

To expand quality comprehensive STI services and enhance appropriate utilization of services.

Strategies:

1. Expand coverage of quality comprehensive STI services to all public, FBO and private health facilities and make the services user friendly particularly for youth and other vulnerable population
2. Assure quality for STI services (clinical aspects).
3. Improve STI programme management and coordination at all levels.

2.1.3.5 Targets

Increase the percentage of STI patients attending health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines from 67% in 2005 to 80% by 2012.

1. Number of STI cases treated annually

| 2008 | 2009 | 2010 | 2011 | 2012 |
|-----------|-----------|-----------|-----------|-----------|
| 1,210,674 | 1,249,346 | 1,288,065 | 1,327,022 | 1,366,235 |

2. Increase the percentage of health facilities providing STI case management by syndromic approach from (3000)66% to (4000)85% by 2012.
3. Increase the percentage of first visit ANC attendees who receive routine antenatal syphilis screening services from 40% in 2006 to 75% in 2012.
4. Increase the percentage of STI patients attending health care facilities who received appropriate advice on condoms use, partner notification and who are referred for HIV testing from 9.3% (2003) to 50% by 2012.
5. Increase percentage of individuals served by health care facilities that have supply of essential STI drugs and that have reported no stock outs lasting longer than one week in the proceeding twelve month from 39.7 (2003) to 60% by 2012.

2.1.3.6 Indicators

1. Proportion of patients with STI/RTIs presenting at selected health facilities that are appropriately diagnosed, treated and counselled according to national guidelines
2. Number of STI cases treated
3. Proportion of health care facilities providing comprehensive STI/RTI case management for symptomatic infections by syndromic approach.
4. Proportion of pregnant women attending antenatal care with a positive serology for syphilis.
5. Proportion of STI patients attending selected health care facilities who receive appropriate advice on condom use, partner identification and who are referred for HIV testing.
6. Proportion of health care facilities providing STI care that report no stock out of STI medicines and related supplies lasting longer than one week in the last 12 months.

2.1.3.7 Key Implementers

Referral, regional and district hospitals, health centres and dispensaries PMORALG NACP/MOHSW, RCHS/MOHSW, RHMTs, CHMTs and community.

2.1.4 Intervention area 2b: Prevention of Sexual Transmission of HIV: Male Circumcision

2.1.4.1 Preamble

The association of male circumcision and reduced HIV prevalence has been reported in a number of observational studies^{vi}. Three randomized controlled trials conducted in South Africa and the neighbouring countries of Kenya and Uganda on male circumcision and HIV transmission have demonstrated a 50-60% decrease in the risk of acquiring HIV infection among men who underwent circumcision during the trial compared to those who were not circumcised^{vii}. Therefore there is compelling global evidence that safe male circumcision should be one of the public health interventions to reduce the transmission of HIV especially in countries with high HIV and AIDS burden and low male circumcision prevalence. Furthermore, other studies have demonstrated a number of other health benefits of male circumcision including reduction of: RTIs in children, Genital Ulcer Disease, cervical and penile carcinoma. Reported social benefits include increased sexual pleasure in both partners and personal hygiene.

2.1.4.2 Situation Analysis

The practice of male circumcision in Tanzania is often for religious and cultural reasons rather than for the purpose of HIV prevention. Modernization and peer pressure have been documented as other reasons for male circumcision. Medical indications for male circumcision include phimosis and paraphimosis. In most regions and districts this is done in health facilities but in some districts traditional male circumcision is still being practiced. In Tanzania, male circumcision is commonly practiced in many communities and the overall prevalence is about 70% (THIS 2003/04).

Though THIS findings indicated that the difference between HIV prevalence among circumcised and uncircumcised men was not significant (7% versus 6%), ecological comparison from the same study show a pattern of lower HIV prevalence in circumcising than in non-circumcising belts. For example the high HIV-prevalence regions of Mbeya and Iringa have relatively low male circumcision rates (34.4% and 37.7% respectively) compared to Manyara with male circumcision rate of above 80%.and HIV prevalence of 2%.

2.1.4.2.1 Challenges

| Aspects | Challenges for Male Circumcision |
|------------------|---|
| Availability | <ul style="list-style-type: none">• Male circumcision has not been institutionalized as a routine service for health benefits and now HIV prevention• Health services are already overburdened and scaling up of male circumcision needs to consider improvement of health systems |
| Equitable access | <ul style="list-style-type: none">• Prevalence, determinants, acceptability and practices of male circumcision vary across regions and districts but has not been well documented• Costs incurred to access MC may become a barrier to scaling up the service for poor people who need the service |
| Quality | <ul style="list-style-type: none">• Substantial male circumcision is done by traditional practitioners where complete removal of prepuce, and safety may not be ensured |

2.1.4.3 Equity, gender and sustainability considerations

Due consideration should be made prior to rolling out male circumcision programmes to ensure that other health services including HIV interventions do not suffer.

Special attention needs to be paid to the involvement of women as mothers and sexual partners in advocacy and mobilization initiatives for male circumcision.

The public should be well informed about the importance of male circumcision

2.1.4.4 Strategic Objective

To promote medically safe accepted male circumcision for health benefits and as a preventive measure against HIV transmission

Strategies

1. Establish national policy framework for coordination and implementation of male circumcision
2. Public advocacy and mobilization for male circumcision
3. Expansion of male circumcision services in the country

2.1.4.5 Targets

1. Strategic framework for male circumcision in place by end of 2009
2. Raise prevalence of male circumcision from the current 70% to 80% by 2012

2.1.4.6 Indicators

1. Male Circumcision Strategic framework in place
2. Number of new male circumcisions conducted per year by age groups

2.1.4.7 Key implementer

MoHSW, TACAIDS, Health facilities, RHMTs, CHMTs, FBOs, NGOs, CSOs, Traditional Practitioners (Ngaribas), Research and Academic Institutions

2.1.5 Intervention Area 3a: Prevention of Transmission in Health-Care Settings: Safe Blood

2.1.5.1 Preamble

HIV transmission through blood-transfusion, contaminated blood-products, occupational exposure in health care settings as well as through traditional practices (skin piercing, female genital mutilation, unsafe male circumcision) account only for a relatively low percentage of the overall transmission. However, reduction of transmission risks in these settings is of importance to safeguard the health of the population in general and of the health service providers.

The MOHSW has continued to ensure that blood transfusion is safe in all levels of health services by screening blood for Transfusion Transmissible Infections (TTIs) which include HIV, HBV, HCV and syphilis. Health care workers have also been trained on injection safety and proper hospital waste management.

2.1.5.2 Situation analysis

2.1.5.2.1 Achievements

- Donor blood screening for HIV started in 1987 and the National Blood Transfusion Service (NBTS) was established in 2000.
- By September 2007, six zonal blood transfusion centres which constitute NBTS had been established in Dar-es-Salaam, Moshi, Mwanza, Mbeya, Tabora and Mtwara. The seventh centre is under construction in Dodoma.
- A database of low risk voluntary blood donors has been established in every region.
- Various guidelines have been developed:
 - National Blood Transfusion Policy, June 2006
 - Blood Donor Recruitment and Retention guidelines,
 - Specific Blood Transfusion Practice guidelines.
 - Clinical use of Blood and Blood Products.

2.1.5.2.2 Challenges

| Aspects | Challenges for Blood Safety |
|------------------|---|
| Availability | <ul style="list-style-type: none">• Limited numbers of voluntary, repeating non remunerated blood donors. |
| Equitable access | <ul style="list-style-type: none">• Weak distribution of donated blood and blood products by Zonal centers to regional and district distribution points• Low blood storage capacity at regional and district levels. |
| Quality | <ul style="list-style-type: none">• Lack of Quality Assurance scheme for NBTS at distribution points.• Inadequate supervision of blood transfusion practices in private hospitals. |

2.1.5.3 Equity, gender and sustainability considerations

Currently the majority of blood donors are replacement donors (90%), out of whom majority are males (81.4%)^{viii}. Half of blood recipients are children followed by pregnant women (30%).

2.1.5.4 Strategic objective

To increase supply of safe blood from 15% to 50% of the blood transfusing hospitals by 2012.

Strategies

1. Strengthen the distribution capacity of NBTS at all levels.
2. Promote community awareness for blood donation.
3. Strengthen the M&E system and Quality Assurance scheme for NBTS.

2.1.5.5 Target

1. Increase low risk blood donations from baseline to 70% in public and private hospitals

2.1.5.6 Indicators

1. % of blood transfusion from non remunerated voluntary repeating blood donations in the last 12 months.
2. % of blood units transfused that have been screened for HIV, syphilis and hepatitis B & C according to National guidelines in the last 12 months.
3. Number / % of blood transfusing hospitals that received blood from NBTS

2.1.5.7 Key Implementers

MoHSW, NBTS, Public & Private Hospitals, MoEVT, RHMTs, CHMTs

2.1.6 Intervention Area 3b: Prevention of Transmission in Health-Care Settings: Workplace Interventions for Health Care Workers (HCW)

2.1.6.1 Preamble

HCWs may acquire infection at places of work as an occupational risk or through sexual networking. In health care settings, universal bio-safety precautions and safe waste management is essential for prevention of nosocomial transmission of infectious agents.

2.1.6.2 Situation Analysis

2.1.6.2.1 Achievements by December 2007

- a) Universal precautions and medical waste management:
 - Guidelines for national hospital waste management have been developed and are being observed in most health facilities in the country.
 - Health facilities have different means of disposing waste such as incinerators and pits.
 - There are satisfactory initiatives to intensify advocacy and sensitize health workers on issues related to HIV transmission risks at the workplace.
- b) Safe injections
 - Safe disposal of needles and sharps is practiced in health facilities in special boxes or improvised alternatives.
 - HCW have been trained on safe injection procedures as part of the Infection Prevention Programme of the MOHSW.
- c) Workplace interventions for HCWs
 - The Occupational Unit of the MOHSW has developed a strategic plan for the control of HIV and AIDS for HCW at the workplace for the period 2006-2011.
 - MOHSW developed National Infection Prevention and Control (IPC) Guidelines for health care services in Tanzania in 2004.
 - 12,000 healthcare workers in 143 health facilities were trained on IPC.
- d) Post-exposure prophylaxis (PEP)
 - PEP is available in all care and treatment clinics where ARVs are provided .

2.1.6.2.2 Challenges

| Aspects | Challenges for Workplace Interventions for HCW |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • Limited awareness about risks of HIV transmission in hospital settings • Limited utilization of PEP. • Inadequate coverage of HIV work place interventions in health facilities |
| Equitable access | <ul style="list-style-type: none"> • Inadequate knowledge and skills among healthcare providers on IPC. • PEP services are available in only 200 Health facilities out of 5,379. |
| Quality | <ul style="list-style-type: none"> • Inadequate functioning of National Quality Improvement Committee (NQIC) on infection control • Lack of harmonized training materials on Infection IPC • No coordination forum for IPC |

2.1.6.3 Equity, Gender and sustainability considerations

Most of Health care workers who are exposed to occupational hazards are women, therefore they should be empowered to protect themselves.

Workplace interventions should focus all levels of health system. Special considerations should therefore be given to gender related issues such as sexual harassment where it exist.

2.1.6.4 Strategic Objective

To implement comprehensive workplace interventions in the health sector focused on the prevention, care, treatment and support of employees, employers and their families.

Strategies

1. Strengthen and promote Health Sector workplace HIV interventions.

2.1.6.5 Targets

Health Sector Workplace HIV intervention strengthened and promoted at all levels

2.1.6.6 Indicators

Proportion of health facilities with comprehensive health sector workplace HIV interventions

2.1.6.7 Key Implementers

MoHSW, Private Hospitals, RHMTs, CHMTs, Zonal Training Centres and Partners.

2.1.7 Intervention area 4a: Vulnerable Population Groups: Targeted Youth Programmes

2.1.7.1 Preamble

Young people aged 10 to 24 constitute a third of the Tanzanian population. About 4% of women aged 15-24 and 3% of men 15-24 are HIV positive. (TDHS 2004-2005). Prevention of HIV in young people is an investment that will ensure future HIV-free generations. In Tanzania 22% of 15-19 year-old girls are married^{ix}. Further research shows that more than 30% of sexually active girls had a coerced sexual debut.^x Once they become sexually active, young people tend to have multiple partners^{xi}. About 52% of female 19 years old, had been pregnant or had had a child, and almost half of these had no formal education^{xii}. Nearly a third of the victims of unsafe abortion were teenagers, of whom almost half were 17 years of age or younger^{xiii}. Females and males aged 15-24 had had sex before 15 and 18 years respectively. Twelve percent of young women and 9% of young men had had sex by age 15. (TDHS 2004-2005). Young people must be proactive to protect themselves from unwanted pregnancies as well as HIV AND AIDS and other Sexually Transmitted Infections

2.1.7.2 Situation Analysis

2.1.7.2.1 Achievements

- IEC and BCC interventions implemented by MoHSW and development partners.
- Youth friendly services established by MoHSW and development partners.
- NGOs initiated programmes targeting displaced young girls and boys.
- ASRH strategy, training package and advocacy materials developed.
- Advocacy for youth friendly reproductive health services has been implemented in 10 regions (Mtwara, Morogoro, Kilimanjaro, Shinyanga, Mwanza, Dar es Salaam, Kigoma, Singida, Arusha and Manyara).
- 250 HCWs trained on Adolescent Sexual Reproductive Health (ASRH) friendly services.

2.1.7.2.2 Challenges

| Aspects | Challenges for Targeted Youth Programmes |
|------------------|--|
| Availability | <ul style="list-style-type: none">• HIV and AIDS interventions addressing young people are insufficient• Inadequate ASRH friendly services and support at facility and community levels respectively• Inadequate skilled HCWs for ASRH interventions including HIV and AIDS |
| Equitable access | <ul style="list-style-type: none">• IEC and BCC interventions on ASRH and HIV interventions targeting young people are insufficient• ASRH and HIV services are not easily accessible to young people• Sexually active adolescents are not well informed on the importance of seeking health care and protecting themselves• Adolescents who are not sexually active do not get proper information to delay sexual debut |
| Quality | <ul style="list-style-type: none">• Weak coordination and collaboration of intra-sectoral, inter-sectoral and partners on ASRH and HIV interventions at all levels• Majority of IEC interventions use ineffective channels of communication for effective behavioural change |

2.1.7.3 Equity, gender and Sustainability Considerations

Young women and girls are more vulnerable than young men to acquire the AIDS virus due to biological, socio-economic and cultural reasons. Additionally there is an increasing intergenerational sexual practice between older males and young girls, and older women and young boys. On this basis, programmes must aim

to empower young women and boys to make their own independent informed decisions about their sexuality options and preferences with regards to safe sex practices.

2.1.7.4 Strategic Objective

To increase adolescents access, participation and utilization of innovative integrated and high quality health services

Strategies

1. Ensure availability of effective HIV- ASRH interventions for youth
2. Promote positive attitude and behaviour change in communities among parents and adolescents through behaviour change communication strategy
3. Strengthen management and coordination mechanism for HIV and ASRH services at all levels.

2.1.7.5 Targets

1. To reduce HIV prevalence among women and men aged 15-24 years from 2.4 percent in 2008 to 1.4 percent in 2012.

2.1.7.6 Indicators

1. The proportion of young women and men aged 15-24 years who had sexual intercourse before reaching 15 years of age.
2. The proportion of young people aged 15-24 years who used condom at last higher risk sex.
3. Number of districts and health facilities with minimum essential package and adhering HIV- ASRH friendly services
4. Number of adolescents receiving ASRH-HIV services
5. Number of community sensitized and providing support (conducive environment) to young people

2.1.7.7 Key Implementers

MoHSW (NACP, RCHS) TACAIDS, PMORALG, Development Partners NGOs, CBOs, FBOs, RHMTs, CHMTs and community

2.1.8.1 Intervention area 4b: Most At Risk Populations (MARPs): CSW, MSM, mobile workers, IDUs,

2.1.8.2 Preamble

Vulnerability to HIV infection is substantially higher in specific population groups than in the general sexually active population. This is either related directly to their occupational activities (sex workers), their social and cultural marginalization (MSM), or their professions which bring them in frequent contacts with places of sexual mixing (bar maids). Such occupations necessitate longer periods of separation from families or stable relationships (migrant workers including miners, military) or complete breakdown of stable social environment (refugees, intravenous drug users). These groups need special attention because of their importance in the dynamics of the epidemic when they act as a bridge for transmission from their sub group to the general population.

a. Men who have sex with men

Although it is widely spoken, there is no hard data regarding MSM although MSM practices have been reported in institutional settings. However, MSM have not been considered to any great extent in national HIV and AIDS interventions. MSM behaviours and sexualities may include bisexuality, and HIV epidemic amongst MSM and the heterosexual HIV epidemic are thus interconnected.

b. Sex Workers

Sex workers are predominantly female and are at very high risk of HIV infection and are vulnerable due to multiple sexual networks and limited capacity to ensure safe sex during each and every sexual encounter.

c. Injecting drug use (IDU)

Injecting drug use has long been recognized as a high risk practice for HIV transmission as needles and syringes may be shared between users without sterilization. The extent of IDU in Tanzania is under-researched.

2.1.8.3 Situation analysis

Drug use enhances the risk of HIV infections either directly or indirectly by lowering inhibitions, which lead to risky behaviours. The results of THIS (2003-2004) showed that there were higher prevalence of HIV, especially when the alcohol use is by the female partner –overall was 8% (13.7% women and 6.9% men).

The spread of HIV is associated with all forms of drug use including smoking, alcohol use, inhalation and drug injecting. In particular, drug in-take through shared syringes poses a higher risk of HIV infection.

A study carried out in 2001 in Dar-es-salaam, in densely populated area, indicated that 18% of drug users are IDUs. More recent studies revealed that between 31% and 42%^{xiv} of IDUs are HIV positive and the situation is more serious among females.

2.1.8.3.1 Achievements

- Some studies have been conducted on the magnitude of HIV infection among some vulnerable groups and their characteristics.

2.1.8.3.2 Challenges

| Aspects | Challenges for MARPs |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • Inadequate data on the characteristics, risk taking behaviours, magnitude, social-economic- situation of MARPs. • Lack of tolerant policies for these groups (since they are largely marginalized and discriminated in society, their behaviors are not legal and they are subjected to criminal prosecution). • Lack of intervention package focusing on MARPs |
| Equitable access | <ul style="list-style-type: none"> • Inability to access various services due to perceived socially and legally unacceptable behaviours. |
| Quality | <ul style="list-style-type: none"> • Poor coordination mechanism among implementers of MARPs activities • Lack of standardized guidelines for training on HIV issues to MARPs. |

2.1.8.4 Equity, Gender and sustainability considerations

Most sex workers are in this occupation due to economic and social constraints. For some reason, stigmatization of sex work does not extend to the customers who in most cases are males.

For substance abusers females are more vulnerable than males due to multiple partners and forced sex.

2.1.8.5 Strategic objective

To prevent transmission of HIV among MARPs.

Strategies

1. Advocacy for policy change for MARPs.
2. Support research studies on the magnitude and characteristics of MARPs
3. Ensure availability of effective HIV risk reduction interventions for MARPs.
4. Establish public - private partnership with appropriate stakeholders dealing with MARPs

2.1.8.6 Targets

1. Availability of favourable policy guideline for MARPs by 2010
2. Establish magnitude of HIV AND AIDS among MARPs and determinants of HIV transmission by 2009
3. A package for HIV prevention for MARPs developed by 2010
4. Public -private partnership for MARPs intervention established at all levels by 2011

2.1.8.7 Indicators

1. Favourable policy on MARPs in place
2. No of research studies on magnitude and determinants of HIV transmission among MARPs
3. A package for HIV prevention for MARPs developed

2.1.8.8 Key implementers

MOHSW, Private Hospitals, RHMTs, CHMTs, Drug Commission, Academic Institutions, NGOs, Ministry of Home Affairs, Ministry of Infrastructure, Ministry of Trade and Industries .

2.1.9 Intervention area 5: Prevention Services for People Living with HIV and AIDS (Positive Prevention)

2.1.9.1 Preamble

Positive prevention aims at assisting people living with HIV and AIDS to take measures that avoid exposing others to infection as well as avoiding re-infection^{xv}. Re-infection has a negative impact on disease pathogenesis. If preventive measures are not undertaken by PLHIV, infection may be transmitted to others including discordant couples. Also, if PLHIV get re infected with new types of viruses, this can aggravate the progression of the infection. Data from Tanzania (THIS 2003/2004) revealed that up to 8% of couples in the country have discordant HIV sero-status^{xvi}. This calls for the need to promote positive prevention. Stigma is still a bottleneck in making PLHIV access care and treatment services. Major stigma incidences are observed in health care settings and in communities.

2.1.9.2 Situation Analysis

2.1.9.2.1 Achievement

- Number of people who have undergone HIV Counselling and Testing Services has increased significantly. Between July and December 2007 about 3.2 million people were tested.
- Free HIV care and treatment services offered to eligible PLHIV.
- National umbrella/apex organization for PLHIV established
- Establishment of support groups and post test clubs is on the increase.
- Number of PLHIV who have disclosed their serostatus has increased

2.1.9.2.2 Challenges

| Aspects | Challenges for positive prevention for PLHIV and stigma reduction |
|------------------|---|
| Availability | <ul style="list-style-type: none">• Inadequate meaningful engagement and involvement of PLHIV for Positive Prevention.• Inadequate integration of positive prevention in the available care and treatment services |
| Equitable access | <ul style="list-style-type: none">• Inability to access the few available services due to stigma and non disclosure of the intended beneficiaries |
| Quality | <ul style="list-style-type: none">• Unavailability of national guidelines for positive prevention |

2.1.9.3 Equity, Gender and sustainability considerations

- Two thirds of people accessing CTC services are women suggesting a need to identify reasons for low male involvement.

2.1.9.4 Strategic Objective

To reduce the risk of PLHIV getting re-infection or infecting others from HIV.

Strategies

1. Encourage meaningful involvement of PLHIV at all levels.
2. Support individually focused health promotion to enhance disclosure of HIV positive status.
3. Integrate positive prevention in prevention, care, treatment and support services at all levels.
4. Encourage couple counselling and testing and other care and treatment services.

2.1.9.5 Targets

1. National guidelines for meaningful involvement of PLHIV (MIPA) developed.
2. Increase the number of couple who are counselled and tested

2.1.9.6 Indicators

1. Number of PLHIVs participating in positive prevention activities (e.g. post test clubs and other support groups).
2. MIPA guideline in place
3. % of counselling and testing clients who attend as couples.

2.1.9.7 Key implementers

TACAIDS, MoHSW, NACOPHA, NGOs, CSO and Partners.

2.2. THEMATIC AREA II: CARE AND TREATMENT

2.2.1 Introduction

Care and treatment services for people living with HIV and AIDS include provision of ARVs, and other clinical services for the management of opportunistic infections. Wide access to ARVs was initiated in the country in October 2004 as part of the National care and treatment plan (2003-2008). The National care and treatment plan targeted to enrol 440,000 patients on ART by end five years of implementation. During the first year for implementation the target was to provide ARV to 44,000 patients. The targets were further increased to provide ART services to 100,000 by end of 2006. In terms of facility coverage the number increased from 96 to 200 by December 2007. These facilities included all referral regional and district hospitals as well as some private and Faith Based hospitals. All the same home based care is a imperative service in mitigating the physical, mental, spiritual, and socio-economic difficulties experienced by PLHIV and their families, completing the bridge in the continuum of care for the health services to the community. HSS target for 2003 – 2006 was to provide services to 5,000 PLHIV by 2005, conversely by the end of 2006 PLHIV reached with HBC services were 50,000 and the services had been established in 70 districts (53%) in Tanzania mainland.

The major challenge has been the capacity to reach the primary health facilities so as to increase access of services to rural communities. Other challenges include widespread stigma and discrimination and ability to sustain quality services.

This section addresses provision of care, treatment and support services across a continuum of care at health facility and community levels.

2.2.2 Intervention Area 1: Facility Based Services

2.2.3 Preamble

The plan focuses on scaling up activities, strengthening adherence to ART, integrating various HIV and AIDS programs with other health programs, and linking facility based interventions to community and home based care services. The strategy has taken into consideration the fact that there is low enrolment of children and males, and has designed activities aiming at increasing enrolment of these populations, including early infants diagnosis and follow up of children exposed to HIV.

2.2.4 Situational Analysis

2.2.4.1 Achievements

- A Five Year National Care and Treatment Plan (2003-2008) was prepared and implemented.
- A phased roll out of ART was implemented beginning with referral hospitals, followed by regional and district hospitals, some private and Faith Based hospitals.
- By end of 2007, a total of 200 Care and Treatment Clinics (CTC) were providing services.
- Facility assessment tool has been developed and is being used.
- Service standards and guidelines were developed and disseminated.
- Training curricula and materials were developed and used in training health workers.
- Infrastructure improvements, including purchase and installation of essential equipments and supplies were done.
- 2,760 HCWs from various cadres were trained by December 2007.
- By 31st December 2007, a total of 262,717 patients were enrolled on care and 135,696 were initiated on ART.
- By March 2006, a total of 9 technical sub committees of the National Advisory Committee of the Care and Treatment were established. These include: Clinical care, PMTCT, Care and Support, Research, M &E, Training, Logistic, Laboratory and IEC sub committee,

2.2.4.2 Challenges

| Aspects | Challenges for Facility Based Services |
|---------------------|---|
| Availability | <ul style="list-style-type: none"> • The majority of rural population has limited access to ART. • As of December 2007, only 32.4% and 8.24% of adult male and children respectively of the targeted number (150,000) of ART received this treatment • Inadequate supply of OI's drugs and other essential supplies. • Inadequate laboratory services • Limited infrastructure for CTC services • Limited number of days for offering ART services in some health facilities |
| Acceptability | <ul style="list-style-type: none"> • Awareness of benefits of knowing one's HIV status and accessing care and treatment early is low. • Public literacy on ART is low. • Some of the health care providers are not proficient in using criteria for initiating ART. |
| Quality of services | <ul style="list-style-type: none"> • Lack of integration of CTC clinics into routine care. • Poor linkage of vertical programmes leading to inefficiency and at times artificial shortages of drugs and other commodities which PLHIV cannot access, e.g. Isoniazid from the TB program is not accessible to the Care and Treatment program, while cotrimoxazole is not accessed by TB patients in districts which have no TB/HIV integration activities. • Poor absorptive capacity of VCT centres to scale up TB activities. • Inadequate human resource capacity in terms of quantity and skills. • Burn out among HCW is common and the rate of attrition is high. • Low capacity at National and Regional level to monitor and supervise ART care and treatment interventions. • Low involvement of PLHIV in the design and implementation of care and treatment plans. |

2.2.4.3 Emerging Issue

- The demand for care and treatment services is still low thus there is need to introduce other approaches for HIV Counselling and Testing including Provider Initiated Testing and Counseling (PITC).
- Limited nutritional counseling and linkages with sources of food and nutrients to complement antiretroviral therapy.
- Disjointed CTC and HBC services in most districts.
- Other interventions apart from care and treatment (PMTCT, TB, STI, RCH) are delivered in vertical manner thus leading to poor coordination and missed cross-referrals.
- More involvement of traditional healers in care and treatment.

2.2.5 Equity, Gender and Sustainability Considerations

- Low enrolment of children and males into care.
- By and large the Care and Treatment programme is resource intensive and the government is consistently increasing its share over external support. e.g. 28% of ARV procurement has been contributed by the Government of Tanzania from 2004 to October 2007.

2.2.6 Strategic Objective - 1

To strengthen and scale up implementation of comprehensive care and treatment services in public and private facilities so as to provide ART services to 90% of all PLHIV in need of ART of which 18% will be children by 2012

Strategies

1. Strengthen capacity for implementing Comprehensive Care, Treatment and Support.
2. Increase access to and delivery of ART for Adults.
3. Increase access to and strengthen paediatric treatment (ART).
4. Advocate for introduction of task shifting to address shortage of human resources

2.2.6.1 Targets

1. A comprehensive package of care and treatment available throughout the Health system according to the level of a facility
2. 90% of all eligible persons put on ART by 2012
3. 18% of patients on treatment are children by 2012 (from the current 8%)
4. All health facilities have at least 2 HCWs trained in HIV and AIDS care and treatment
5. Policy on task shifting is in place

2.2.6.2 Indicators

1. % of health facilities involved in providing care and treatment services.
2. % of adult and children eligible for ART receiving treatment
3. % of adult and children with HIV still alive and known to be on treatment twelve months after initiation of ART.
4. % of individuals who are still on treatment and who are still prescribed a standard first line regimen after twelve months from initiation of treatment.
5. % of health facilities providing paediatric care and treatment linked with PMTCT, RCH, IMCI and community HBC programs
6. % of PLHIV enrolled for care and treatment and eligible for cotrimoxazole prophylaxis and currently receiving cotrimoxazole prophylaxis.

2.2.6.3 Key Implementers

MoHSW, Public, FBOs, PMORALG and Private health facilities, RHMTs, CHMTs, Academic Institutions.

2.2.7.1 Strategic Objective - 2

To improve the quality of care for both PLHIV as well as TB patients by strengthening the collaboration between TB and HIV programmes at all levels.

Strategies

1. Establish and implement mechanisms for collaboration between TB, HIV and AIDS related services.
2. Strengthen the capacity of health care workers to ensure adequate and appropriate screening for prophylaxis or early treatment of TB in PLHIV.
3. Reduce the burden of HIV in TB patients.
4. Reduce the burden of TB in PLHIV.

2.2.7.2 Targets

1. All CTCs screening PLHIV for TB.
2. All TB clinics screening patients for HIV co-infection.
3. All TB clinics at all levels of health services providing HIV care and treatment.

2.2.7.3 Indicators

1. Policy guidelines on TB and HIV collaboration developed and disseminated.
2. TB/HIV co-morbidity management guidelines adapted.
3. Number of districts with TB/HIV coordinating committees.
4. Number of health care workers trained in managing TB/HIV co-morbidity.
5. % of TB patients tested for HIV
6. % of TB patients with HIV co-infection that are treated for TB and HIV.
7. % of health facilities with TB clinics providing Cotrimoxazole prophylaxis and ARVs
8. % of HIV infected patients screened for TB.

2.2.7.4 Key Implementers

MoHSW, PMORALG, Public, FBOs and Private Health Facilities, RHMTs, CHMTs, Academic Institutions.

2.2.8 Strategic Objective - 3

To provide quality HIV and AIDS care and treatment to PLHIV and improve the quality of life by 2012.

Strategies

1. Establish packages of HIV treatment and care appropriate for different levels of care.
2. Strengthen and scale up HIV Care and Treatment related training to enhance skills of HCWs at all levels.
3. Strengthen the system of Quality Assurance of HIV Care and Treatment Services.
4. Strengthening capacity for decentralized monitoring and evaluation of HIV care and treatment at all levels with efficient system for tracking patients.

2.2.8.1 Targets

1. All HIV care and treatment health facilities to provide essential package of care
2. All Health Care facilities to have at least two Health Care Workers trained to provide care and treatment services
3. All facilities providing care and treatment are supervised at least twice a year.

2.2.8.2 Indicators

1. Standard packages of care developed for different levels of care.
2. % of districts with staff trained on supportive supervision.
3. % of health care facilities provided with supportive supervision

2.2.8.3 Key Implementers

MoHSW, PMORALG, Public, FBOs and Private Health Facilities, RHMTs, CHMTs, Academic Institutions.

2.2.3 Intervention Area 2: Community Based Care Services

2.2.3.1 Preamble

The number of patients with HIV and AIDS related diseases continues to increase steadily. Between 50% - 60% of adult patients admitted in medical wards are believed to be due to HIV related causes. This places a significant burden on health professionals caring for the terminally ill. It is becoming difficult to give quality care in many of the already overburdened public health care facilities. In addition, results from studies done among patients with advanced HIV disease showed that many preferred to be nursed at home.

The introduction of ART services in Tanzania has been challenged to establish effective linkages with successful home based care programmes in order to increase patient identification, support adherence to treatment and follow-up.

2.2.3.2 Situational Analysis

HSS target for 2003 – 2006 was to provide services to 5,000 patients by 2005 through:

1. Establishment of comprehensive HBC services in selected districts ,
2. Establishment and implementation of M & E system.

2.2.3.2.1 Achievements

- Guidelines for home based care services (2005) including training manuals (2005) have been developed to ensure the provision of quality of care across the continuum.
- The numbers of CSOs, NGOs and FBOs offering HBC services has increased significantly.
- HBC services were initiated in 70 districts (53%) and 50,000 PLHIV were reported to be receiving services by 2006.
- District home based care trainers, facility and community based home based care providers have been trained using the National curricula.

2.2.3.2.2 Challenges

| Aspects | Challenges for Community Based Services |
|------------------|---|
| Availability | <ul style="list-style-type: none">• 50,000 patients were receiving HBC services out of 320,000 who are in need by the end of 2006.• As of December 2006, 70 districts (out of 124) had trained district HBC coordinators, HBC facility focal persons and community HBC providers using the national curriculum. However, establishment of HBC services in these districts are partial.• Irregular supply of HBC kits.• Home based care is mainly implemented as projects not included adequately in Comprehensive Council Health Plans (CCHP) |
| Equitable access | <ul style="list-style-type: none">• Uncoordinated and non-standardized provision of HBC services leading to duplication of efforts and inefficient use of the meagre resources. |
| Quality | <ul style="list-style-type: none">• Poor coordination and poor referral systems and networking among key HBC implementers at all levels• Inadequate capacity to coordinate and supervise HBC activities at all levels• Inadequate provision of comprehensive care inclusive of medical/nursing, psychosocial, socio-economic, nutritional and legal/human rights needs.• Inadequate involvement of PLHIV• Inadequate community participation and involvement.• Low motivation and non standardized incentive packages to the care providers.• Low adherence to national home based care guidelines and standards.• No standardized monitoring, evaluation and reporting systems and tools. |

2.2.3.2.3 Emerging Issues

- Missed opportunities for HIV prevention in general and “prevention with positives” in particular.
- Lack of policy for pain management using oral morphine particularly in home based care.

2.2.3.3 Equity, Gender and Sustainability Considerations

- There is need to strengthen community support and ownership to facilitate sustainability
- Increased burden of care for women and girls.
- Inadequate male involvement in care provision.

2.2.3.3.4 Strategic Objective - 1

To strengthen and scale up the implementation of standard package of home based care services for HIV and AIDS in all districts.

To strengthen effective linkages and referrals between community based and clinical service to ensure the provision of comprehensive services across a continuum of care for PLHIV

Strategies

1. Ensure accessibility and availability of standard package of HBC and support services for PLHIV through collaboration and networking with NGOs, FBOs and CSOs
2. Formulate policy guidelines to allow the use of oral morphine at home setting
3. Strengthen collaborative TB, HIV and AIDS interventions at the community level.
4. Inclusion of standard package of HBC services in the comprehensive council health plans (CCHPs).
5. Strengthen coordination and standardisation of HBC services
6. Strengthen capacity for supportive supervision, for HBC services
7. Establish mechanisms for effective referrals and networking among key stakeholders.

2.2.3.3.4.1 Targets

1. All districts implement standard package of HBC and support services
2. Review the national package for HBC services
3. Policy guideline on use of oral morphine for home use formulated by 2010
4. Partners providing HBC, their package and their locality identified and documented in each district.
5. At least two health care workers per facility trained on standard package of HBC care.
6. At least two community HBC providers per village trained on standard package of HBC care.
7. All HBC patients effectively linked to CTC and other support services
8. Reach 495,300 adults and children living with HIV who receive care and support services outside health facilities by 2012.

2.2.3.3.4.2 Indicators

1. % of districts providing standard package of HBC and support services
2. National package for HBC services in place by end of 2009.
3. Policy guidelines on use of morphine in place
4. Mapping of partners providing HBC in each district in place.
5. Number of PLHIV and chronically ill people receiving HBC services
6. Number of facility based HBC providers trained using the national curriculum.
7. Number of community home based care service providers trained using the national curriculum.
8. % of HBC patients effectively linked to CTC and other support services.
9. Number of adults and children living with HIV who receive care and support services outside health facilities.

2.2.3.3.4.3 Key implementers

MOHSW, PMO-RALG, TACAIDS, CHMTs, CMACs, VMACs, NGOs, CSO, FBOs

2.3. THEMATIC AREA III: CROSS-CUTTING ISSUES

2.3.1. Introduction

The National Multi-Sectoral Strategic Framework on HIV AND AIDS 2008-2012, lists cross cutting issues including the enabling environment and gives a set of strategic objectives and core strategies for each objective. The areas are mentioned as follows:

- Laboratory services,
- Counselling and testing,
- IEC, BCC and fighting stigma, and
- Condom promotion.

These areas are cross-cutting and have a bearing on each of the activities in prevention, treatment, care and support thematic areas.

2.3.2 Intervention Area 1: Laboratory Services

2.3.3 Preamble

Laboratory is one of the important components in HIV and AIDS interventions. It supports prevention, care and treatment services as well as monitoring the epidemic and drug susceptibility activities. In order to support the comprehensive HIV and AIDS interventions, it is important to have good quality and equitable laboratory services.

2.3.4 Situation Analysis

The following achievements and challenges were encountered during the implementation of HSS on HIV and AIDS 2003-2006:

2.3.4.1 Achievements

The following trainings have been conducted;

- A total of 287 laboratory staff from public and private hospitals were trained to test for HIV, CD4, haematology and chemistry.
- In addition, 842 health workers (laboratory and non laboratory) were trained on HIV rapid testing.
- A total of 30 laboratories (zonal, regional and district) were renovated.

The following laboratory equipments were procured and installed;

- 76 CD4 machines, 133 haematology analyzers and 113 chemistry analyzers. These equipments were installed in all referral, regional and some district hospitals.
- DNA PCR machine for HIV infant diagnosis was installed at Bugando Medical Centre;
- Laboratory Quality Assurance (QA) Guidelines was developed and disseminated.
- QA and training laboratory was constructed.
- Also External Quality Assurance (EQA) system for CD4 was initiated and implemented in all laboratories performing the test
- Algorithm for Rapid HIV Testing was revised and the updated one was rolled out.
- Distribution mechanism for STI, HIV and AIDS laboratory reagents and supplies was established.
- The Parliament passed the Laboratory Practitioners Act (2007) which allows rapid testing by non-laboratory health workers.
- A model of transporting laboratory samples (sample transportation system) is in pilot phase. Lessons learnt will be used to scale up the system in the rest of the country.
- Standard Operating Procedures (SOPs) for testing and equipments used were developed and rolled out.
- Laboratory information systems (laboratory forms and registers) for data recording and reporting were developed and in use,

2.3.4.2 Challenges

| Aspects | Challenges for Laboratory Services |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • There is no high containment laboratory (P3) in the country for virus isolation and characterization. • Lack of capacity for HIV drug resistance testing • There is inadequate supply for test kits ,laboratory reagents and other consumables to support HIV and syphilis testing services in various interventions • Use of laboratory reagents and other consumables in activities not intended for • Increase in demand for some HIV laboratory reagents |
| Equitable access | <ul style="list-style-type: none"> • There is shortage of CD4 equipment, haematology and chemistry analyzers and HIV infant diagnosis equipment. • Shortage of qualified laboratory personnel • Most laboratory services are based in urban areas. • Weak logistic system leads to stock out and expiry of stocks sometimes. |
| Quality | <ul style="list-style-type: none"> • There is inadequate monitoring of use of testing kits and laboratory supplies. • There are inadequate cold storage facilities for test kits and reagents especially in the remote areas • Slow implementation of the National guidelines for laboratory quality assurance system. • Irregular maintenance and repair of laboratory equipment • Poor laboratory infrastructure • No laboratory accreditation system. • Laboratory personnel do not have Good Laboratory Practice (GLP) training • Inadequate quality control to most of the laboratories • Non adherence to the national testing algorithm |

2.3.5 Equity, Gender and Sustainability Considerations

- Most of the good quality laboratory services are in urban areas.
- Limited capacity for early infant HIV diagnosis and CD4 % monitoring.
- Laboratory upgrading is expensive and the government should increase its funding in this area in order to ensure sustainability

2.3.6 Strategic Objective

Strengthen laboratory system at all levels to support prevention, care, treatment and other interventions for STI, HIV and AIDS.

Strategies

1. Ensure availability of appropriate laboratory infrastructure and equipment in health facilities including infant diagnosis
2. Strengthen logistic system to ensure uninterrupted supply of reagents in all health facilities for diagnosis and monitoring of STI, HIV and AIDS and major OI
3. Strengthen capacity to monitor drug resistance for ARV, Anti TB, STI and OI drugs.
4. Implement and strengthen the national laboratory quality assurance scheme
5. Develop system for regular equipment maintenance including strengthening of laboratory equipment workshops.

2.3.7 Targets

1. Establish quality assurance systems in all public and private hospital laboratories by 2012.
2. Establish Infant HIV diagnosis capacity in three regional hospitals and ensure equitable services by 2012.
3. Establish capacity for HIV drug resistance testing in one laboratory at one of the referral hospital by 2012 .
4. Establish a functional and sustainable equipment maintenance mechanism by 2009.
5. Establish logistic management system to ensure uninterrupted supply of test kits and laboratory reagents

2.3.8 Indicators

1. % of laboratories that meet the national quality assurance standards.
2. Number of regional hospital laboratories with capacity to perform HIV early infant diagnosis.
3. Number of laboratories performing HIV drug resistance testing in country according to international standards.
4. % of CD4 machine serviced according to equipment requirements.
5. Master plan for logistic management operational by 2012.

2.3.9 Key Implementers

MOHSW, NIMR, PMORALG, RMO, RAS, DED, Referral Hospitals, National Public Health Laboratory.

2.3.3 Intervention Area 2: HIV Testing and Counselling (HTC) Services

2.3.3.1 Preamble

The National Guidelines for Voluntary Counselling and Testing (2005) clearly state that HTC provides an opportunity to access accurate and comprehensive information on HIV, AIDS and STIs. It serves as an entry point to prevention, care, treatment and support, programmes and enables people to understand their HIV status and learn about supportive behaviours for protecting and preventing further spread of HIV.

It has been noted that the demand for counselling and testing is high creating the need to introduce new approaches for HIV Testing and Counselling (HTC) to complement the client initiated Voluntary Counselling and Testing (VCT). These new approaches include Provider Initiated Testing and Counselling (PITC) and Home Based Counselling and Testing a (HBCT). Further more; the existing public, private and voluntary agencies services are available in only a small proportion of health facilities and cannot handle the high demand for this service. The establishment of stand alone VCT sites has been slow and unsatisfactory. Therefore, there is need to expand the existing systems in order to address this situation,

2.3.3.2 Situation Analysis

The target for the 2003-2006 HSS was to train 1,600 counsellors countrywide and establish six VCT sites in each district.

Below are the achievements and challenges in implementing HTC services during the past HSS 2003-2006:

2.3.3.2.1 Achievements

- Trainings have been conducted as follows;
 - 2,739 counsellors, 96 national VCT trainers and 62 regional and district VCT supervisors had been trained.
 - Sixty members of CHMT were oriented on managerial skills on the supervision of VCT and other HIV and AIDS-related interventions.
- Training Curriculum for counsellors was reviewed.
- National guidelines for VCT (2005) was developed
- 1,035 VCT sites were established by 2006.

2.3.3.2.2 Challenges

| Aspects | Challenges for HIV Testing and Counseling |
|------------------|--|
| Availability | <ul style="list-style-type: none"> • Irregular supply of HIV test kits at all levels. • 33% of the districts have less than 6 VCT sites. • VCT services being partially included in the Council Comprehensive Health Plan • Lack of recognition of counselling as a career path (counsellors is not a cadre in the health system). |
| Equitable access | <ul style="list-style-type: none"> • Only 15% of people aged 15 to 49 have been tested and know their status. • The available number of trained counsellors does not match with the existing demand. • Groups with special needs are marginalised due to lack of skills to provide counselling to special groups, for example, auditory and visually impaired individuals, children and MARPs • Inequitable distribution of VCT sites across the country • Most of the VCT services were not youth friendly |
| Acceptability | <ul style="list-style-type: none"> • Fear and stigma prevent uptake of VCT services • VCT services are mostly health facility based and provided on part time |
| Quality | <p><u>Programme management</u></p> <ul style="list-style-type: none"> • Inadequate coordination of VCT services at all levels, • A weak referral and networking system. • Inadequate supervision and support to counsellors, • Non adherence to national VCT guidelines. • Poor infrastructure which compromise privacy and confidentiality <p><u>Quality improvement</u></p> <ul style="list-style-type: none"> • Insufficient motivation to counsellors. • Heavy workload for counsellors leading to burnout. • Irregular supportive supervision • Lack of specialised skills to provide counselling to clients with special needs • Inadequate quality assurance for counselling and testing services |

2.3.3.2.3 Emerging Issues

- Private for profit partners find it uneconomical to conduct VCT-related activities due to various factors including
 - They are required to provide free HIV testing
 - Transporting samples for quality control without reimbursement of costs involved.
 - Perceived as additional work without remuneration
- Existence of discordance among couples

2.3.3.3 Equity, Gender and Sustainability Considerations

- Low coverage in rural areas and among vulnerable populations.
- More women than men are accessing HTC services in the health facilities.
- Inadequate coordination for handing over programs by implementing partners

2.3.3.4 Strategic Objective

To improve access and enhance use of quality HIV Testing and Counselling (HTC)

Strategies

1. Strengthen existing VCT services and promote the establishment of other HTC approaches testing including services for special groups
2. Ensure availability of appropriate standard operating procedures (SOPs) for HTC to all health and non health services
3. Strengthen and support HTC as an integral component for HIV/AIDS/STI/TB prevention, treatment care and support.
4. Ensure availability of a comprehensive HTC guideline to include all testing and counselling approaches.

2.3.3.5 Targets

1. Annual number of people who received HIV testing and counselling services and received their test results reaches 4,933,450 by 2012.
2. Proportions of women and men aged 15-49 years who receive HTC services and receive their test result increase from 37% and 27% of women and men respectively to 60% and 40% by 2012.
3. More than 20% of dispensaries throughout the country provide VCT services by 2012.
4. PITC services are established in all hospitals and health centres and at least 10% of the dispensaries by 2012.
5. Five hundred (500) VCT counsellors are trained to meet the needs of special groups such as auditory and visually impaired individuals, children and MARPs by 2012.
6. Fifty percent (50%) of VCT sites are assessed by 2012.
7. Comprehensive HTC guidelines, standard operating procedures (SOPs) and cue cards are distributed to all HTC service sites by 2011.
8. Annual coordination and quarterly subcommittee meetings at the national level are organised.

2.3.3.6 Indicators

1. Number of people who received HTC services and received their test results
2. Proportion of women and men aged 15-49 who received HTC services and received their test results
3. % of dispensaries providing VCT services
4. % of health facilities providing PITC services
5. Number of VCT counsellors trained to meet the needs of special groups such as auditory and visually impaired individuals, children and MARPs
6. % of VCT sites assessed
7. Number of health facilities received comprehensive HTC guidelines, SOPs and cue cards
8. Number of annual coordination and quarterly subcommittee meetings at the national level

2.3.3.7 Key Implementers

MOHSW, PMORALG, TACAIDS, RHMT, CHMT, FBOs, NGOs, public and private health facilities.

2.3.4 Intervention Area 3a: IEC, BCC Programming and Stigma Reduction Interventions: Behavioural Change Communication (BCC)

2.3.4.1 Preamble

Behaviour change communication (BCC) is a process by which information and skills are shared and disseminated to people in the specific target audience with the intention of influencing them to adopt sustained changes in behaviour or attitude. Behaviour change as a process, involves knowledge and attitudes,

a favourable social, cultural and physical environment for the expected change to take place. The processes behind what happens are summarised on the **Figure 5** below.

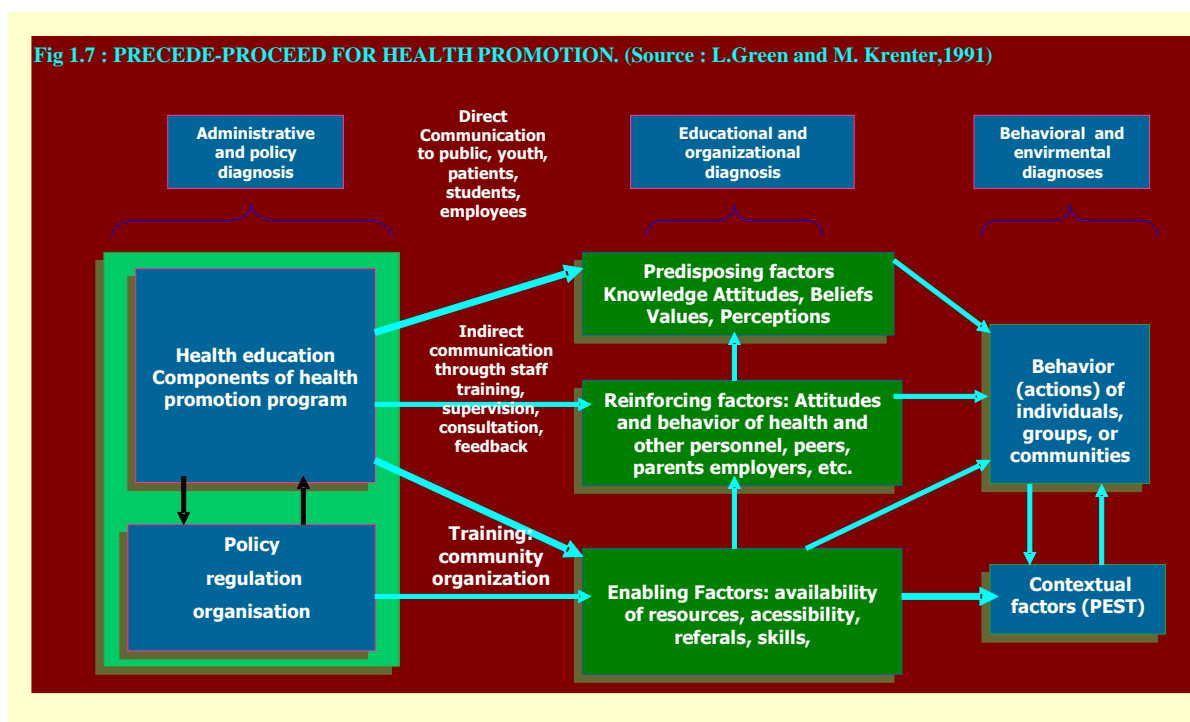


Figure 5: Precede-Proceed Model for Health Promotion-

2.3.4.2 Situation Analysis

In the previous health sector strategy 2003-2006, the terms IEC and BCC were integrated as “Health Promotion” on the understanding that health promotion is a cross-cutting issue. In this health sector strategy the components were separated to give more emphasis on BCC interventions.

Below are the achievements and challenges gathered from various behavioural surveys conducted during the period 2003-2006:

2.3.4.2.1 Achievements

- Age at first sexual intercourse among female and male adolescent has risen slightly from 16.7 in 1999 to 17 years in 2004 -2005. (DHS 2004-05)
- 15% of Tanzanians aged 15-49 years have ever been tested for HIV. (THIS 2003-2004)

2.3.4.2.2 Challenges

| Aspects | Challenges with BCC Programming |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • No Health sector specific communication strategy • Inadequate BCC programming in HIV and AIDS interventions • Public awareness on some of the core interventions still low and many myths and misconceptions persist • Inadequate human resource in BCC programming at all levels • Insufficient dissemination of data on behaviors that influence HIV epidemic |
| Equitable access | <ul style="list-style-type: none"> • Inadequate messages in rural areas • Messages are not focused to MARPs and people with disabilities eg. auditory and visually impaired people |
| Quality | <ul style="list-style-type: none"> • IEC has often resulted in the production of discrete communication materials. • Lack of quality assurance and quality control system for effectiveness of BCC intervention. • Current messages are not contextualised to various cultural settings |

2.3.4.3 Equity, Gender and Sustainability Considerations:

The difference in prevalence between males and females in the country calls for the proper understanding of gender dynamics in order to address the situation in a comprehensive manner.

2.3.4.4 Strategic Objective

Improve provision of BCC interventions for HIV and AIDS using the contextual approach

Strategies

1. Establish a profile of information on knowledge, Attitude and behavioural practices of various communities in Tanzania.
2. Ensure the formulation of the health sector specific HIV and AIDS Communication Strategy to support implementation of the HSHSP II
3. Strengthen the linkages with key stakeholders of BCC from both public and private sectors.

2.3.4.5 Targets

1. Four focused KAP studies conducted by 2010 to address key knowledge gaps on the determinant of the epidemics in Tanzania
2. Health sector HIV and AIDS Communication Strategy developed by 2009
3. Mechanisms to link various BCC stakeholders established by 2010

2.3.4.6 Indicators

- Number of KAP studies conducted
- Health sector HIV and AIDS Communication Strategy in place.
- A framework for linking various BCC stakeholders in place.

2.3.4.7 Implementers

MoHSW, PMORALG, partners, TACAIDS, NGOs, FBOs, CBOs

2.3.5 Intervention Area 3b: IEC, BCC programming and Stigma Reduction Interventions: Information, Education and Communication (IEC)

2.3.5.1 Preamble

Information Education and Communication is a process that informs, motivates and helps people to adopt and maintain healthy practices and life skills. It aims at empowering individuals and enabling them to make correct decisions about safe behaviour practices. IEC also attempts to create an environment which is conducive to support access to treatment and services to those already infected.

2.3.5.2 Situation analysis

Below are the achievements and challenges in implementing IEC in HSS 2003-2006:

2.3.5.2.1 Achievements

- Awareness of HIV and AIDS in Tanzania is 99% among age group 15- 49 (THIS 2004)
- Print materials: 280,000 wall calendars, 1,351,000 brochures, 200,000 booklets, 394,000 posters and 535,000 newsletters.
- Audio visual: TV and radio programs (film, spots & live talk shows).
- Various IEC materials produced by local NGOs.
- NACP website developed and key documents posted

2.3.5.2.2 Challenges

| Aspects | Challenges in IEC materials production |
|------------------|--|
| Availability | <ul style="list-style-type: none">• No evaluation done on impact of different types of media used for channelling messages to the public• Website not yet comprehensive.• Insufficient IEC materials• Cumbersome procurement process and poor distribution system |
| Equitable access | <ul style="list-style-type: none">• Centralized and inadequate production of IEC materials.• Local media and other communication channels are rarely used• Messages are not focused to MARPs and people with special needs eg. Auditory, visually impaired people and elders |
| Quality | <ul style="list-style-type: none">• Lack of coordination mechanism of production of IEC materials• Current messages are not contextualised to local settings |

2.3.5.3 Equity, Gender and Sustainability Considerations:

- Access to information is limited to certain geographical settings, age and social groups,
- Some of the IEC materials are not sensitive to gender, economic dimensions political-legal context which influence sexual relations

2.3.5.4 Strategic Objective

Improve the provision of HIV and AIDS information through innovative approaches based on available evidence.

Strategies

1. Produce IEC materials targeting different age and social groups
2. Ensure availability of print and electronic IEC materials for universal access to prevention, care, treatment and support at all levels.
3. Strengthen collaborative IEC activities/ interventions with different partners.
4. Strengthen NACP library
5. Strengthen distribution of IEC materials especially to rural areas.

2.3.5.5 Targets

1. IEC materials for universal access to prevention, Care, treatment and support are available in rural areas
2. Coordinate production of major IEC materials.
3. NACP website fully developed by 2010
4. NACP library strengthened

2.3.5.6 Indicators

1. % of produced IEC materials for universal access available in rural areas
2. % of IEC materials produced under coordination
3. Number of NACP library users.

2.3.5.7 Key implementers

MOHSW, PMORALG, TACAIDS, Public and Private Sector partners, Tanzania library services board, CSOs₂

2.3.6 Intervention Area 3c: IEC, BCC programming and Stigma Reduction Interventions: Stigma and Discrimination

2.3.6.1 Preamble

Stigma is a mark of shame or discredit on a person or a group of people. Stigma can manifest itself in a variety of ways, from ignoring the needs of a person or group to psychologically or physically harming those who are stigmatized.

Stigma causes discrimination which in turn leads to human rights violations for PLHIV and their families. Stigma and discrimination fuel HIV and AIDS epidemic because they hamper prevention and care efforts by sustaining silence and denial about HIV and AIDS. Also they contribute in the marginalization of PLHIV and those who are particularly vulnerable to HIV infection like men who have sex with men (MSM), sex workers (SWs), survivors of rape, Injecting Drug Users (IDUs), migrant populations and others.

The importance of addressing stigma in the context of BCC campaigns has programmatic implications that go beyond compassion and humane treatment. Failure to address stigma jeopardizes BCC programs in prevention, quality of care and policy.

2.3.6.2 Situation analysis

Below are achievements and challenges encountered when implementing 2003-2006 plans:-

2.3.6.2.1 Achievements

- Training materials on stigma and discrimination for health workers developed
- Production and distribution of leaflets and posters on stigma
- Production and airing of TV/Radio programmes (film “Hali Halisi” and talk shows).

2.3.6.2.2 Challenges

| Aspects | Challenges in Stigma Reduction among HCW |
|------------------|--|
| Availability | <ul style="list-style-type: none">• Minimal stigma reduction activities in health care setting.• Health workers lack skills to educate people on stigma and discrimination• There is no clear law to minimize stigma and promote respect for PLHIV |
| Equitable access | <ul style="list-style-type: none">• Limited coverage of training for health care workers on issues related to stigma and discrimination• Lack of stigma reduction services to MARPs and marginalised people. |
| Quality | <ul style="list-style-type: none">• Stigma reduction activities not coordinated. |

2.3.6.3 Equity, Gender and Sustainability Considerations

Women and the poor PLHIV are more stigmatized. Stigma depletes meager resources due to shopping around for care from different providers. PLHIV are frequently subjected to poor quality of health care.

2.3.6.4 Strategic Objective

Ensure stigma reduction interventions at all levels of health system..

Strategies

1. Promote development and integration of stigma reduction interventions at all levels of health system.
2. Strengthen coordination mechanism on stigma and discrimination reduction activities at all levels

2.3.6.5 Targets

1. Stigma reduction interventions developed, integrated and implemented at all levels of health system by 2012.
2. Incorporate stigma and discrimination reduction modules in various health training materials by 2012.

2.3.6.6 Indicators

1. % of districts with Stigma and discrimination reduction plans.
2. Number of health care facilities implementing stigma reduction activities.
3. Number of interventions training materials containing stigma and discrimination modules.

2.3.6.7 Key Implementers

MOHSW, PMORALG, TACAIDS, CHMT, RHMT and Partners

2.3.7 Intervention Area 4: Condom Promotion and Use

2.3.7.1 Preamble

Promotion of female and male condoms and their proper use are recognised to be an important aspect for prevention of sexual transmission of HIV and STIs/RTIs. Despite the concerted efforts towards condom promotion, their wider acceptance and use is still a challenge. Myths and misconceptions surrounding condom use still exists. There is a strong need to continue with rigorous efforts and/or campaigns including social marketing in order to minimize barriers towards condom use.

2.3.7.2 Situation analysis

Below are achievements and challenges encountered when implementing 2003-2006 plans

2.3.7.2.1 Achievements

- 41.7% of youth aged 15-24 years used condoms at their last higher risk sex (THIS 2003/04).
- Total number of male and female condoms procured by the Ministry of Health and Social Welfare in 2006 was 85 million and 0.75 million respectively.
- Increased partnership with NGOs in condom promotion

2.3.7.2.2 Challenges

| Aspects | Challenges in Condom Distribution |
|------------------|--|
| Availability | <ul style="list-style-type: none"> • Condom outlets are limited in number and variety • Youth friendly outlets are limited • While the cost of condoms is comparatively small in the social marketing, it is not affordable by certain segments of the population. • Female condoms are not widely available. • Inadequate number of penile and pelvic models for demonstration |
| Equitable access | <ul style="list-style-type: none"> • 74% (68% F, 83% M) of urban youth know of a condom outlet but only 55% (44% F, 67% M) of rural youth do (THIS, 2004) • Distribution through health facilities was a hindrance to people needing them from alternative source. • Condom availability in rural areas is erratic • Inadequate condoms for vulnerable groups |
| Awareness | <ul style="list-style-type: none"> • In health facilities, condom use is usually promoted for family planning and for STI patients |
| Acceptability | <ul style="list-style-type: none"> • 65% (61% F, 69% M) of 18 to 49 year old people think that children aged 12 to 14 should be taught about condoms (THIS, 2003/04) • Female condoms not widely acceptable |
| Affordability | <ul style="list-style-type: none"> • 54.2 % of male condoms are free, 45.8% are sold through social marketing (2006 NACP) @ TZS. 100 for a pack of 3. • Female condoms are relatively expensive @ TZS. 1000 each (PSI) |

2.3.7.3 Equity, Gender and Sustainability Considerations

Accessibility of female condoms is a challenge. Similarly, the distribution of free male and female condoms through health facilities limits access to people who are not sick.

2.3.7.4 Strategic Objective

Strengthen promotion, availability, accessibility and use of condoms

Strategies

1. Establish private-public partnership to create alternative condom distribution outlets
2. Establish private-public partnership to promote use of condom using different innovative approaches
3. Provide comprehensive information and education to health care workers
4. Strengthen condom programming and monitoring systems
5. Support operational research on condoms

2.3.7.5 Targets

1. At least 60% of youth aged 15-24 years use condoms in all risk sexual exposure
2. Condom use promoted using ten different innovative approaches through private- public partnership at all levels by 2012
3. Develop training materials on dual protection of condoms for HIV and STIs prevention and family planning
4. Identify five additional partners for condom distribution by 2012
5. Conduct four operational research on condom promotion and distribution by 2010

2.3.7.6 Indicators

1. Percent of youth aged 15-24 years who used condoms in their last risk sexual exposure
2. Number of innovative approaches used to promote condom use
3. Training materials on dual protection of condoms for HIV and STIs prevention and family planning operational by 2012.
4. Number of condom outlets established
5. Number of operational research studies on condom promotion and distribution conducted and documented

2.3.7.7 Key Implementers

MOHSW, PMORALG, TACAIDS, NACOPHA, NGOs, CSO, Research Institutions

2.4. THEMATIC AREA IV: HEALTH SYSTEM STRENGTHENING

2.4.1. Introduction

Successful scale-up and utilisation of a broad range of HIV and AIDS services and products requires a well functioning health system. The system should be able to respond, not only to current, but also to future emerging and re-emerging HIV and AIDS issues

In order for the system to produce the expected outcomes, it is necessary to have a mechanism that will ensure that appropriate inputs and processes are in place and are based on a strong foundation. Conceptually, as can be seen from Table 8, the system is expected to have a strong leadership base, strong programme management system, adequate human resource mix, efficient procurement and supply system. In addition, it requires strategic information and a good financial base to sustain it.

Table 8: System Model for HIV and AIDS interventions

| Support Systems (Factory or base) | Inputs | Process or interventions, activities | Outputs | Outcomes | Impacts |
|--|--|---|---|---|-------------------------------------|
| What inputs are the systems producing? (<u>Stewardship-leadership</u>) | Resources (<u>Resources created by a functioning health or support system</u>) | Tasks & responsibilities. (<u>Delivering good services in all fairness</u>) | Direct product of process (<u>fairness</u>) | Short term effects on the clients (<u>responsiveness</u>) | Wider community (<u>fairness</u>) |
| Programme management system | General strengthening of existing institutions Specific new infrastructure for HIV and AIDS programme expansion or scale up | Prevention PMTCT Prev. Sexual Transmission Health Care Settings Vulnerable Populations Positive Prevention & stigma | Persons informed. Infections prevented Infections treated | Changes in client knowledge, attitude, behaviour (good and healthy practices) | Reduced prevalence |
| Human resource for health system | Skilled HCWs as a whole Specific HCWs hired | Treatment, care and support Facility based (OIs, ART, TB/HIV) Community based services | | | |
| Procurement and supply management | System for all commodities Specific drugs for HIV and AIDS | | | | |
| Quality improvement (Strategic information) | General QI and strategic system for health sector Specific M&E for HIV and AIDS programmes | Cross-cutting issues Laboratory HIV Testing & Counselling IEC,BCC & Stigma Condom promotion Operational research | | | |
| Financing system | Health sector budget Allocation to HIV and AIDS programmes | | | | |

It is recognised that health systems constraints are the root cause of the poor outcomes of health interventions. It is therefore, necessary to examine the health system and find out whether it is able to provide answers to the following questions:

- Is it possible and what constraints need to be overcome to make HIV and AIDS interventions in the health sector available to the large numbers of people in need- **i.e. are we delivering good services and ensuring healthy outcomes in a fair manner for the whole health sector?**
- How will the equity principle be maintained in the inevitably incremental process of scale up or roll-out- **i.e. is it possible to leverage the additional HIV and AIDS resources to address existing health challenges and improve the overall health care delivery?**
- Is it feasible to structure the investments in HIV and AIDS interventions so that they do not divert scarce resources away from other essential activities and instead benefit the health system for delivery of all health programmes- **i.e. when introducing HIV and AIDS interventions, are we safeguarding the existing programmes from further deterioration- stewardship, leadership role?**

The major health system constraints in general can be grouped into 2 parts:

- Demand side where there is lack of universal access to a service delivery infrastructure. Examples of demand side barriers are. affordability, distance and governance to accessing services, inadequate service delivery infrastructure, weak drug regulatory and supply systems and multiple donor interests which might not be in tandem with national interests.

- The supply side of the constraint are human resources, inadequate infrastructure, organization of the health facilities and the way the service delivery is traditionally organized. However, the constraints of the two parts are not mutually exclusive. Strengthening health systems as part of HIV and AIDS scale up plan should ensure that
- Wider benefits of the general health system are achieved by making possible the integration of HIV and AIDS intervention into existing health systems and
- Specific scale up or expansion of HIV and AIDS programmes are realized through building the necessary new infrastructure.

The entry points for the integration of STI, HIV and AIDS interventions can be at the point of service delivery, in the management of programmes at district or local level, in the financing, procurement of resources and in the monitoring of programmes at national level.

Therefore the two aspects of health system strengthening in terms of ensuring wider benefits while scaling up STI, HIV and AIDS programmes will be addressed in this thematic section.

2.4.2 Intervention Area 1: National Strategic Planning and Programme Management

2.4.2.1 Preamble

As indicated in the introduction, HIV and AIDS epidemics have increased the burden in the already overstretched health care delivery system. This calls for innovative and renewed thinking on health systems and service delivery as well as infrastructure, human resources development and planning.

This section explores how strengthening health service delivery at all levels would be done through:

- Innovative and renewed thinking on the organization of the health services
- Joint program management in:
 - Planning, implementation and reporting of activities,
 - quality improvement and standard setting
 - resource mobilization, utilization and accountabilities
- Providing technical support to non health sectors and development partners
- Options for delivering HIV interventions at community and household levels through partnerships and involvement of community-based organizations and PLHIV.

2.4.2.2 Situation analysis

Below are the achievements and challenges of the general health sector reform and the introduction of specific HIV and AIDS scaling up programmes.

2.4.2.2.1 Achievements

General health sector reform-Programme management:

- **At national level the Ministry of Health and Social Welfare has initiated a process for improving the following:**
 - Decentralization of services and the strengthening of existing institutions and other management structures.
 - Harmonization of policies, guidelines and development of strategic plans for human resources development and capacity-building;
 - Harmonization of management of major commodities (i.e. ITNs, antimalarial medicines, ARVs, OI, STI medicines, diagnostics) at all levels;
 - Ensuring drug quality including establishing pharmacovigilance activities
 - Strengthening strategic information management and health information systems
 - A process for harmonisation and clarification of roles and responsibilities between the MOHSW and Local government health institutions. Within the framework of the ongoing local government reforms, the local government authorities have responsibilities for delivering health services. The responsibilities for MoHSW are technical guidance; policy formulation; supportive supervision, capacity building, coordination, setting standards and evaluation of health services within the councils.

At regional, district and facility levels

- RHMTs perform roles similar to those of national level to provide technical support to CHMTs
- There are autonomous Council Health Boards under the respective local government authorities.
- Existence of most accessible primary health care services which include reproductive and child health services, STI, TB and other communicable diseases.
- Existence of services that are linked with, households and communities:

- Reproductive and child health services, serve as pivotal entry point for the delivery of interventions for the prevention of HIV in pregnant women, their partners and children. Other services include: IMCI, TB DOTS, Care and Treatment for PLHIV and control of communicable diseases.

- **Planning, financing and quality improvement at all levels**

- Strategic plans exist
- Resource mobilization is done including funding for STI, HIV and AIDS and major communicable and non communicable diseases at all levels
- Documents on modalities of channelling funds are available
- Quality improvement framework is available.

Programme management for specific STI, HIV and AIDS interventions

- **At national level**

Direct management and planning for the Health Sector HIV and AIDS Strategy is the responsibility of National AIDS Control Programme (NACP). To date the NACP has:

- Developed and harmonized HIV related guidelines
- Strengthened the capacity of different cadres of health care workers.
- Facilitated and provided technical assistance to other stakeholders at all levels.
- Established linkages with other departments of the MoHSW, other government sectors, agencies, NGOs, development partners, academic institutions, CSOs and community resources.
- Strengthened the capacity of Regional Health Management Teams to supervise, monitor, and assist the CHMTs in planning and implementing interventions.
- Fostered partnerships and collaboration among relevant programmes or interventions which are a prerequisite for joint planning and implementation of effective integrated services.
- Developed a National plan for care and treatment and started gradual initiation of ART beginning with referral and regional hospitals followed by district hospitals.
- Developed resource centre for HIV AND AIDS including the website
- Developed a large variety of IEC materials (electronic and printed).
- Coordination of research activities on HIV and AIDS
- Conducted supportive supervision to RHMTs and CHMTs.
- Promoted scaling up of HIV and AIDS interventions including:
- Coordination of all partners involved in Care and Treatment Plan (Regionalization)
- Harmonization of management of the major commodities (i.e. ARVs, diagnostics) at all levels; and
- Strengthening management of strategic information (surveillance and M&E).
- Integration of HIV and AIDS interventions into existing services.
- Developed national training curricula for different health cadre and for different interventions.
- Supply of laboratory equipments, reagents and other commodities to support STI, HIV and AIDS interventions.
- Development of a collaborative policy guideline for TB/HIV activities in collaboration with TB programme.
- Preparation and dissemination of different documentations on the management of the programme and trends of the epidemics.

District and Primary health care levels

- Strengthened management capacity on STI, HIV and AIDS interventions including:
 - Infrastructure improvements, purchase and installation of essential equipments and supplies.
 - Coordination of partnerships between public, NGOs and private (for profit or not-for-profit) actors
 - Coordination of partnerships between interventions of HIV and AIDS programme
 - Capacity building on different STI, HIV and AIDS interventions
 - Supply of different tools for STI, HIV and AIDS interventions

2.4.2.2 Challenges Specific to the General Health Sector Strategy

| Aspect | Challenges for general health system strengthening |
|------------------|--|
| Availability | <ul style="list-style-type: none"> • Inadequate internal mainstreaming of HIV and AIDS into MoHSW departments at all levels. • Difficulties in identifying HIV and AIDS as a priority despite prioritization guidelines particularly at local government authority. • Inadequate budget for HIV and AIDS interventions as part of MTEF at all levels. |
| Equitable access | <ul style="list-style-type: none"> • At district level financial resources are insufficient for routine operations • Budget allocations for HIV and AIDS at Councils levels are not sufficient to trickle down to village levels.. |
| Quality | <ul style="list-style-type: none"> • Limited capacity to appropriately operationalize national guidelines and standards |

2.4.2.2.3 Challenges Specific to scaling up of HIV and AIDS interventions

| Aspect | Challenges for specific HIV and AIDS scale up |
|------------------|--|
| Availability | <ul style="list-style-type: none"> Limited HIV and AIDS services in rural areas and for vulnerable populations Lack of infrastructure to accommodate the increasing number of patients Weak logistic system for distribution of commodities particularly to the lower level of the health system. |
| Equitable access | <ul style="list-style-type: none"> Availability of human resource in hard to reach areas is a bottleneck for quality services Poor logistic for commodities create shortages in remote areas while supply at central level are abundant |
| Quality | <ul style="list-style-type: none"> No functional feedback loop on quality improvement issues Inadequate documentation and dissemination of best practices at all levels. Inadequate dissemination of national guidelines and protocols. Inadequate supportive supervision. |

2.4.2.3 Equity, Gender and Sustainability Considerations

- Comprehensive HIV and AIDS interventions should contribute to strengthening health systems and capacity for equitable service delivery, to address the needs of poorer communities and those most at risk.
- Delivery of comprehensive HIV interventions within a strong existing social, health and a functioning referral system in a coherent manner may permit effective implementation and widespread utilization of human resources and address serious resource constraints.

2.4.2.4 Strategic Objective

Strengthen managerial capacity for planning, resource allocation, utilization, implementation and monitoring of all, HIV and AIDS interventions at all levels.

Strategies

- Ensure capacity improvement for planning, resource allocation and implementation of HIV and AIDS programs.
- Strengthen coordination of HIV and AIDS interventions at all levels
- Strengthen and implement system of quality improvement of HIV and AIDS interventions.

2.4.2.5 Targets

- Improve management capacity for planning, resource allocation and coordination in 20% of district levels by 2012.
- Quality improvement in implementation of all HIV and AIDS interventions institutionalised by 2012

2.4.2.6 Indicators

- % of districts with improved management capacity
- Number of comprehensive supportive supervisions for HIV and AIDS interventions conducted

2.4.2.7 Key Implementers

MoHSW, TACAIDS, PMORALG, POPSM.

2.4.3 Intervention area 2: Procurement and supply management Systems for STI, HIV and AIDS medicines, health commodities, laboratory reagents and supplies

2.4.3.1 Preamble

Procurement, supply and management of medicines, health commodities and reagents are an important element for the HIV and AIDS responses. The Medical Stores Department was established to offer a centralized procurement, storage and distribution system for all health commodities. The MSD is the main stockists and distributor of all medicines and laboratory supplies. Due to emerging demands of major public health diseases including HIV and AIDS, the ability of MSD coping with the demands is constrained.

Most HIV and AIDS medicines have been developed in the recent years and hence their long term safety in large populations have not been well established. For that reason, Tanzania Food and Drug Authority (TFDA) has in place a pharmacovigilance system for all medicines whereby health workers report adverse drug reactions occurring in their places of work.

Pharmacovigilance is a terminology used to indicate the process of detection, assessment, understanding and prevention of adverse effects, particularly long term and short term side effect of medicines. The long term and short term side effects are termed Adverse Drug Reactions (ADR) on patients that are using a pharmaceutical product.

2.4.3.2 Situation Analysis

2.4.3.2.1 Achievements

Based on the general health sector reforms.

- Procurement and supply management Systems for STI, HIV and AIDS medicines, health commodities and laboratory reagents and supplies is established
- Presence of infrastructure for procurement, storage, supply and distribution
- Established computerized inventory system covering the medical store departments (headquarter and zones)
- Indent and Integrated Logistics Management (ILS) system for ordering all the major supplies is in place.
- The system of allocating funds at MSD for Health Facilities to draw supplies based on the allocated funds is working
- Mechanisms of selecting and reviewing medicines for the management of HIV and AIDS are in place through the National Essential Medicine List for Tanzania (NEMLIT).

Medicines Registration and manufacturing.

- Existence of mechanisms for fast tracking registration of HIV and AIDS medicines (ARVs) through TFDA
- Local companies have started manufacturing some ARVs

Pharmacovigilance and quality assurance

- Existence of a system for monitoring Adverse Drug Reaction (ADR) for HIV and AIDS medicines.
- A system for monitoring the quality of medicines from the ports of entry as well as those circulating in the market exists in the country.

2.4.3.2.2 Challenges

Procurement and supply management Systems for HIV and AIDS medicines, diagnostic supplies and laboratory reagents

- Two competing systems (Push and Pull) for acquisition of supplies from the same source to the end users
- Erratic supplies especially of STI/RTI medicines, HIV diagnostics tests and laboratory commodities
- Inadequate capacity for forecasting and ordering required commodities especially in rural areas and at primary health facilities.
- Inefficient fall back opportunities at facility level to use alternative methods of acquiring supplies when MSD has stock outs.
- Poor coordination and communication about available stocks and demands from end users

Pharmacovigilance

- There is gross under reporting of ADR .
- Poor coordination and dissemination of ADR information in both vertical and horizontal directions.

2.4.3.3 Equity, Gender and sustainability considerations

Rural areas have less commodities because of poor logistic system and storage capacity for the required supplies. Funding of supplies for HIV and AIDS is donor dependent and so a local and sustainable alternative funding sources need to be sought including private sector involvement.

2.4.3.4 Strategic objective

To strengthen procurement, supply management and pharmacovigilance systems for STI, HIV and AIDS medicines, diagnostics and other commodities

Strategies

1. Build capacity of Medical Stores Department for procurement, storage and supply management systems for HIV and AIDS medicines, diagnostics and other commodities
2. Regular revision of NEMLIT and availability of HIV and AIDS, STI and OIs related medicines.
3. Strengthen the National Pharmacovigilance system for tracking and providing feedback on ADR associated with HIV and AIDS, STI and OIs medication.

2.4.3.5 Targets

1. Medical Stores Department able to respond to the needs and requirements of supplies for HIV and AIDS services by 2012.
2. Annual revision of NEMLIT
3. Pharmacovigilance reports compiled and disseminated annually.

2.4.3.6 Indicators

- % of facilities dispensing ARVs which have experienced stock out in the last 12 months.
- Revised NEMLIT operational
- Number of pharmacovigilance reports disseminated

2.4.3.7 Key Implementers

MoHSW, MSD, TFDA, Development partners, Academic Institutions, CHMTs Health facilities

2.4.4 Intervention area 3: Human Resource

2.4.4.1 Preamble

Implementation of the HS HIV and AIDS Strategy II (2008-2012) to a large extent will depend on the number and quality of health workers at all levels in the health system. Tanzania has serious human resource for health shortage reaching a crisis situation. The establishment requires 55,404 HCWs of different cadre while only 21, 248 HCW (15,403 public and 5,845 private) are in place. Therefore, the implementation of the country's health policy relies on the available 38% of the required human resource.

2.4.4.2 Situation analysis

Below are the achievements and challenges with regards to human resources

2.4.4.2.1 Achievements

General health reform considerations

- Data on human resource mix from various sources exist
- In-service and pre-service training of HCWs exists
- Staff have opportunities for career advancement.
- Task shifting activities initiated

Specific HIV and AIDS human resource issues

- In-service trainings for some HIV and AIDS interventions
- Long term training for HIV and AIDS programming has been done in country and abroad
- Some informal task shifting practices have been initiated

2.4.4.2.2 Challenges

The health sector has several human resource challenges. These include:

Planning and management

- Inadequate capacity in planning and management of required and available human resource.
- Inadequate team building and leadership skills at all levels
- Limited reliable data on existing human resource
- Imbalances in the geographical distribution of available human resources.
- Lack of mechanisms for the management of the migration of human resource for health

Training

- Lack of a master plan for training in the health sector.
- Inadequate facilities and equipments for training in all institutions including Universities in order to meet the increased demand for student enrolment.
- Inadequate quality assurance in training institutions.

Retention schemes

- Lack of monetary and non-monetary incentives for workers
- Poor working environment

Career development

- A large number of existing work-force needs upgrading.
- Lack of opportunities for continuing education for workers in hard to reach areas

- No mechanism for mentoring newly qualified HCW especially in rural areas.
- Lack of career development scheme

Specific HIV and AIDS human resource issues

- Multiple bodies responsible for recruitment and management of human resources for health.
 - The tendency of recruitment of staff by projects and secondment practices
- Health workers training
 - Different schedules of in-service training practices by various HIV and AIDS interventions or programmes
- Task shifting policy.
 - No standardized programme for training and certification that guarantees essential standards of care.
 - No regulatory framework
 - Unclear incentive package for implementing task shifting plan (policy).
- Under the reform process recruitment and placement of human resources is the responsibility of local authorities while technical supervision is under MoHSW. This creates dual allegiance for HCWs

2.4.4.3 Equity, Gender and Sustainability Considerations

- There are imbalances in the distribution of available human resources between rural and urban areas by type of health facilities and interventions which need to be considered.
- Use of special salaries and other emoluments as a way of attracting and retaining staff in projects is not sustainable and worsens the human resource crisis.
- There is need to develop a criteria for defining hard to reach areas and develop an incentive mechanism for motivating, deployment of HCW in those areas.

2.4.4.4 Strategic Objective

Establish a system to build and sustain human resource.

Strategies

1. Strengthen the institution responsible for managing the response at national level (NACP secretariat) with the optimum number of human resource mix
2. Strengthen regions so that they have the human resource capacity for providing technical support to council at district levels
3. To contribute to human resource training master plan for the staff required for managing the HIV and AIDS responses

2.4.4.5 Targets

1. Functions and skills required for comprehensive HIV and AIDS responses at all levels established.
2. Human resource capacity required for managing the HIV and AIDS responses strengthened.

2.4.4.6 Indicators

% of the optimal number of human resources available at all levels

2.4.4.7 Key implementers

MoHSW, PMORALG, POPSM, Development partners, RAS, DED, ESAMI, Mzumbe University, Ministry of Finance

2.4.5 Intervention area 4a: Strategic information: Monitoring and Evaluation System

2.4.5.1 Preamble

Tanzania AIDS commission (TACAIDS) is responsible for organisation and coordination of the national HIV and AIDS monitoring and evaluation (M&E) plan. Drawing from the national multisectoral M&E, the Ministry of Health and Social Welfare, through its NACP, organises the health sector M&E plan. M&E unit of NACP is responsible for second generation surveillance and M&E of health sector interventions according to the health sector strategy for HIV/AIDS.

In collaboration with partners and academic institutions the M&E unit is responsible for standardization of M&E of HIV and AIDS intervention through development of protocols, training materials, and supervision guides. It also develops, prints and distributes data collection tools to all facilities, train regional and district trainers. It also coordinates implementation, analysis of data to produce reports and disseminate to all levels.

In addition to the second generation surveillance. The unit is currently implementing M&E activities for HIV and AIDS chronic care, HTC, PMTCT and STI, and M&E system for HBC is being established. Service data is collected and summarised at service provision points using standardised forms and it flows to the district, regional and national levels. At each level a summary is generated and disseminated.

2.4.5.2 Situation Analysis

Below are the achievements and challenges with regards to M&E implementation during the past HSS for HIV and AIDS (2003-2006)

2.4.5.2.1 Achievements

1. HIV/AIDS/STI data are regularly available for national and international use. National monitoring systems for PMTCT, HTC, STIs and C&T are in place.
3. Utilisation of Care and Treatment data at sub-national levels
4. High involvement and support from implementing partners.
5. Electronic database system for care and treatment has been established

2.4.5.2.2 Challenges

| Aspect | Challenges of monitoring and evaluation |
|------------------|--|
| Availability | <ul style="list-style-type: none"> • Inadequate coverage of all interventions e.g. effectiveness of IEC messages not monitored. • Delayed availability of M&E reports |
| Equitable access | <ul style="list-style-type: none"> • Inadequate scaling up of electronic monitoring systems especially in rural areas • Lack of capacity (human resource, infrastructure, communication) for M&E at regional and district level • Inadequate dissemination of M&E information to rural areas. |
| Quality | <ul style="list-style-type: none"> • Inefficient reporting i.e. incomplete, under reporting • Low usage of data at all levels • Lack of compliance to reporting guidelines • Analysis is maintained simple and basic • Lack of integrated supervision and adequate feedback at the facility levels to ensure improved quality of data. • Lack of linkage between M & E system for various interventions. • Lack of information or documentation on best practices |

2.4.5.2.3 Emerging Issues

Relevancy of AIDS cases reporting in the era of HIV care and treatment

2.4.5.3 Equity, Gender and Sustainability Considerations

The M&E infrastructure is poor in rural areas. Vulnerability of data systems due to financial, security and technological reasons. Therefore there is need to strengthen M&E infrastructure at all levels of health care systems

2.4.5.4 Strategic Objective

Strengthen monitoring and evaluation system to provide relevant comprehensive information in a timely manner for programme management and planning.

Strategies

1. Formulate a comprehensive M & E system for HSHSP II
2. Strengthen supportive supervision for M& E.
3. Build capacity for M&E at facility, district, regional and national levels.
4. Establish data quality assurance system

2.4.5.5 Targets

1. Comprehensive monitoring and evaluation system for HSHSP II operational by December 2009.
2. M & E to feature in the national comprehensive supervision manual by December 2009.
3. The national comprehensive supervision manual fully operational by 2012.
4. Develop and disseminate comprehensive HIV and AIDS Strategic Information report annually effective 2008.
5. All facilities submit timely, accurate and complete reports on HIV and AIDS interventions by 2010

2.4.5.6 Indicators

1. Comprehensive monitoring and evaluation system for HSHSP II operational
2. Comprehensive HIV and AIDS Strategic Information reports disseminated annually,
3. % of regions submitting timely, accurate and complete reports

4. % of national supervisions conducted as per specifications of the national guidelines.

2.4.5.7 Key implementers

MoHSW, TACAIDS, PMORALG, Health care facilities –private and public, RHMT, CHMT, partners, Academic and research institutions

2.4.6 Intervention area 4b: Strategic information: Behavioural and Biological Surveillance on STI, HIV and AIDS

2.4.6.1 Situation analysis

In the transmission of HIV infection, both biological and behavioural factors play a significant role. Thus surveillance of HIV and AIDS needs to include both biological and behavioural aspects.

2.4.6.1.1 Achievements

- ANC surveillance increased from 10 regions in 2003 to 21 regions in 2006
- In collaboration with partners, Behavioural Surveillance Survey (BSS) were conducted in five regions and results disseminated
- Comprehensive module of BSS is included in THIS and DHS
- One round of national HIV indicator survey was completed and disseminated.

2.4.6.1.2 Challenges

| Aspect | Challenges |
|------------------|---|
| Availability | <ul style="list-style-type: none"> • Inadequate capacity to intensify surveillance activities at district level. • National surveillance results are presented in scientific formats not easily understandable by majority of targeted users. • Results are not packaged according to target audiences |
| Equitable access | <ul style="list-style-type: none"> • No surveillance activities targeting the most-at-risk sub populations (MARPs) • Results are not packaged according to target audiences • Results from national surveys are not disaggregated by districts. |
| Quality | <ul style="list-style-type: none"> • Use of RPR test in STI surveillance poses difficulties in remote areas due to the cold chain requirement and cumbersome methodology • False positive RPR results due to interactions with other antigens in the environment. |

2.4.6.1.3 Emerging issue

- BSS among populations in the ANC catchment areas is no longer considered the right methodology.
- Emerging sources of prevalence data needs to be validated and become part of surveillance systems.

2.4.6.2 Equity, Gender and sustainability considerations

Need to supplement population based surveys with anthropological data from hard to reach populations and by geographic areas.

2.4.6.3 Strategic Objective

Strengthen surveillance activities to monitor the dynamics of the epidemic and the impact of STI, HIV and AIDS interventions.

Strategies

1. Strengthen biological and behavioural surveillance systems for STI, HIV and AIDS
2. Establish surveillance activities for most at risk populations (MARPs).
3. Introduce alternative and user friendly technologies for syphilis testing.
4. Validate PMTCT and HTC HIV prevalence data

2.4.6.4 Targets

- Biennial surveillance reports produced and disseminated timely.
- Surveillance activities for at least one MARPs population established by December 2009.
- Adoption of alternative and user friendly kit for syphilis testing performed by 2010.
- PMTCT and HTC HIV prevalence data validated by 2010

2.4.6.5 Indicators

- Biennial surveillance reports produced and disseminated .
- Types of MARPs covered by surveillance activities
- Alternative and user friendly kit for syphilis testing adopted.
- Validation reports available and disseminated

2.4.6.6 Key Implementers

MoHSW, TACAIDS, NBS, RHMTs, CHMTs, Academic and Research institutions, Ministry of Home Affairs, PMORALG, Reference Laboratories

2.4.7 Intervention area 4c: Strategic information: Surveillance of HIV, STIs and TB Drugs Resistance as well as Drug Adverse Effects

2.4.7.1 Situation Analysis

While the HIV and AIDS interventions are scaled up, there is a risk of emergence of HIV drug resistance. This risk needs to be identified early so that appropriate measures are instituted.

It must be borne in mind that before the start of the national HIV care and treatment programme already there were PLHIV on ARVs. These individuals had used ARVs without existence of national HIV and AIDS treatment guidelines. Therefore, there is a fear of having a pool of people with resistant organisms.

There is also need to monitor STI and TB drug susceptibility patterns to inform policies on management of STIs and possible emergence of multi-drug resistant TB.

2.4.7.1.1 Achievements

- Country adaptation of internationally recommended strategy for early identification of HIV drug resistance
- Tanzania has initiated and implemented surveillance of transmitted HIV drug resistance in one region.
- Activities for HIV drug resistance monitoring have been initiated
- Availability of pharmacovigilance system for all pharmaceutical products
- TB drug resistance monitoring system is functional

2.4.7.1.2 Challenges

| Aspect | Challenges |
|------------------|---|
| Availability | <ul style="list-style-type: none">• Activities for drug resistant monitoring are inadequate.• Available capacity to carry out STI drug susceptibility monitoring is not utilized |
| Equitable Access | <ul style="list-style-type: none">• Limited coverage of drug resistance and adverse drug monitoring in rural areas |
| Quality | <ul style="list-style-type: none">• Insufficient capacity to correctly identify and report on side effects of ARVs |

2.4.7.2 Equity, Gender and Sustainability Considerations

Resources involved in conducting regular surveillance activities, in selected facilities is substantially funded by foreign donors.

2.4.7.3 Strategic objective

Strengthen surveillance of ARVs and STI drug resistance as well as pharmacovigilance of ARVs, STI drugs and OI medication

Strategies

1. Establish a system for monitoring STI drugs susceptibility
2. Implement HIV drug resistance strategy
3. Strengthen pharmacovigilance activities for ARVs, STI and OI medication

2.4.7.4 Targets

1. Four laboratories to perform STI drug susceptibility monitoring by 2011.
2. HIV drug resistance early warning indicators monitored in 30 HIV care and treatment facilities by 2012.
3. Effective implementation of pharmacovigilance for ARVs, STI and OIs drugs in 100 facilities by 2012
4. Implement ten rounds of HIVDR Threshold surveys by 2012.

2.4.7.5 Indicators

1. Number of laboratories performing STI drug susceptibility monitoring
2. Number of sites conducting HIV drug resistance early warning indicators,
3. Number of sites reporting on ADRs.
4. Number of rounds of HIVDR threshold survey conducted .

2.4.7.6 Key Implementers

MoHSW, Research institutions, NACOPHA, TFDA, RHMTs, CHMTs, Academic Institutions, MSD, Reference and Zonal laboratories

2.4.7 Intervention Area 5: Priority HIV and AIDS and STI Research

2.4.7.1 Preamble

Research is essential in providing evidence- based information needed to support the national response against HIV and AIDS epidemic. Research facilitates the identification and understanding the drivers of HIV spread and maintain quality of response (interventions)

2.4.7.2 Situation Analysis

The National Policy on HIV and AIDS has provisions for promoting and supporting multi-disciplinary operational research on HIV and AIDS, in order to produce information relevant for solving operational issues.

2.4.7.2.1 Achievements

- The existence of two national institutions namely, the National Institute for Medical Research (NIMR) and the Tanzania Commission for Science and Technology (COSTECH) has facilitated coordination of research in the country.
- Existence of research agenda on HIV and AIDS /STIs for Health sector strategy on HIV and AIDS.
- Collaboration with local research institutions and implementing partners including Traditional Healers.
- Available local capacity to conduct research e.g National Institute for Medical Research, Muhimbili University for Health and Allied Sciences (MUHAS), University of Dar es Salaam (UDSM) and Ifakara Health Institute (IHI) (formerly Ifakara Health Research and Development Centre (IHRDC)
- Several researches have been conducted and have influenced policy change.

2.4.7.2.2 Challenges

| Aspects | Challenges of Priority HIV and AIDS and STI research |
|------------------|--|
| Availability | <ul style="list-style-type: none">• Limited capacity and resource to conduct research at the district level• Limited research projects that address equity and gender dimensions in HIV and AIDS• Inadequate dissemination of local research findings, to policy makers , programmes managers and the beneficiaries• Limited research in the area of Paediatrics HIV and AIDS.• Lack of fund within health sector to conduct operational research. |
| Equitable access | <ul style="list-style-type: none">• Most funds provided by partners are committed to specific research areas determined by them and urban settings. |
| Quality | <ul style="list-style-type: none">• Weak research coordination within Health sector• Poor communication between research coordinators and consumers of research findings.• Limited research on quality issues regarding HIV and AIDS interventions.• The mandate to clear research proposals reside in multiple institutions• |

2.4.7.3 Emerging Issue

- Research priority agenda for HIV and AIDS is not well disseminated.
- Consequently, most researchers address research questions that are not of priority to the programme.

2.4.7.4 Equity, Gender and Sustainability Considerations

- Most researches on HIV and AIDS in Tanzania are concentrated in Dar es Salaam, Kilimanjaro, Lake zone and Mbeya regions. All studies have to respect equity in terms of urban and rural areas as well as gender considerations. Very little has been done to address the issue of gender disparities.

2.4.7.5 Strategic Objective

To strengthen the health sector capacity to contribute to national HIV and AIDS and STI related research and development

Strategies

1. Strengthen research coordination on STI, HIV and AIDS.
2. Promote national research priorities in HIV/AIDS
3. Ensure adequate national dissemination of research findings
4. Conduct Operation Research (OR) in HIV and AIDS and promote use of evidence generated for Programming and Policy making

2.4.7.6 Targets

1. Review and disseminate STI, HIV and AIDS research priorities by December 2009.
2. Allocate enough funds for five research projects which are within HIV and AIDS research agenda annually..
3. Build capacity of seventy districts to conduct operational research by 2012.

2.4.7.7 Indicators

1. Research agenda for HSHSP II formulated and disseminated
2. Number of research projects funded.
3. Number of districts conducting operational research.

2.4.7.8 Key implementers

MoHSW, TACAIDS, PMORALG, COSTECH, NIMR, Academic and Research institutions, CHMTs and RHMTs

2.4.8 Intervention Area 6: Documentation of Best Practices on HIV and AIDS in Tanzania

2.4.8.1 Preamble

A Best Practice on HIV and AIDS is a body of knowledge about an aspect of HIV prevention, treatment or care that is based on practical experiences and lessons learned in a maturing field. A best practice should be replicable to improve the quality of an intervention that has as its objective the mitigation of one aspect of the HIV epidemic.

The primary purpose of a Best Practice is to :

- document, understand and appreciate good and bad experiences
- facilitate learning about what works and what doesn't
- share experiences
- assist the replication of successful interventions on a larger scale

2.4.8.2 Situation Analysis

In Tanzania many practices that could qualify as best practice exist among the interventions that are being implemented by the government and its partners. . However, not much has been documented for sharing.

2.4.8.2.1 Challenges

| Aspects | Challenges in documentation of best practices |
|------------------|--|
| Availability | <ul style="list-style-type: none">• <u>Lack of national mechanism to track and document best practices.</u>• <u>Some best practice documents are available but not widely disseminated</u> |
| Equitable access | <ul style="list-style-type: none">• Tanzanians have got access to other best practices .from other countries and very few from the country• The existing documentation on best practices on Tanzania and other countries is not equitably accessible to all Tanzanians. It is only accessible to those who access public libraries and internet services. |
| Quality | <u>Most of the existing documentation focus on results and ignore the process through which the experience emerged.</u> |

Emerging issue

- Lack of skilled personnel to orient stakeholders in documentation of best practices
- Lack of skilled personnel to document best practices

Equity, Gender and Sustainability Considerations

- Most of best practise documentation is done and used by foreigners
- There are no best practices documentation addressing gender disparities due to AIDS

2.4.8.3 Strategic Objective

Ensure establishment of mechanisms to document best practices on HIV and AIDS

Strategies

1. Ensure availability of a framework to guide documentation and sharing of best practices on HIV and AIDS in the Health Sector

2.4.8.4 Targets

1. National Frameworks for documenting and sharing best practices on HIV and AIDS formulated by 2009
2. Ten Best Practices documents produced by 2012
3. Capacity for documentation of best practices established by 2009

2.4.8.5 Indicators

1. Framework on best practices disseminated and operational.
2. Number of people with skills and competency for documenting best practices
3. % of best practices documents produced

2.4.8.6 Key implementers

MOHSW, PMORALG, TACAIDS, NACOPHA, NGOs, CSO, Partners, CHMTs, RHMTs, Academic and Research Institutions

SECTION THREE

IMPLEMENTATION FRAMEWORK AND ITS OPERATIONALISATION

3.1. Implementation Arrangements

The Strategy defines the activities to be implemented at central level by the Ministry of Health and Social Welfare in all its structures with the oversight of the MOHSW through the NACP. It also provides guidance concerning the activities which need to be implemented at district and community levels through the District and Municipal Councils. The Non Governmental Organisations, Faith Based Organisations, private sector and civil society will participate in the implementation of the activities at both national and lower levels according to their capacities and comparative advantages.

Each department of the MOHSW at central level will develop annual work plans in line with the fiscal year, for implementation, based on this strategy. These annual work plans will be funded through the budget within the MTEF. The Health Sector HIV and AIDS Strategy has defined the interventions to be implemented at district level. The implementation of these activities will be under the Local Government Authorities. Therefore, the District and Municipal Councils will have to incorporate the HIV and AIDS interventions into their comprehensive district plans based on the Strategic Plan for the health sector.

The Council Health Management Teams (CHMTs) will be responsible for implementation, monitoring and evaluation of the district health sector based HIV and AIDS activities. In so doing, they will involve all relevant stakeholders at the district and community levels. The activities in the district plan will be part of the Comprehensive Council Health Plan which will be budgeted for funding under the MTEF of the Prime Minister's Office, Regional- Administration and Local Government and also supported through the activities of the Community Based Organizations (CBOs).

In order to operationalize the HIV and AIDS Health Sector Strategy, the MOHSW will work with regional health management teams and all stakeholders to help the councils incorporate the interventions suggested in the Health Sector Plan.

In addition to supporting the councils in planning, the MOHSW will continue to undertake quality assurance for the response at district level as well as advocate for the health sector HIV and AIDS responses to the districts. It will play this role through RHMTs, and CHMTs.

3.2. Coordination Framework

This strategic plan will be operationalised at three levels – the national, regional and district – in overlapping phases. This section describes the institutional arrangements, which are in place or those which need to be created at different levels in order to ensure efficient and effective implementation of the strategic plan.

3.2.1 National level

At the national level it will be necessary to create the conditions for implementing the plan. Measures towards this end include:

- Strengthening institutions responsible for HIV and AIDS response within the organizational structure of the Ministry of Health and Social Welfare.
- Conducting a study to explore the appropriate functions and skills required for all levels of service delivery before a decision is made for it being either an agency of the MOHSW or a directorate
- Involving the President's Office Public Service Management (POPSM) for approval and posting of additional staff with the requisite skills.
- Bringing the institutions to an optimum level in terms of the quality of its professional staff to enable it perform its role effectively;
- Orienting MOHSW leadership and officials as well as the heads of health institutions in the country towards integrating HIV and AIDS fully in their core business. This will involve issuing official circulars, retreats and meetings;
- Strengthening further the harmonization of the roles of NACP and TACAIDS on one hand, and of MOHSW and PMO RALG on the other hand.

3.2.2 Regional level

Regional Authorities still retain a supervisory function over the performance of District Authorities on behalf of the Central Government. Measures should be taken to strengthen the capacity of RHMTs to enable them to provide effective supportive supervision in the districts.

3.2.3 District level

At the district level the thrust will be towards strengthening the capacity of CHMTs/District Health Boards (DHBs), working within the statutory committees of the Councils, Wards and Villages to plan, and integrate HIV and AIDS interventions as part of their comprehensive council health plans, and ultimately in their council development plans. This activity should be spearheaded jointly by the CHMTs and the Council AIDS Multisectoral Committees (CMACs), in collaboration with all the district heads of departments. The RHMTs, CHMTs and Health Boards will be oriented in their roles in moving forward the HIV and AIDS agenda within the health sector.

Terms of reference for the health sector District AIDS Control Coordinator (DACC) will be revised so that the position becomes the right hand person of the DMO and function more or less in the same specialised function as the NACP at the MOHSW. The HSHSP II is not intended to be an HIV and AIDS operational plan for districts, but interventions proposed are meant to constitute important inputs when districts formulate their plans. This plan and the strategies/ interventions do not remove the need for districts to review the HIV and AIDS situation and response in their areas and decide on the strategies/interventions which provide a good match.

Advocacy to the districts in favour of this plan needs to be undertaken by the MOHSW through RHMTs. This is in line with the spirit of decentralization and respect for districts' autonomy while giving them the information necessary to make informed choices.

3.2.4. Community level

Many districts have a number of NGOs and CBOs who are active in the health aspects of HIV and AIDS. The MOHSW, will strengthen the capacity of district based NGOs/CBOs to deliver quality and efficacious services not only by providing them with guidelines but also by providing skills through training and supportive supervision. This is a critical area for providing technical assistance in planning, implementing, as well as monitoring and evaluation.

3.3. Financing the Response

3.3.1. The cost of the health sector response to HIV and AIDS

In Tanzania, a MKUKUTA based MDGs costing for the health sub-sector was done in 2006 by the Economic and Social Research Foundation (ESRF). Health Sector Costing was an attempt to estimate the cost, in terms of human resources, infrastructure and financial resources-to meet the MDGs as well as the MKUKUTA targets by 2015 and 2010 respectively. The costing strongly acknowledged the fact that the health systems need strengthening in order to be able to respond to all health challenges.

The unit costs used are attached as *Annex 1*. The Tables below show the estimates of two scenarios.

Table 10: MKUKUTA based MDGs costing for the Health Sector sub-sector – HIV and AIDS, HRH and Health facilities- Scenario 1 US\$

| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Total |
|-------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------------|
| HIV | 51,045,150 | 51,198,084 | 51,354,930 | 51,515,789 | 51,691,093 | 256,805,046 |
| HRH | 144,101,046 | 190,443,228 | 243,016,031 | 302,702,506 | 370,492,897 | 1,250,755,708 |
| Health facilities | 186,619,692 | 188,192,254 | 189,395,495 | 147,483,378 | 214,735,233 | 778,942,674 |
| Total | 381,765,888 | 429,833,566 | 483,766,456 | 354,218,295 | 636,919,223 | 2,286,503,428 |

Table 11: MKUKUTA based MDGs costing for the Health Sector sub-sector –HIV and AIDS, HRH and Health facilities- Scenario 2 US\$

| | 2007/08 | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Total |
|-------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------------|
| HIV | 51,045,150 | 51,198,084 | 51,354,930 | 51,515,789 | 51,691,093 | 256,805,046 |
| HRH | 126,546,636 | 162,482,114 | 203,109,708 | 249,105,024 | 301,190,126 | 1,042,433,608 |
| Health facilities | 186,619,692 | 188,192,254 | 189,395,495 | 147,483,378 | 214,735,233 | 778,942,674 |
| Total | 364,211,478 | 401,872,452 | 443,860,133 | 300,620,813 | 567,616,452 | 2,078,181,328 |

3.3.2. Resource Management

There is a continued emphasis on mobilising financial resources into 2008 -2012 within the framework of HSHSP II, at national and international levels in anticipation of achieving the scale up of activities needed to control the crisis of HIV and AIDS. However, as more resources are made available nationally, the capacity to allocate to prioritised and cost effective interventions, and to disburse funds to the providers and communities, who implement these actions are also critically important. In the strategic management of resources for the Health Sector Response, it is imperative that all three aspects of resource management be considered that is mobilisation, allocation and disbursement.

3.3.2.1 Resource Mobilisation

To achieve effective resource management, sources and flows of financial resources need to be estimated so as to indicate broadly to the Implementing Partners (IP) who complete more detailed operational plans the resource envelope in which they should plan.

The most likely trends on financial resources available for implementing the NMSF for the next five years have been estimated. Three possible scenarios were considered. The analysis was based on existing trends (using actual disbursement rather than planned or budgeted levels). Development partners accounted for close to 90% of total public expenditure on HIV and AIDS in 2005/6.

Table 12: Summary of financial resources for implementing NMSF (TZS, billion)

| Scenario | Actual | | | | Projections | | | | | | Cumulative 2007/08-2012 |
|-----------------------------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------|----------------------------|
| | 2002 - 2003 | 2003 - 2004 | 2004 - 2005 | 2005 - 2006 | 2006 - 2007 | 2007 - 2008 | 2008 - 2009 | 2009 - 2010 | 2010 - 2011 | 2011 - 2012 | |
| <i>Scenario 1:</i> Best Case | 47.1 | 61.3 | 148.4 | 290.8 | 330.7 | 364.7 | 406.6 | 446.6 | 486.5 | 526.5 | 2,230.9 |
| <i>Scenario 2:</i> Middle case | 47.1 | 61.3 | 148.4 | 290.8 | 304.0 | 325.3 | 347.3 | 372.1 | 396.9 | 421.8 | 1,863.4 |
| <i>Scenario 3:</i> Worse Case | 47.1 | 61.3 | 148.4 | 290.8 | 230.5 | 264.2 | 279.1 | 294.0 | 308.9 | 323.8 | 1,470.0 |

Source: Assessment of the Human and Financial resources for the Revised HIV and AIDS NMSF Report of 2007

Since under any scenario financial resources are likely to be tight, prudent allocation of resources between the four thematic areas is of critical importance to achieve the highest impact for every shilling spent on HIV and AIDS interventions.

3.3.2.2 Resource Allocation

It is often shown that it is not only lack of funding that constrains implementation, but rather uncertainty and delayed flows of funds.

a) Overall Trends in HIV and AIDS Expenditure

Total expenditure (including donors off-budget spending) was equivalent to 7.5% of total Government budget spending in 2005/6 and about 14% of total Government revenue. The Budget for 2006/07 shows slight decrease (Table 13)

Table 13: Trends in Public Expenditure on HIV AND AIDS (Tshs, Billions)

| | Actual 2002/03 | Actual 2003/04 | Actual 2004/05 | Actual 2005/06 | Budget 2006/07 |
|---|-------------------|-------------------|-------------------|-------------------|-------------------|
| Total Public & Donor Expenditure on HIV/AIDS | 47.06 | 61.3 | 148.43 | 290.84 | 406.67 |
| Government | 7.1 | 8.1 | 12.6 | 35 | 60.3 |
| Development Partners (Donors) | 39.96 | 53.2 | 135.83 | 255.84 | 346.37 |
| Donors spending as % of total HIV AND AIDS spending | 84.9 | 86.8 | 91.5 | 88.0 | 85.2 |
| Total HIV AND AIDS spending as a % of:- | | | | | |
| Total Government Spending | 2.47 | 2.91 | 4.56 | 7.52 | 5.63 |
| Total Revenue | 3.6 | 4.7 | 8.37 | 14.12 | 11 |
| Nominal GDP | 0.41 | 0.52 | 1.14 | 2.02 | 1.65 |

Source: PER 2003, PER 2004, PER 2005, PER 2006, Ministry of Finance External Database, TACAIDS Mid-term evaluation of the National Multi-sectoral Strategic Framework, March 2006, National Bureau of Statistics, Tanzania in Figures 2005, Ministry of Finance Budget Speech, 2006/07.

The Table 14 below shows the trend of expenditure in the health sector for the period 1998/99 and 2003/04.

Table 14: Total health expenditure in Tanzania, FY99 – FY04 (TZS billion)

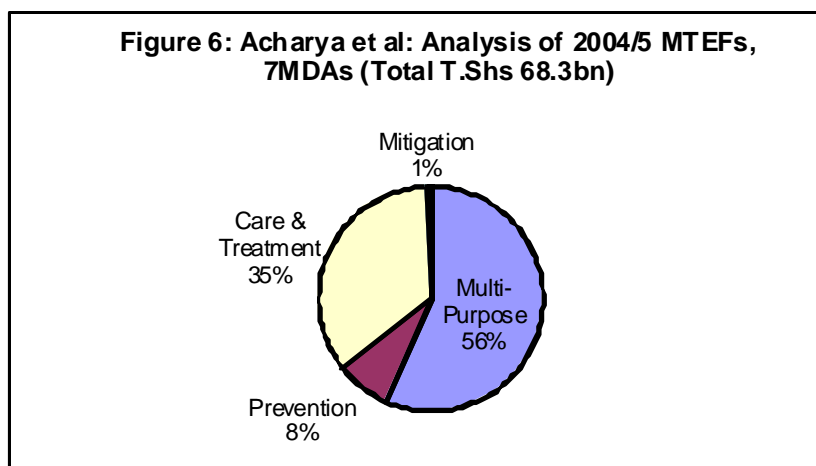
| | 1998/99 | | 1999/2000 | | 2000/2001 | | 2001/2002 | | 2002/2003 | | 2003/04 |
|-------------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget |
| Recurrent | | | | | | | | | | | |
| AGO | - | - | - | - | - | - | 8.97 | 5.61 | 6.92 | 6.55 | 6.62 |
| MOH | 37.25 | 37.15 | 39.20 | 32.39 | 49.39 | 44.25 | 61.60 | 58.99 | 82.16 | 69.90 | 86.38 |
| Region | 9.25 | 8.68 | 9.36 | 9.01 | 6.21 | 5.61 | 7.06 | 6.58 | 7.86 | 7.82 | 8.83 |
| Local Govt | 15.72 | 16.34 | 18.69 | 17.95 | 36.35 | 35.67 | 46.26 | 46.28 | 57.66 | 57.48 | 66.14 |
| Total rec. | 62.21 | 62.18 | 67.25 | 59.34 | 91.95 | 85.53 | 123.89 | 117.47 | 154.60 | 141.75 | 167.97 |
| Development | | | | | | | | | | | |
| MOH | 21.21 | 17.27 | 17.75 | 10.19 | 20.47 | 14.84 | 32.07 | 21.12 | 34.07 | 29.03 | 27.18 |
| Regions | 5.00 | 0.67 | 2.57 | 0.79 | 4.62 | 1.39 | 2.35 | 1.28 | 4.99 | 2.48 | 3.53 |
| Local Govt | 0.62 | - | 1.18 | 1.06 | 1.73 | 1.52 | 1.70 | 1.45 | 1.75 | 2.38 | 2.34 |
| Total devt | 26.83 | 17.94 | 21.50 | 12.03 | 26.81 | 17.74 | 36.12 | 23.86 | 40.80 | 33.89 | 33.05 |
| Total on budget | 89.04 | 80.11 | 88.75 | 71.38 | 118.76 | 103.27 | 160.01 | 141.33 | 195.40 | 175.64 | 201.02 |
| Off budget expenditure | | | | | | | | | | | |
| Cost sharing | - | 1.09 | - | 1.49 | - | 1.86 | - | 1.24 | - | 1.67 | 1.67 |
| Other foreign funds | 35.55 | 42.76 | 52.33 | 60.04 | 59.41 | 75.00 | 66.14 | 79.37 | 49.25 | 59.11 | 68.99 |
| Total off budget | 35.55 | 43.85 | 52.33 | 61.53 | 59.41 | 76.86 | 66.14 | 80.61 | 49.25 | 60.77 | 70.66 |
| Grand total | 124.58 | 123.96 | 141.08 | 132.91 | 178.18 | 180.13 | 226.16 | 221.94 | 244.66 | 236.41 | 271.68 |

Source: Public Expenditure Review (PER) 2004 Notes: Accountant General Office spending on National Health Insurance Fund (NHIF). Basket funding included under recurrent or development as appropriate

Given the fact that in previous years, the MOHSW and TACAIDS account for over 95% of budgeted and 97% of actual spending in 2005/06, then the Health sector relies heavily on Development partners' funding. This implies, among other things, the need to carry out sustainability analysis, particularly on funding related to recurrent expenditure supported by external financing.

b) Functional analysis of HIV and AIDS spending

Functional analysis of HIV AND AIDS spending done by Acharya et al., (2004) for fiscal year 2004/05 is shown in the Figure 6 below.



The Table 15 below shows the expenditure in the health sector. The analysis shows that about 56% of the funds were used for multi-purpose activities related to HIV/AIDS, 35% went specifically for care and treatment, 8% for prevention and 1% for mitigation.

Table 15 :Classification of HIV Expenditure (Tshs, Millions) by Thematic Area; Analysis of TACAIDS and Health Sector MTEFs, FY2004/05

| | Multi-Purpose | Prevention | Care & Treatment | Mitigation | Total |
|---|---------------|------------|------------------|------------|--------|
| Budget (Aid and GOT combined) from pre-final MTEFs | | | | | |
| TACAIDS | 23,769 | 2,044 | 518 | 229 | 26,560 |
| Health | 12,429 | 2,337 | 22,880 | 43 | 37,689 |
| Percentage Distribution of Functional Categories for each TACAIDS and Health | | | | | |
| TACAIDS | 89% | 8% | 2% | 1% | 100% |
| Health | 33% | 6% | 61% | 0% | 100% |

Source: PER (2005)

In another study by Tax and Phillip (2004) that specifically analysed Development Partner's spending, about 38% was spent on multipurpose activities, 25% on care and support, 16% on cross-cutting issues, 14% on preventive interventions, 5% on unclassified activities and 2% on impact mitigation. In yet another study related to HIV AND AIDS funding by Deloitte (2006), about 64% of the funding went for care and support, 14% for prevention, 8% each for cross-cutting issues and multi-purpose interventions, 4% for policy and administration and 2% for impact mitigation.

The Deloitte study (2006) observes that resources are increasing being directed towards care and support interventions in recent years. The increase is due to a recent emphasis on treatment, including the introduction of ARVs.

The financial needs can also be analysed from the overall Ministry of Health and Social Welfare MTEF and 2006/07 budget which includes the budget for the HIV and AIDS component shown in number 5 in the table below:

Table16: The MOHSW Trends of Allocation of Priority Areas requiring additional funding in US\$ mil.

| Priority services/Areas | Resource allocation as per Ceiling | | | | | |
|---|------------------------------------|--------------|---------------|--------------|--------------|---------------|
| | 2005/06 | | | 2006/07 | | |
| | Local | Foreign | Total | Local | Foreign | Total |
| Drugs and Medical Supplies | 29.49 | 0.4 | 29.89 | 30.33 | - | 30.33 |
| Immunization Services | 8.42 | 8.58 | 16.82 | 5.04 | - | 5.04 |
| RCHS-Family Planning & SMI | 7.36 | 4.78 | 12.14 | 5.22 | 1.61 | 6.82 |
| Integrated management of Childhood Illness (IMCI) | 0.50 | - | 0.50 | 0.56 | - | 0.56 |
| HIV and AIDS (Including ARVs and non ARVs) | 19.43 | 27.22 | 46.65 | 19.29 | 32.99 | 52.28 |
| Control of Tuberculosis and Leprosy | 1.68 | 2.09 | 3.77 | 1.69 | 1.75 | 3.43 |
| Control of Malaria | 1.76 | 18.56 | 20.32 | 3.04 | 1.88 | 4.92 |
| Rehabilitation of health facilities | 4.00 | 6.31 | 10.31 | 5.70 | 13.38 | 19.07 |
| Total | 72.46 | 67.93 | 140.36 | 70.86 | 51.60 | 122.47 |

Source: Ministry of Health Strategic Plan 2008

The above table shows the total budget for the MOHSW according to the MTEF for the period indicated (2005/06 and 2006/07). From the table the allocation for the HIV and AIDS component is about 19 million USD (exchange rate 1250/= for 1USD) with a gap of about 33 million USD for the total of 52 million required in 2006/2007. The overall budget for the MOHSW in 2006/2007 has deficit of about 15% and this has a serious bearing on all the departments and programmes of the Ministry including HIV and AIDS.

Given the findings discussed above the suggested allocation of the resources for the health sector response to HIV and AIDS is as shown in Table 17 below:

Table 17: Proposed allocation of estimated funding by Theme of HSSP 2008-12

| THEME | % Allocation | 2008 | 2009 | 2010 | 2011 | 2012 | 2008-12 |
|--------------------------|-----------------------------|------|------|------|------|------|------------|
| ESTIMATED FUNDING | | | | | | | |
| I | Prevention | 20% | 20% | 20% | 20% | 20% | 20% |
| II | Treatment, Care, Support | 50% | 50% | 50% | 50% | 50% | 50% |
| III | Cross cutting | 15% | 15% | 15% | 15% | 15% | 15% |
| IV | Health system Strengthening | 15% | 15% | 15% | 15% | 15% | 15% |

3.3.2.3. Resource Disbursement and Tracking of Funds

Ensuring the timely and efficient transfer and disbursement of funds to implementing partners is also a key element of the management of funds. Given the complexity of HIV and AIDS funding due to the multi-sectoral nature of the response, the systems for resource disbursement and fund tracking are expected to be equally complex. However, much work is ongoing to harmonise and align international funding sources as well as to strengthen public and civil society capacities for resource management for HIV and AIDS. The strategy to mainstream or integrate HIV and AIDS action into operational plans and budgets will actively facilitate the harmonisation agenda.

3.3.5. Sustainability

The government of Tanzania is committed to fighting HIV and AIDS. The strengthening of the linked components - from facility to the community is intended to ensure that the health system regains its capacity to regenerate and maintain its workforce. The government is committed to work and support the private sector in its initiative of public/private/partnership to ensure the services are sustainable. The inclusion of Private sector, NGOs, CBOS and FBOs ensures consistency and joint commitment to the process. Support from other partners will continue to be sought to complement the government efforts.

The HSHSP II will be operating within the existing government health infrastructure. This provides administration and management of the plan in an integrated manner.

3.3.5.1. Management System

The coordination structure and management system put in place by the government will be used as an entry point to scale up and sustain the activities in this plan. The MOHSW through the NACP will oversee the implementation of the Strategy.

3.3.5.2. Community Participation and Involvement

Community mobilization efforts, which will enhance the achievement of community 'ownership' of the strategy will be supported. This includes the encouragement of wide participation of community members particularly traditional and vulnerable groups who may not have a voice such as women, children. Partnerships with different sectors both public and private, PLHIV and Civil Society Organizations (Faith Based Organizations and Community Based Organizations) will be strengthened to institutionalize the use of the participatory learning and action methodology which will aim to involve community members in the implementation of the strategy. One of the strategies is to ensure community ownership of the HIV and AIDS responses that entails that the community continue to give care and support to HIV and AIDS issues even when there is no external support.

3.3.5.3. Financial Sustainability

National Level

The government of Tanzania is committed to long-term funding to support the implementation of the Health Sector Strategy for HIV and AIDS 2008-2012. It is envisioned that the Government's financial contribution to HIV and AIDS activities will increase by 74% from TZS 35 billion in 2005/06 to TZS 61.0 billion in 2007/08 and to a further 75% to TZS 82 billion by 2012. The Development Partners are expected to maintain their level of financial support of the last years or to slightly scale it up.

District and Community Level

Through Community Funds, communities will learn how to mobilize resources within their communities. Moreover, the awareness created through small scale or village mobilization campaigns to leverage money for the Community Fund will create an awareness of the problems due to HIV and AIDS. Communities that are more aware of the problems that confront them due to HIV and AIDS are more likely to devote resources. Communities will be empowered through skills and confidence in handling funds to access resources from other sources.

The existence of mechanism that directly deposits funds to the village accounts instead of the district accounts will help in inculcating the spirit of responsibility and accountability. The village financial management training package developed by Department of Social Welfare is in place, hence the CMAC and VMAC in the districts will be trained on such key issues as keeping records, fundraising and financial management.

3.4. Monitoring and Evaluation of the Plan

3.4.1 Objectives

The objective of the M&E mechanism for HSHSP 2008-2012 are the following:

- 1.To generate information for the management to assess the progress of implementation of HSHSP 2008-2012
- 2.To make recommendations on strategies to improve designs and future performance

3.4.2. Monitoring and Evaluation Components

Monitoring and evaluation of the implementation of the HSHSP 2008-2012 will be conducted through appropriate existing and new systems, procedures and mechanisms. The National Monitoring and Evaluation Sub-Committee will be responsible for providing advice on all matters concerning monitoring and evaluation.

A list of the basic minimum indicators for the planning period is designed and the indicators are classified according to the strategic objectives.

HSHSP Indicators

The indicators to be used in monitoring and evaluating this HSHSP cover 4 major themes: Prevention, Treatment, care and support, Cross-cutting and Health System Strengthening. The goals/objectives and indicators were guided by the following sources:

- Millennium Development Goals and indicators;
- Indicators covered in the previous Health Sector Strategic Plans (HSSPs) that are still deemed relevant;
- Goals, indicators and targets of national programmes and international declarations/commitments (UNGASS, MKUKUTA, Abuja Declaration, etc); and
- Other emerging high priority areas for the health sector in Tanzania.

MOHSW and the CPs will harmonise sector performance indicators and use these as the basis for the joint reviews. Indicators will include: output and process indicators to assess service delivery (quality, access, efficiency) and indicators of health status (impact). They will be derived as far as possible from routine monitoring systems (HMIS) and build on those required for the monitoring and evaluation of the MKUKUTA, NMSF and the MTEF in order to avoid duplication of effort.

Monitoring

Depending on the type and relevance of the indicators, routine monitoring will be undertaken, on a monthly, quarterly, bi-annual and annual basis. The HMIS, and other routine systems will be the major tools for data collection. The TACAIDS, MoHSW, implementing partners and other agencies will primarily use this data and its analyses for decision making.

MoHSW will produce quarterly activity and financial reports for all levels of the health system for consideration at the Joint Review meetings. It will also produce an Annual Performance Review Report, on the performance of the sector against annual plans and output targets.

MoHSW will be responsible for sector performance monitoring and review. It will plan and lead the Joint Annual Reviews (JAR), together with appropriate involvement and support of development partner P, other Government ministries and other key stakeholders.

Development partners and other key stakeholders will actively and fully participate in the JAR and will accept the JAR as satisfying their own review requirements. To the extent possible, they will not undertake separate monitoring or review missions, without the approval of the National M&E Sub Committee.

Evaluation

There will be two evaluations over the duration of this plan. These will consist of a mid-term assessment after the first three years of implementation and a comprehensive summative evaluation in 2012. MOHSW will organise a joint mid-term review (MTR) before the end of the third year of HSHSP II. An independent external evaluation will be undertaken in the final year of HSHSP II. All stakeholders will agree on the timing, terms of reference and composition of these two review missions. All costs will be included in the Health Sector Budget. Where appropriate, the MTR and the final HSHSP evaluations will be combined with the JAR for that year.

The mid-term assessment will focus on progress made in plan implementation and assess the appropriateness of the overall strategic direction. It will therefore be designed to inform the remaining period of the plan and recommend adjustments where needed.

The summative evaluation will focus on outcome/impact of the HSHSP and assist in providing the contextual framework for the subsequent planning period.

3.4.3. M&E Implementation roles and responsibilities

The implementation of the overall Monitoring and Evaluation functions regarding the HSHSP 2008-2012 will be done under the management and supervision of Directorate of Preventive Services in the MOHSW through the Manager of NACP. However participation and involvement of other stakeholders from both public and private sectors will be encouraged in the process.

The Monitoring and Evaluation functions will be implemented at three levels namely, the national, regional and district levels. At national level, NACP will be directly responsible, while at the regional and district levels, the RHMT and CHMT respectively will be responsible.

3.4.2 Documentation of Lessons Learned

In the monitoring and evaluation process, best practices will be identified and strategies will be developed to improve weaknesses. The identified best practice will be documented and shared with other stakeholders to improve practices across the sector.

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- ii “generalised” in the classification of the HIV epidemics of UNAIDS means that at least 1% of the sexually active population (15 to 49 years of aged) are infected with the virus; the World Bank and WHO at times use the threshold of 5% infection rate as criterion for “generalized”.
- iii The last HIV Surveillance Report of the NACP concluded: “In general, there is a significant downward trend in HIV infection over the three survey rounds since 2001/02.” p.7
- iv A.D. Kiwara: “*HIV AND AIDS in Adolescents – A Window of Hope or Mirage*”; Institute of Development Studies, Muhimbili Dar es Salaam, 2001. 3 district study, n=1600
- v Ministry of Health; Health Sector HIV AND AIDS Strategy for Tanzania, 2003-2006. February 2002, p. 5.
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- x Mgangile 1992, 1999, sited from the Web 15 March 2005: http://www.who.int/reproductive-health/adolescent/publications/RHR_01_8/RHR_01_08_chapter4.en.html [NOT THERE NOW...]
- xi 52% of sexually experienced adolescents from Mtwara and 24% of those from Makete reported having had two or more partners during the previous month (*Adolescent Sexuality And HIV AND AIDS in Mtwara Rural and Makete Districts*, p. iv; Muhondwa 1999)
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