THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH AND SOCIAL WELFARE–
TANZANIA MAINLAND

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

FINAL DRAFT
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ACRONYMS AND ABBREVIATIONS

AfDB	African Development Bank
CBAW	Women in Child Bearing Age
CSO	Civil Society Organisation
D by D	Decentralisation by Devolution
DCF	Development Co-operation Forum
DP	Development Partner
DPG	Development Partners Group
EU	European Union
FY	Financial Year
GBS	General Budget Support
HIPC	Heavily Indebted Poor Countries
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IFMS	Integrated Financial Management System
JAST	Joint Assistance Strategy for Tanzania
LGA	Local Government Authority
LGRP	Local Government Reform Programme
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Tanzania
MPAMITA	Mkakati wa Pamoja wa Misaada Tanzania (JAST)
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organisation
NPES	National Poverty Eradication Strategy
NSGRP	National Strategy for Growth and Reduction of Poverty
ODA	Official Development Assistance
O&OD	Opportunities and Obstacles for Development
PAF	Performance Assessment Framework
PEFAR	Public Expenditure and Financial Accountability Review
PER	Public Expenditure Review
PFMRP	Public Financial Management Reform Programme
PHDR	Poverty and Human Development Report
PMS	Performance Management System
PRS	Poverty Reduction Strategy
PSRP	Public Service Reform Programme
RAS	Regional Administrative Secretary
SWAp	Sector-Wide Approach
TA	Technical Assistance
TAS	Tanzania Assistance Strategy
TOR	Terms of Reference
UK	United Kingdom
UN	United Nations
URT	United Republic of Tanzania
USAID	United States Agency for International Development

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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 resources. The country has recorded successes in key HIV and AIDS interventions, such as: increased coverage for PMTCT, introduced 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:	"A country 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/AIDS and mitigate its impacts by providing essential interventions and quality care.
Goals:	➢ 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	12% of HIV positive pregnant women are receiving ARV prophylaxis 38% of identified HIV positive pregnant women received Nevirapine (NVP). 54% of HIV+ exposed infants receive ARV prophylaxis after birth 6.9% HIV infected women opt for replacement feeding.	To reduce the transmission of HIV from mothers to their children and ensure entry into care and treatment for mothers and babies.	HIV positive pregnant women who receive ARVs prophylaxis increased to at least 80%
1.2. Prevention of sexual transmission of HIV a) STI	Inadequate screening for syphilis in RCH services Few youth friendly reproductive health services STI services addressing high risk population groups are limited. Weak monitoring of aetiologies and antimicrobial susceptibility patterns of STI pathogens Poor contact tracing (21-35%)	To expand quality STI services and enhance appropriate utilization of services	% of patients with STIs at selected health care facilities who are appropriately diagnosed and treated according to national guidelines increased from 67% in 2005 (NACP) to over 75%
b) Male circumcision	Male circumcision has not been integrated in HIV prevention services currently in the country	To promote safe, socio-culturally accepted male circumcision as a preventive measure against HIV transmission	Promote awareness of male circumcision where traditionally this is not done
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 reduce the risk of HIV transmission through blood and blood products	Increased low risk blood donations 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	Comprehensive Health Sector Workplace HIV intervention implemented 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	To develop effective interventions to reduce HIV infection among youth	Joint planning and implementation of ASRH and HIV interventions targeting young people with key stakeholders at all levels
b) CSW, MSM, IDU	Inadequate data on the characteristics, risk taking behaviours, magnitude, social-economic- situation of vulnerable populations Lack of policy issues for the VP	To contribute to the reduction of risk of HIV infection among vulnerable population groups including IDUs.	Harm reduction for injecting drug users, focusing on risk reduction information and education
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 Public disclosure of HIV sero-status by champions of change

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 offering ART services Lack of integration of CTC clinics into routine care	To strengthen and scale up implementation of comprehensive care and treatment strategies in public and private facilities	60% of all eligible persons put on ART 20% of patients on treatment are children
b) TB/HIV collaborative	Poor absorptive capacity of VCT centers to scale up TB activities Inadequate linkage of CTC clinics into TB interventions	To improve the quality of care for both PLHIV and TB patients by strengthening the collaboration between these programs	All CTCs screening PLHIV for TB All TB health facilities screening patients for HIV co-infection
c) Quality of facility based services	Low capacity at National and Regional level to monitor and supervise ART care and treatment interventions	To provide quality HIV and AIDS care and treatment to PLHIV to reduce morbidity, mortality and improve the quality of life	All HIV care and treatment health facilities provided with mentoring and supportive supervision
2.2. Community based services a) HBC	Only 50,000 are receiving HBC services out of 320,000 who are in need Erratic supply of HBC kits resulting in inadequate use of effective pain management medicines including oral morphine.	To strengthen and scale up the implementation of comprehensive care and treatment services	All districts develop and implement strategies for comprehensive community care and treatment services
b) Quality of community based services	Low Motivation and incentives of the care givers. Low adherence to national home based palliative care service standard	To improve the quality of life and reduce morbidity and mortality of PLHIV through the provision of comprehensive HIV and AIDS care and treatment services in the community	All community HBC providers should deliver quality services
c) Linkages and referral system	Poor coordination, referral systems and networking Inadequate support to MVC No Standardized monitoring, evaluation and reporting systems and tools	To strengthen community based support to establish effective linkages and referrals between civil society organizations and public institutions to ensure the provision of comprehensive services across a continuum of care for PLHIV and orphans and most vulnerable children (MVC)	Effective linkages and referrals established for community based services
3. Cross-cutting issues			
3.1. Laboratory services	No high containment laboratory (P3) for virus isolation and characterization. Inadequate supply of laboratory reagents and other consumables, No capacity to monitor drug resistance (ARVs and antimicrobial agents-STI, TB) Different specifications of laboratory equipment so difficulties in maintaining them Irregular maintenance of laboratory equipment	To strengthen diagnostic services to support prevention, care and other interventions for HIV and AIDS, STIs and major OIs	Quality laboratory services achieved
3.2. HIV Testing & Counselling	10.5% of people aged 15 to 49 in urban areas had been tested in the past year against 3.4% in rural areas 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) A weak referral and networking system Inadequate supervision and support to counsellors, Existence of different HTC standards	To improve access to and use of quality HIV testing and counselling (HTC).	Increased utilization of HIV testing and counselling (HTC) services

3.3. IEC and BCC and Stigma reduction	**BCC** Non inclusion of BCC programming in HIV and AIDS interventions Current messages are not contextualised to local settings No monitoring tools are available to establish effectiveness of the BCC programs **IEC** Centralized and inadequate production of IEC materials. Regional media and other communication channels are rarely used No evaluation done on impact of different types media used for channelling messages to the public Regional media and other communication channels are rarely used **Stigma** No clear law to minimize stigma and promote respect for Human Rights of persons living with HIV and AIDS	To contribute to the production of culturally sensitive IEC strategies that promote behaviour change and support stigma reduction	Culturally sensitive IEC strategies in place at all levels
3.4. Condom programming	Condom outlets are limited in number and variety (health facilities, shops, youth clubs). 1/6 of male condoms are free, 5/6 are sold through social marketing (2005) @ TZS. 100 for a pack of 3. Female condoms are relatively expensive @ TZS. 350 each Condoms stock outs in rural areas and for vulnerable groups	To contribute towards the promotion, distribution and use of condoms	Additional potential partners identified New outlets for condom distribution identified
4. Health System Strengthening			
4.1. National Planning and Programme management	NACP directly implementing some HIV and AIDS interventions at lower levels. The creation of vertical structures that drain the limited resources within the health care delivery system Poor linkage of vertical programs leading to inefficiency and at times artificial shortages of drugs and other commodities Poor coordination between HIV and AIDS programmes and actors Inadequate documentation and dissemination of best practices at all levels	To strengthen managerial capacity and adoption of integrated approaches to planning, resource allocation and utilization for HIV and AIDS programming at all levels.	Innovative management arrangements established Strengthened mechanisms for collaboration and integrated planning Quality improvement in service delivery assured and institutionalised
4.2. Procurement, supply management	Two competing systems (Push and Pull) for acquisition of supplies Erratic supplies Improper utilization of maximum-minimum so adhoc order placement. Inefficient fall back opportunities at facility level to use alternative methods of acquiring supplies when MSD has stock outs. No central tool for commodity forecasting for HIV and AIDS commodities No regular consumption feedback of HIV and AIDS commodities from end users There is gross under reporting of ADR.	To have secure and functional procurement and supply management systems for HIV and AIDS medicines, diagnostics and other commodities	Uninterrupted supply of STI, OIs, HIV and AIDS medicines, diagnostics and other commodities

4.3. Human resources for health	**Recruitment and hiring-establishment** The tendency of recruitment of staff by projects and secondment practices **In service training** Different schedules of in service training practices by various HIV and AIDS interventions or programmes **Task shift policy.** -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).	To build human capacity at all levels to manage and sustain a comprehensive health sector response to HIV and AIDS	Strengthened human resource capacity and mix required for managing the HIV and AIDS response at all levels
4.4. Strategic information a) M&E	Unclear flow of data and inefficient reporting – incomplete, under reporting Doubtful use of data at all levels – Lack of integrated supervision and adequate feedback at the facilities level to ensure improved quality of services. Lack of harmonized M & E system (each program with a database and M & E) Lack of information or documentation on best practices	To strengthen and institutionalize monitoring and evaluation system for it to provide relevant comprehensive information in a timely manner for programme management and planning.	Strengthened HIV and AIDS, STI and OIs monitoring and evaluation system
b) Biological and behavioural surveillance on STI, HIV and AIDS	Inadequate biological and behavioural surveillance on STI and HIV No surveillance activities targeting the most-at-risk sub populations (MARPS) Absence of testing facilities or infrastructure for diagnosis of HIV in children ; Use of RPR test in STI surveillance pauses difficulties in remote areas due to the cold chain requirement	To strengthen and expand surveillance activities to monitor the dynamics of the epidemic and the impact of interventions.	STI, HIV and AIDS trends monitored
c) HIV, STI and TB drugs resistance and drug side effects	Inadequate surveillance activities concerning drugs resistance monitoring (for STI and ARV) . Insufficient capacity to carry out STI drug susceptibility monitoring Insufficient capacity to correctly identify and report on side effects of HIV drugs (ADR)	To strengthen and sustain HIV drug resistance activities, STI drug resistance monitoring and pharmacovigilance of HIV drugs	4 Zonal laboratories to perform STI drug resistance testing 1 special hospital and 1 referral hospital perform TB drug resistance testing HIV drug resistance monitoring activities to be done in all health facilities providing ART services HIV drug resistance surveillance testing in 1 HIV Reference lab
4.5. Priority STI, HIV and AIDS, Research	Limited understanding of the nature and driving forces of the HIV epidemic at the sub-national level and among sub-populations Lack of research policy on HIV and AIDS and Weak research coordination Inadequate dissemination of the results of research locally, to policy makers , programmes managers and the beneficiaries Very little has been done in the area of Paediatrics HIV/AIDS.	To strengthen the national capacity for HIV and AIDS related research and development including Operations Research	The national response against HIV/AIDS/STIs is supported in the Country OR conducted in new HIV and AIDS research priority areas Disseminated and evidence of use of OR findings in HIV and AIDS programming and policy making

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 January 2008 to 31 December 2012. 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 other 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) , 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.

1.0. SECTION ONE:

STRATEGY FRAMEWORK

1.1. COUNTRY BACKGROUND AND HISTORY

1.1.1 Introduction

The Health Sector Strategy for HIV and AIDS 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/AIDS according to their comparative advantage
    - By addressing HIV/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, Ministry of Health and Social Welfare (MOHSW) has the overall Health Sector Strategic Plan (HSSP-2008) which is expected to end soon. The development of a new health sector strategy will include the HIV and AIDS health sector component and will be done later.
- 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

- Operationalisation of the TACAIDS NMSF 2008-2012.
- Operationalisation 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 2008-12 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 and was subjected to external reviews.

1.1.3. Geographic and administrative

Tanzania mainland has 21 regions and about 121 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 (PORALG) 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 38,710,723 million projected from the 2002 population Census . It has an annual population growth rate of 2.9%. Crude birth rate is 42.5 per 1,000 populations and life expectancy at birth is 47 years for men and 49 years for women. Thirty three percent (33%) of the population resides in urban areas whereas the majority (77%) of population is rural dwellers.

Table1. Demographic and socioeconomic parameters

Parameter	2006	2007	2008	2009	2010	2011	2012
Total population	37,452,378	38,710,723	40,005,918	41,338,695	42,709,649	43,484,118	44,523,388
Above 15	21,024,544	21,710,169	22,436,576	23,218,500	24,030,512	24,466,266	25,051010
Growth rate	2.11%	2.39%	2.39%	2.39%	2.39%	2.39	2.39
0 – 11 Months	1,570,943	1,606,401	1,642,882	1,680,580	1,719,334	1,758,088	1,798,088
Under 5 Years	7,012,134	7,215,011	7,418,446	7,612,290	7,801,587	7,990,884	8,180,884
Under 15 Years	16,427,834	17,000,554	17,569,342	18,120,195	18,679,137	19,679,137	19,472,378
CBAW(15-49 yrs)	8,003,907	9,114,964	9,424,784	9,750,742	10,459,146	11,167,550	11,875,954
Crude birth rate	39.2	39.7	39.7	39.7	39.7	39.7	39.7

Source – National Bureau of Statistics – Population Census results (2002) and National projections (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%.

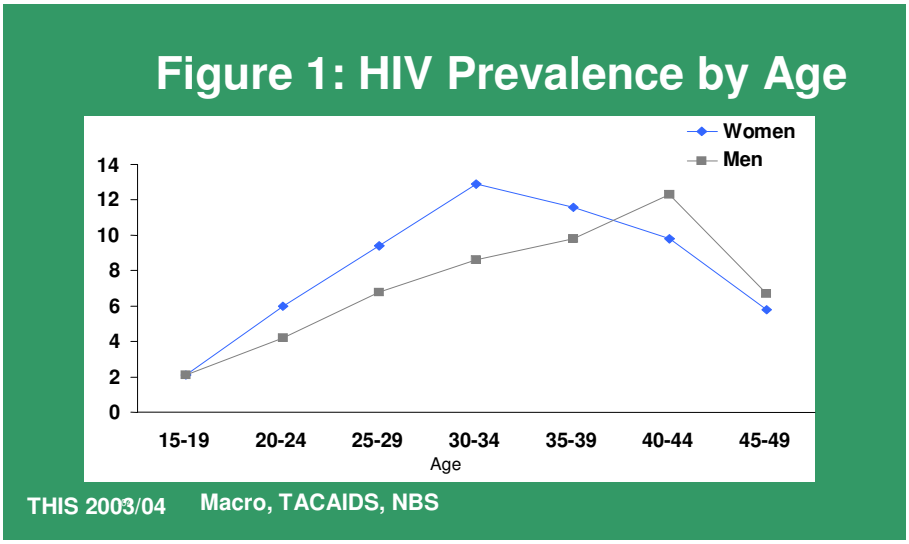
1.1.6. HIV and AIDS

1.1.6.1. Burden of disease

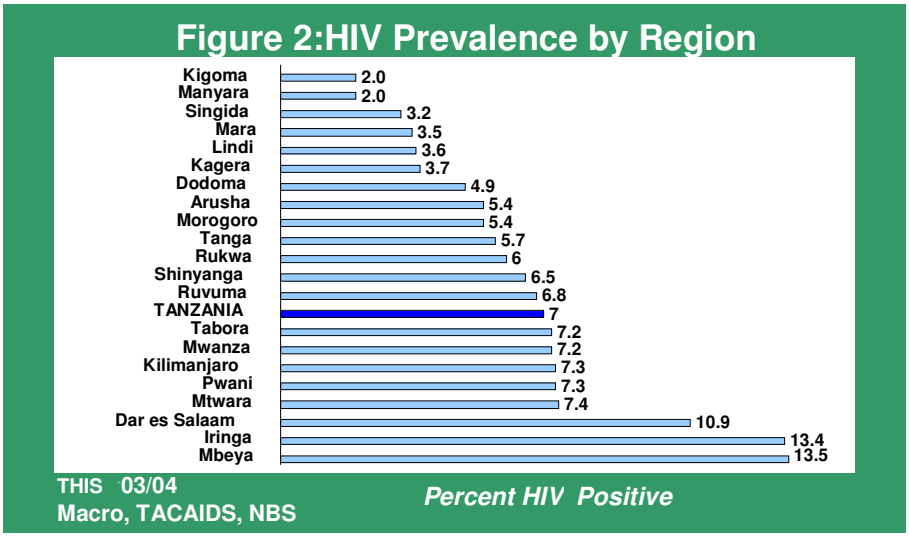
The Tanzania HIV/AIDS Indicator Survey (THIS) of 2003/4 shows that the predominant mode of transmission has remained heterosexual contact, constituting about 80% of all new infections. Mother to child transmission is estimated to account for about 18% of new infections. About 1.8% of young persons aged 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 cutting[i].

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 'generalized[ii]' 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.

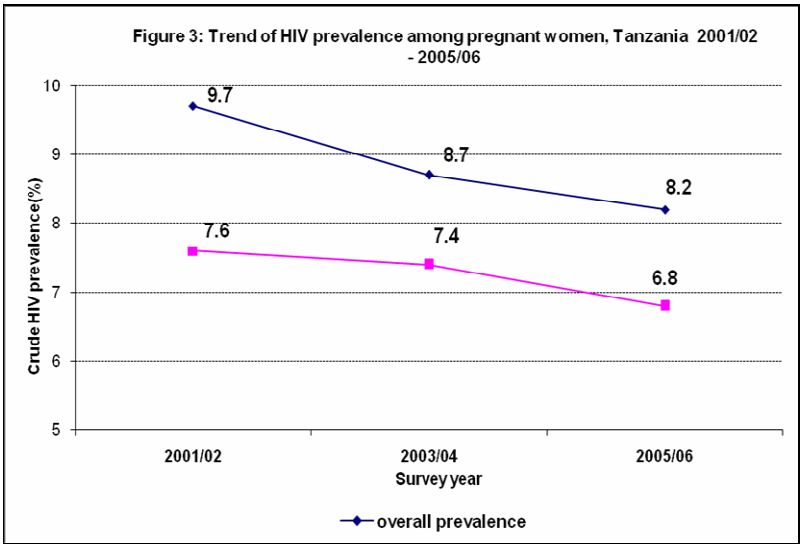


The distribution of the infection across the regions shows that there are 3 regions with adult prevalence above 10% (Mbeya, Iringa and Dar es Salaam), 7 regions with prevalence below 5% (Manyara, Kigoma, Singida, Mara, Lindi, Kagera and Dodoma) while the remaining 11 regions have a prevalence between 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 years[iii].



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 center 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/ refferal 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 Panning, Social Welfare, Adminstration 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 PORALG.

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

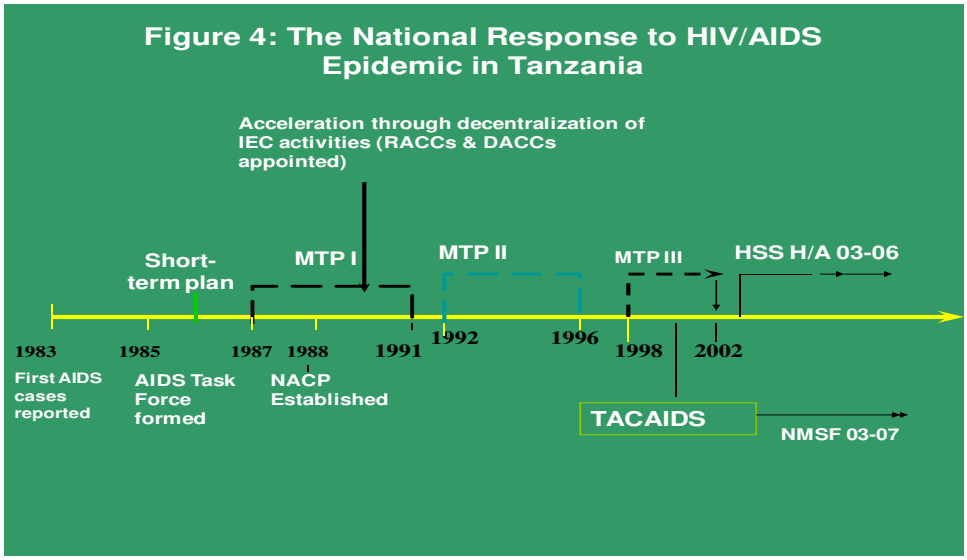
SOURCE: "Assessment of the Human and Financial Resources for the Revised HIV and AIDS National Multi-sectoral Strategic Framework" 2007

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 and1991. (See Figure 4)

Figure 4: The National Response to HIV/AIDS Epidemic in Tanzania



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 :								
Testing and Counseling	**16,427,834**	**21,710,169**	**22,436,576**	**23,218,500**	**24,030,512**	**24,466,266**	**25,051,010**	Population aged above 15 or 15-49yr
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)	**294,344** (75,000 + 80% of pop in need)	**303,942** (100,000 +90% of pop in need)	**342,000** (220,000+ 64% of pop in need)		**470,000**			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
B. People CURRENTLY RECEIVING or ANTICIPATED TO RECEIVE (TARGET) Key Services :								
Testing and Counseling	**427,000** (2005)		**1,200,000**	**1,400,000**	**1,800,000**	**2,000,000**	**2,200,000**	Increase from 25% to 40% of pop. 15-49
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) 150,000	**220,000**	**310,000**	**400,000** (85% of pop. in need)			
C. UNMET NEED OR GAP in terms of people in need of Key Services ($A^1 – B^1 = C^1$, $A^2 – B^2 = C^2$ etc.)								
Testing & Counseling	**16,000,834**		**21,236,576**	**21,818,500**	**22,230,512**	**22,466,266**	**22,8510,010**	
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

	2007/8	2008/9	2009/10	2010/11	2011/12	Totals
Domestic (A)	Million US$	Million US$	Million US$	Million US$	Million US$	Million US$
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/AIDS Strategy is a major contributor to the attainment of the vision of the overall multi-sectoral response expressed in the National Multi-sectoral Strategy Framework for HIV/AIDS i.e.

> *"A country 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/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 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.

The three goals of the heath 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

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

2.0 SECTION TWO:

NARRATIVE AND JUSTIFICATION OF THE MATRICES

2.1. THEMATIC AREA: 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 inequality 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 using innovative and alternative channels and outlets.

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 this and other literature by Staugard (2002) 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.

Intervention area 1: Prevention of Mother to Child Transmission of HIV

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 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 and counseling on preventing HIV transmission (Primary prevention)
- Family planning for women living with HIV and AIDS.(Prevent unintended pregnancies)
- Use of antiretroviral drugs to prevent HIV transmission from mother to child.
- Infant feeding counseling.
- HIV treatment and care for infected mothers, infants and other family members.

Situation analysis

In 2002, the MOHSW established the first five pilot sites. The pilot sites have been evaluated and the major recommendation was to scale up PMTCT to all the regions in a phased approach manner.

Achievements

- Currently 659 sites (10.6%) out of 5,379 are providing the core elements of PMTCT services including HTC, antiretroviral prophylaxis, and infant feeding counseling integrated in reproductive and child health services. Table 5 below.

Table 7: Expansion of PMTCT services: coverage by region, district and facility type

Attribute	*National*	*PMTCT Coverage*	*Percent*
Number of Regions	21	21	100.0%
Number of Districts	126	120	95.2%
Hospitals	219	137	62.5%
Health Centres	481	191	39.7%
Dispensaries	4,679	331	07.1%
Total number of facilities	**5,379**	**659**	**12.2%**

- In 2006, PMTCT sites recorded 363,516 bookings (26%) of all ANC bookings. About 336,745 (93%) of these first ANC bookings were pre tested, while 95% of those counseled (8.2%) were found to be HIV positive. About 53 percent of eligible HIV positive mothers received a course of ARV prophylaxis (at ANC, during labour and at delivery).
- Developed structures to coordinate the planning and implementation of PMTCT including having a PMTC Coordinator.
- Reviewed, printed and distributed national PMTCT guidelines,
  - PMTCT guidelines, training materials, monitoring tools, managers orientation manual and a draft Communications Strategy for PMTCT interventions
- Trained 203 Trainers Of Trainers (TOT) and 2758 service providers from all the 659 sites providing PMTCT services in the country
- Developed and pre tested a set of IEC materials addressing issues of male involvement, stigma associated with MTCT, home deliveries and follow up services for the mother and child
- In certain areas PMTCT funds have been used to renovate some RCH clinics and labor and delivery wards that were in bad shape.

Challenges

Aspects	**Challenges for PMTCT**
Availability	• Only 659 health facilities out of a total of 5379 are providing PMTCT services • Only 12% of HIV positive pregnant women are receiving ARV prophylaxis
Equitable access	• Rural pregnant women are less likely to be offered HIV testing than urban women in RCH. • 27.8% of urban and 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) • limited access of pregnant women identified to a comprehensive package of Reproductive Health and HIV prevention, care and treatment services inspite of the existence of 216`ART centers.
Quality	• Only 38% of identified HIV positive pregnant women received Nevirapine (NVP). • Only 54% of HIV+ exposed infants receive ARV prophylaxis after birth • Reasons include frequent stock-out of NVP and the practice to give NVP at 28 weeks gestation and low institutional deliveries • Only 6.9% HIV infected women opt for replacement feeding. • Weak coordination of implementing partners • Central unit involved in direct implementation of projects
Sustainability	• Funds to accelerate PMTCT efforts from Government, Partners and the community

- Only a few women (17%) and men (19%) know that there are special drugs that can be given to pregnant women infected with HIV to reduce the risk of transmitting the virus to the baby[vi].
- Low uptake of maternal and infant ARV prophylaxis
- Limited access of pregnant women and children to a comprehensive package of Reproductive Health and HIV prevention, care and treatment services
- Inadequate staffing (number and skills) in the health facilities
- Weak coordination of implementing partners
- NACP PMTCT Unit engaged in implementing instead of coordination

Equity, gender and sustainability considerations

Women confront a number of gender-based obstacles in accessing PMTCT services such as, utilizing HIV testing and counseling services in RCH, 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.

Strategic objective

Reduce the transmission of HIV from mothers to their children and ensure entry into care and treatment for mothers, families and babies.

Strategies

- Advocate for and increase awareness and communication to addressing PMTCT and paediatric HIV prevention, care, treatment and support among key stakeholders at all levels
- Strengthen the provision of PMTCT in all sectors and to all levels of health facilities
    - Decentralize responsibility of PMTCT planning and implementation to the Zonal, Regional and District levels
    - Ensure the continuous availability of good quality medicines, diagnostics and other medical supplies for PMTCT
- Improve delivery of community PMTCT and referral of HIV-infected women, their children and families
    - Improve programme management, coordination and supervision for PMTCT programme activities at all levels
        - Operationalize the linkage between the delivery of PMTCT and reproductive health and other health services
        - Improve the monitoring and evaluation of PMTCT including surveillance and research
        - Mobilize resources to implement the 2008-12 Strategic Plan

Targets

- At least 80% of women living with HIV enrolled in PMTCT and care and treatment services receive family planning services (either on site or through referrals)
- HIV positive pregnant women who receive ARVs prophylaxis increased to at least 80%
- At least 60% of infants born to women living with HIV receive co-trimoxazole prophylaxis for 24 months
- At least 96% of pregnant women living with HIV receive continuous and sustained infant feeding counselling by a trained counsellor
- At least 80% of infants born to women with unknown HIV status are screened for HIV exposure at age of 6-8 weeks.
- All referral, regional, district hospitals and at least 76% of health centres and 44% of dispensaries with RHC services provide integrated PMTCT services according to national guidelines

Indicators

- Number of health institutions offering PMTCT
- Proportion of identified+ women receiving ARV prophylaxis (stratified by single dose Nevirapine (sdN) versus more efficacious regimes)
- Proportion of identified exposed babies receiving ARV prophylaxis
- Proportion of exposed infants and children receiving cotrimoxazole prophylaxis
- Proportion of HIV exposed babies tested for HIV at 18 months or earlier
- Number/percentage of clinically eligible HIV infected pregnant women starting ART during pregnancy

Key implementers

- Referral, regional and district hospitals), Health centres and dispensaries, MOHSW, RHMTs and CHMTs

Intervention area 2: Prevention of Sexual Transmission of HIV

A. *STI prevention and management*

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. 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, people in general, particularly young people, tend to be ill-informed about STIs.

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 attendee 2005/2006).

Situation analysis

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

Achievements

- All public hospitals including Referral, Regional, District hospitals and DDH, health centers and 60% 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.
- 7,926 Health care providers have been trained in STI syndromic case management.
- Developed National Guidelines for the Management of STI/Reproductive Tract Infections
- Over 484 Health Care workers from Antenatal Clinics trained in management of syphilis in pregnancy under NACP coordination.
- Development, production and distribution of varieties of educational materials (posters, leaflets and video tapes) on STI prevention and control
- About 67.2% of service providers make correct choice of drugs, dosage and duration of treatment for their clients
- Counseling aimed at safer sex options and risk reduction strategies is routinely done in VCT centers and in the course of management of STI and HIV/AIDS.

Challenges

Aspects	Challenges in STI prevention and management
Availability	• Inadequate screening for syphilis in RCH services • Inadequate condom distribution in STI services • Poor coordination of STI control activities at all levels
Equitable access	• 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	• Poor reporting system in place • 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 • Poor contact tracing (21-35%)

Emerging issues

- There appears to be a shift of interest among partners in supporting STI programme.
- Shortage of HCWs at the facility level coupled with increased HIV intervention has resulted into displacement of previously trained HCWs from the STI clinics to other services
- Sexual violence and abuse especially for young girls and boys remains a problem

Equity, gender and Sustainability Considerations

STIs like gonorrhoea are acute in men, but asymptomatic in women, while others like trichomoniasis have symptoms in women, but remain often asymptomatic in men 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. HCW will need to increasingly seek laboratory confirmations in cases where symptoms do not exist but circumstantial evidence of infection exists.

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 boys.

Strategic objective

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

Strategies

- Expand coverage of quality STI services to all health facilities in all districts in the country and make services youth friendly
- Guideline, curriculum development and training for STI prevention and management at facility and community levels

Targets

- % of patients with STIs at selected health care facilities who are appropriately diagnosed and treated according to national guidelines increased from 67% in 2005 (NACP) to over 75% by 2012
- STI case management by syndromic approach integrated into the curricula of pre-service training medical institutions including universities, in-service as well at community levels

Indicators

- % of clients served by public health facilities' providing STI care
- % of men and women reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care
- % facilities that report no stock-outs in the last 3 months.
- Number of special STI clinics for vulnerable groups established

Key implementers

- Referral, regional and district hospitals, health centres and dispensaries, NACP/MOHSW, RCHS/MOHSW, RHMTs and CHMTs

B. *Male circumcision*

Preamble

The association of male circumcision and decreased risk of HIV transmission has been reported in some studies[vii]. Randomized controlled trials conducted in South Africa and the neighbouring countries of Kenya and Uganda on male circumcision and HIV transmission have demonstrated a significant decrease in the risk of HIV infection among men who became circumcised during the trial compared to those who were not circumcised[viii]. Therefore there is compelling global evidence that safe male circumcision should be one of the public health interventions to reduce the transmission of HIV.

Situation analysis

The practice of male circumcision in Tanzania is often for religious and cultural reasons rather than for the purpose of HIV prevention. In most regions and districts this is done in hospitals 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%.

Though THIS findings indicated that HIV prevalence between circumcised and uncircumcised was not significant (7% versus 6%), more sophisticated analysis is needed to explore the relationships- for example the high HIV-prevalence regions of Mbeya and Iringa have relatively low male circumcision rates (34.4% and 37.7% respectively).

Challenges

- Male circumcision has not been integrated in HIV prevention services currently in the country

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

Strategic objective

To promote safe, socio-culturally accepted male circumcision as a preventive measure against HIV transmission

Strategies

- Conduct operational research by rapid assessments to determine key providers, assess acceptability, estimate costs and evaluate the quality of safe male circumcision services provided by health care workers.

Target

- Promote awareness of male circumcision where traditionally this is not done

Indicator

Proportion of male children and youth circumcised

Key implementer

- Districts, CHMTs, FBOs, NGOs NIMR, Academic Institutions

Intervention area 3: Prevention of transmission in health-care settings

A. Safe blood

Preamble

HIV transmission through blood-transfusion, contaminated blood-products and interventions / accidents happening in hospital settings as well as through traditional practices (skin piercing, genital mutilation etc.) 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 workers / professionals in particular.

The MOHSW has continued to ensure that blood is safe at all levels of health facilities by training laboratory staff in blood and injection safety, screening for HIV anti-bodies, hepatitis and syphilis.

Situation analysis

Achievements

- Though donor blood screening for HIV started in 1987 establishment of the National Blood Transfusion Service (NBTS). Was done in 2000
- There are 6 zonal blood transfusion centers in Dar-es-salaam, Moshi, Mwanza, Mbeya, Tabora and Mtwara
- Efforts to establish a pool of low risk voluntary blood donors have started.
- NBTS has in place National Blood Transfusion Policy, Blood Donor Recruitment and Retention guidelines, Specific Blood Transfusion Practice guidelines and Guidelines on the Clinical use of Blood and Blood Products.

Challenges

Aspects	Challenges for Blood Safety
Availability	• Limited numbers of blood donors
Equitable access	• Weak distribution of donated blood and blood products by Zonal centers to regional distribution points
Quality	• Lack of Quality Assurance scheme for NBTS at distribution points • Inadequate supervision of blood transfusion practices in private hospitals

Equity, gender and sustainability considerations

Currently the majority of blood donors are replacement donors (90%) out of whom majority are males (81.4%)[ix]. Half of blood recipients are children followed by pregnant women (30%).

Strategic objective

Reduce the risk of HIV transmission through blood and blood products

Strategies

- Strengthen the distribution capacity of NBTS and regional distribution units
- Promote community awareness for blood donation
- Establish an efficient and appropriate M&E system and a Quality Assurance scheme for NBTS

Target

- Increased low risk blood donations in public and private hospitals

Indicator

- % of blood units transfused that have been screened for HIV, syphilis and hepatitis according to National guidelines

Key implementers

- MoHSW, Private hospitals, RHMTs, CHMTs

B. Workplace interventions for HCW

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.

Situation analysis

Achievements

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.
   - Facilities have ways 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 are trained on the need to avoid recapping of syringes 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.
   - Training of healthcare providers has been done in the zonal hospitals.

d) *Post-exposure prophylaxis (PEP)*
   - Despite MoHSW guidelines on PEP so far only facilities with Care and Treatment Clinics have PEP kits for needle stick injuries.

Challenges

Aspects	Challenges for Workplace Interventions for HCW
Availability	• Limited awareness about risks of HIV transmission in hospital settings • Low rate of implementation of PEP. • Inadequate coverage of HIV work place interventions in health facilities
Equitable access	• Inadequate knowledge and skills among healthcare providers on IPC.
Quality	• Inadequate functioning of National Quality Improvement Committee (NQIC) on infection control • Lack of harmonized training materials on Infection IPC • No coordination forum for IPC

Equity, Gender and sustainability considerations
Workplace interventions should focus not only at central levels but also peripheral levels. Specific considerations should therefore be given to gender related issues especially in some aspects for example female HCW may be subjected to sexual harassment in the course of their work.

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

Strategies
- Scaling up of Health Sector workplace HIV interventions

Targets
- Comprehensive Health Sector Workplace HIV intervention implemented in all levels

Indicators
- Proportion of health facilities with Comprehensive Health Sector Workplace HIV interventions

Key implementers
- MoHSW, Private hospitals, RHMTs, CHMTs

Intervention area 4a: Vulnerable population groups: Targeted Youth Programmes

Preamble
Young people aged 10 to 24 constitute a third of the Tanzanian population. 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[x]. Further research shows that more than 30% of sexually active girls had a coerced sexual debut.[xi] Furthermore 20 % of girls have had intercourse by age 15 and 68 % by 18[xii]. Once they become sexually active, young people tend to have multiple partners[xiii]. About 52% per cent of 19 year olds have been pregnant or have a child, and almost half of these had no formal education[xiv]. Nearly a third of the victims of unsafe abortion are teenagers, of whom almost half were 17 years of age or younger[xv].

Situation analysis
Achievements
- IEC and BCC interventions implemented by many NGOs
- Youth friendly services established by some NGOs
- NGOs initiated programmes targeting displaced young girls and boys
- Youth friendly reproductive health services established in 10 districts.

Challenges

Aspects	Challenges for Targeted Youth Programmes
Availability	• Adolescent sexual and reproductive health (ASRH) not mainstreamed into HIV and AIDS at all levels • Inadequate skills for ASRH interventions including HIV and AIDS
Equitable access	• IEC and BCC interventions on ASRH and HIV interventions targeting young people are inadequate
Quality	• 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

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 increasing intergenerational sexual practice

between older males and girls. On this basis programmes must aim to empower young women to make their own independent informed decisions about their sexuality options and preferences with regards to safe sex practices.

Strategic objective
To develop effective interventions to reduce HIV infection among youth

Strategies
- Develop effective HIV risk reduction interventions for youth
- Establish linkage between HIV and AIDS and ASRH services.

Targets
- Contribute to the reduction of new HIV infections among the youth aged 15-19
- Joint planning and implementation of ASRH and HIV interventions targeting young people with key stakeholders at all levels

Indicators
- % of regions and districts with IEC and BCC interventions targeting youth integrated in their plans
- % of young men and women who have had sexual intercourse before the age of 15 reduced from 9.5% and 10.6% in 2003/4 to below 8% in 2012
- HIV interventions integrated into ASRH at all levels

Key implementers
- MoHSW, Private hospitals, RHMTs, CHMTs

Intervention area 4b: Vulnerable population groups: CSW, MSM, mobile workers, prisoners, IVDU

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 professional activities (commercial sex workers), to their social and cultural marginalization (Men who have sex with men), or associated to their professions bringing them either in frequent contact with places of sexual mixing (bar maids), necessitating longer periods of separation from families or stable relationships (prisoners, migrant workers including miners, military) or the complete breakdown of stable social environment (refugees, intravenous drug users). There are other vulnerable groups like those who are either mentally or physically challenged and orphans. 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.

Situation analysis
Drug and Alcohol abuse enhances the risk of HIV infections either directly or indirectly by lowering inhibitions, which lead to risky behaviours. The results of the THIS showed that there was 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, 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 indicates that 18% of drug users are IDUs. More recent studies revealed that between 31% and (42%)[xvi] of IDU users are HIV positive and the situation is more serious among females.

Achievements
- Studies have been conducted on magnitude of HIV infection among some vulnerable groups and their characteristics

Challenges

Aspects	Challenges for other vulnerable groups
Availability	• Inadequate data on the characteristics, risk taking behaviours, magnitude, social-economic- situation of vulnerable populations • Lack of policy issues for these groups (since they are largely marginalized and discriminated in society, their behaviors are not legal and they are subjected to criminal prosecution)
Equitable access	• Inability to access various services due to perceived socially and legally unacceptable behaviours
Quality	• Poor coordination mechanism among implementers of vulnerable Population activities • Lack of standardized guidelines for training on HIV issues to vulnerable populations

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.

Strategic objective

To contribute to the reduction of risk of HIV infection among vulnerable population groups.

Strategies

- Develop effective HIV risk reduction interventions for vulnerable populations including IDUs
- Establish partnership with appropriate stakeholders

Targets

- Contribute to the reduction of new HIV infections among the vulnerable populations
- Harm reduction for injecting drug users, focusing on risk reduction information and education
- Joint planning and implementation of HIV interventions targeting vulnerable groups with key stakeholders at all levels

Indicators

- % of regions and districts with IEC and BCC interventions targeting vulnerable populations
- % of HIV infection among IVDUs
- HIV interventions integrated into programming for vulnerable populations at all levels

Key implementers

- MoHSW, Private hospitals, RHMTs, CHMTs, Drug Commission, Academic Institutions

Intervention area 6: Prevention services for people living with HIV and AIDS (positive prevention and stigma reduction

Preamble

Positive prevention aims at assisting people with HIV to take measures that avoid exposing others to infection as well as avoiding re-infection[xvii]. 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. Data from Tanzania (2003/2004) revealed that up to 8% of couples in the country have discordant HIV sero-status[xviii]. This calls for the need to promote positive prevention.

Situation analysis

Achievement

- More people accessing HIV Counseling and Testing Services
- Free HIV care and treatment services offered to eligible PLHIV
- National umbrella/apex organization for PLHIV established

Challenges

Aspects	Challenges for positive prevention for PLHIV and stigma reduction
Availability	• Inadequate meaningful engagement and involvement of PLHIV for Positive Prevention.
Equitable access	• Some of PLHIV are not volunteering to disclose their HIV sero-status because of stigma • Some cultural practices (like inheritance of widows) promote high risk behaviour
Quality	• Several PHLA groups are poorly organized and weak

Equity, Gender and sustainability considerations

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

Strategic Objective

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

Strategies

- Encourage meaningful involvement of PLHIV at all level
- Support individually focused health promotion to enhance disclosure of HIV positive status

Targets

- National guidelines for meaningful involvement of PLHIV (MIPA) developed
- Public disclosure of HIV sero-status by champions of change

Indicators

- % of PHLAs participating in positive prevention activities
- % of PHLAs and other actors with National guidelines for MIPA
- Number of champions of change who have publicly disclosed

Key implementers

- PLHIV, SHIDEPHA+, WAMATA, TANOPHA, MoHSW

2.2. THEMATIC AREA: CARE AND TREATMENT

2.2.1. Introduction

Scaling up access to ART and decentralizing implementation to include primary health facilities and the community so as to reach underserved populations is important. It is also critical that the challenges that will be faced in ensuring quality, equitable access and overcoming stigmatization and discrimination are addressed. .

This section addresses the continuum of care, treatment and support services at facility and in the community .

Intervention Area 1: Facility Bases Services

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-and-from community and home based care activities. The strategy is also mindful of low enrolment of children and males and has designed activities which aim to increase enrolment of these populations, in addition to ensuring early detection and follow up of children exposed to HIV.

Situational Analysis

Achievements

- Infrastructure improvements, including purchase and installation of essential equipments and supplies; 200 Care and Treatment Clinics (CTC) inclusive of referral, regional and district hospitals, faith-based and some private hospitals were established.
- A facility accreditation system was developed and implemented, services standards and guidelines were developed and used in training health workers
- 1,427 HCWs from various cadres have been trained
- Plan for gradual initiation of ART was implemented beginning with referral hospitals and followed by regional and district hospitals.
- 162,922 patients were enrolled for general care and 79,181 were initiated into ART. Among these 15, 505 (9.5%) were children.

Challenges

Aspects	Challenges for Facility Based Services
Availability	• The majority of rural population has no access to ART. • Poor patients cannot afford paying for cost of treating OIs • Only 19.4% and 12.8% of adults and children in need of ART receive this treatment • Lack of quality laboratory services to effectively support ART • Inadequate laboratory services • Limited infrastructure for CTC services • Limited number of days for offering ART services • Limited involvement by the private sector in care and treatment
Acceptability	• Awareness of benefits of knowing one's HIV status and accessing care and treatment early is low • People do not know criteria for initiating ART
Quality of services	• Lack of integration of CTC clinics into routine care • Poor linkage of vertical programs leading to inefficiency and at times artificial shortages of drugs and other commodities which PLHIV cannot access, e.g.

Aspects	Challenges for Facility Based Services
	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 centers 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

Emerging issue
- Provider Initiated Testing and Counseling (PITC) practice is low
- Limited nutritional counseling and linkages with sources of food and nutrients to complement antiretroviral therapy
- Disjointed CTC and HBC services in most districts
- Vertical programs leading to poor coordination and missed cross-referrals between CTC and other programs, including: PMTCT, TB , STI, RCH
- Limited initiatives to address the roles of traditional healers

Equity, Gender and sustainability considerations
- Low enrolment of children and males into care
- 90% of the Care and Treatment is donor dependent, alternative funding mechanisms need to be identified overtime

Strategic objective 1:
To strengthen and scale up implementation of comprehensive care and treatment strategies in public and private facilities

Strategies
- Strengthen capacity for implementing Comprehensive Care, Treatment and Support
- Increase access to and delivery of ART for Adults
- Increase access to and strengthen paediatric care
- Introduce task shift to lessen burden among HCWs

Targets
- All health centers providing comprehensive package of care and treatment
- 60% of all eligible persons put on ART
- 20% of patients on treatment are children
- All HCWs trained in HIV and AIDS care and treatment

Indicators
- Number of private facilities providing ART services
- Percentage of people eligible for ART receiving treatment
- Number of health facilities delivering ART services for ART for children
- Percentage of eligible children receiving antiretroviral therapy
- Number of health care facilities providing PITC
- Number of health facilities providing paediatric care integrated with PMTCT, MCH, IMCI, general health care and community HBC programs
- Number of HIV exposed infants given cotrimoxazole up to 18 months
- Number of PLHIV on cotrimoxazole prophylaxis

Key implementers
- MoHSW, Private hospitals, RHMTs, CHMTs, Academic Institutions

Strategic objective 2

To improve the quality of care for both PLHIV and TB patients by strengthening the collaboration between these programs.

Strategies

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

Targets

- All CTCs screening PLHIV for TB
- All TB health facilities screening patients for HIV co-infection
- All TB health facilities at regional and district hospitals providing HIV care and ART

Indicators

- Policy on TB and HIV integration developed and disseminated
- TB/HIV co-morbidity management guidelines adapted
- Number of districts with TB/HIV coordinating committees
- Number of health care workers trained in managing TB/HIV co-morbidity
- Percentage of TB patients tested for HIV
- Percentage of TB patients with HIV co-infection that are treated for TB and HIV.
- Number of hospitals with TB clinics providing cotrimoxazole prophylaxis and ARV
- Percentage of HIV infected patients screened for TB

Key implementers

- MoHSW, Private hospitals, RHMTs, CHMTs, Academic Institutions

Strategic objective 3

To provide quality HIV and AIDS care and treatment to PLHIV to reduce morbidity, mortality and improve the quality of life

Strategies

- Establish packages of HIV treatment and care appropriate for different levels of care.
- Strengthen and scale up HIV Care and Treatment related training to enhance skills of HCWs at all levels
- Develop a system of Quality Assurance of HIV Care and Treatment Services
- To develop mechanism for decentralized supportive supervision for HIV Care and Treatment Services

Targets

- Strengthen capacity for monitoring and evaluation of HIV care and treatment at all levels
- All HIV care and treatment health facilities provided with mentoring and supportive supervision
- Accreditation of health facilities offering HIV and AIDS care and treatment services
- Establish effective referral systems between CTC and HBCs
- Pre-service training in HIV and AIDS care and treatment institutionalized in training institutions including universities.

Indicators

- Number of HCW trained to offer HIV and AIDS care and treatment services
- Standard packages of care developed for different levels of care
- % of regions with qualified staff for supportive supervision
- Mentoring and supervision tools developed and used.
- Number of health facilities accredited to offer HIV and AIDS care and treatment services

Key implementers

- MoHSW, Private hospitals, RHMTs, CHMTs, Academic Institutions

Intervention Area 2: Community Based Care Services

Situational Analysis

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 programs in order to increase patient identification, adherence to treatment and patient follow-up.

Achievements

- To date MoHSW has approved the extension of care and support services to include the community and household levels.
- Guidelines for home based care services including training manuals have been developed to ensure the provision of quality of care in a continuum encompassing health care facilities, the community and homes.
- Recognition of NGO, CBO, and FBO offering HBC services by the government
- HBC services have been initiated in 70 districts (53%) and about 50,000 PLHIV are reported receiving services

Challenges

Aspects	Challenges for Community Based Services
Availability	• Only 50,000 are receiving HBC services out of 320,000 who are in need. • Nearly half of the district have no HBC services • About 70 districts (out of 121) have trained HBC facility focal persons Erratic supply of HBC kits resulting in inadequate use of effective pain management medicines including oral morphine.
Equitable access	• Households that have orphaned children in urban areas are twice more likely to receive support than in rural areas (THIS 2003/4).
Quality	• Poor coordination, referral systems and networking among key HBC implementers at national and district levels. • Inadequate capacity to coordinate and supervise HBC activities in districts inadequate provision of comprehensive care inclusive of medical/nursing, psychosocial, socio-economical and legal/human rights needs • Inadequate delegation of some tasks to community members including PLHIV • Low Motivation and incentives of the care givers. • Low adherence to national home based palliative care service standard • No Standardized monitoring, evaluation and reporting systems and tools.

Emerging Issues

- Missed opportunities for HIV prevention in general and “prevention with positives” in particular.

Equity, Gender and sustainability considerations

- There is need to strengthen community support and ownership to facilitate sustainability
- There are inadequate programs addressing Most Vulnerable Children (MVC) and uptake of services by males

Strategic objective 1

To strengthen and scale up the implementation of comprehensive care and treatment services for HIV and AIDS in community settings

Strategies

- Scale up the accessibility and availability of comprehensive community home based care and support services for PLHIV
- Improving care and management of pain and other common symptoms of chronic diseases including HIV and AIDS
- Strengthening the integration of TB, HIV and AIDS services at community level

Targets

- All districts develop and implement strategies for comprehensive community care and treatment services

Indicators

- Number of civil society organizations providing home based care per district
- Number of chronically ill people receiving services from trained home based care service providers

Key implementers

- MOHSW, CHMTs, CMACs, VMACs, CSO, FBOs

Strategic objective 2

To improve the quality of life and reduce morbidity and mortality of PLHIV through the provision of comprehensive HIV and AIDS care and treatment services in the community

Strategies

- Strengthen the capacity for appropriate management of common OIs and STIs in PLHIV
- Establish and disseminate service standards for all institutions and individuals providing home based care services
- Develop and implement capacity building strategies to increase technical skills of community home based care service providers
- Strengthen the supervision, monitoring and evaluation capacity for civil society organizations and public institutions

Targets

- All community HBC providers should deliver quality services

Indicators

- Number of community home based care service providers trained and providing services
- Percentage of HBC patients effectively linked to CTC services
- Proportion of patients receiving effective pain medication
- Proportion of health workers at national, regional and district level with full responsibilities for monitoring and supervising HBC services
- Proportion of districts reporting HBC services on a regular basis
- Percentage of patients adhering to treatment at 95% level

Key implementers

- MOHSW, CHMTs, CMACs, VMACs, CSO, FBOs

Strategic objective 3

To strengthen community based support to establish effective linkages and referrals between civil society organizations and public institutions to ensure the provision of comprehensive services across a continuum of care for PLHIV and orphans and most vulnerable children (MVC)

Strategies

- Develop mechanisms to enhance community ownership, participation and involvement in home

based care services
- Establish mechanisms for effective referrals and networking among all key stakeholders in community home based care services
- Develop effective strategies to mitigate the impact of HIV/AIDS in communities and households with MVC

Targets
- Effective linkages and referrals established for community based services

Indicators
- Number of districts providing direct support to HBC implementing civil society organizations
- No of organizations providing HBC per district
- Number of patients referred for non-health essential services
- Number of orphans and other vulnerable children identified and supported
- Number of community-based organizations mobilizing services for MVC
- Strengthen community sensitization to improve literacy on non ART care including cotrimoxazole prophylaxis

Key implementers
- MOHSW, CHMTs, CMACs, VMACs, CSO, FBOs

2.3. Thematic Area 3: Cross-cutting issues

2.3.1. Introduction

The National Multi-Sectoral Strategic Framework on HIV/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.

Intervention Area 1: Laboratory services

Preamble

In order to support the comprehensive HIV and AIDS interventions, it is important to have good quality laboratory services.

Situation analysis

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

Achievements

- Trainings have been conducted as follows
  - A total of 200 laboratory staff from public and private health facilities have been trained on HIV, CD4, hematology and chemistry testing.
  - Non laboratory medical staff have been trained to perform HIV testing
- Thirty laboratories have been renovated.
- Laboratories have been equipped
  - 59 CD4 machines, 109 haematology analyzers and 103 chemistry analyzers have been installed in all referral hospitals, some regional and district health facilities.
  - HIV infant diagnosis capacity have been established at Bugando;
- Laboratory QA Guidelines have been developed,
  - QA and HIV training laboratory is under construction at NIMR (final stages),
  - External QA (EQA) for CD4 has been initiated and sustained in all labs performing the test
- New algorithm for Rapid HIV Testing has been developed and validated.
- Existence of good procurement and supply management
  - Distribution mechanism of laboratory reagents and supplies has been established through MSD.
  - A reporting and requisitioning (R&R) form through MSD system is in place.
- Laboratory Act has been reviewed and tabled to allow HIV testing by non-lab health workers
- A model of transporting laboratory samples (sample transport system) has been set up
- Standard Operating Procedures (SOP) for HIV tests, equipment and Opportunistic infections especially TB have been created
- Laboratory information systems (registers, data capture, reporting, and requisitions) necessary for planning and implementation purposes are being developed.

Challenges

Aspects	Challenges for Laboratory Services
Availability	• There is no high containment laboratory (P3) in the country for virus isolation and characterization. • There is inadequate supply of laboratory reagents and other consumables, test kits to support PMTCT, Clinical Diagnosis, Surveillance and HIV Testing services. • No capacity to monitor drug resistance (ARVs and antimicrobial agents-STI, TB) • Different specifications of laboratory equipment so difficulties in maintaining them
Equitable access	• There is shortage of CD4 equipment, haematology and chemistry analyzers and HIV infant diagnosis equipment. • Acute shortage of laboratory personnel and staff burn out. • Most of the good quality laboratory services are in urban areas.
Quality	• There is also inadequate monitoring of rational use of testing kits • There is inconsistent distribution of HIV and STI and testing materials and inadequate cold storage facilities especially with the use of Capillus. • National guidelines for laboratory quality assurance system have been developed but are not yet operational • Irregular maintenance of laboratory equipment • Most of laboratory buildings are in poor conditions

Equity, Gender and sustainability considerations

Most of the good quality laboratory services are in urban areas. Currently the laboratory services are heavily dependent on donor support so there is a need to develop alternative ways of sustainability.

Strategic Objective I

Strengthen diagnostic services to support prevention, care and other interventions for HIV/AIDS/STIs and major OIs

Strategies

- To ensure nation-wide access to quality and timely delivery of laboratory services
  - Ensure availability of appropriate laboratory infrastructure and equipment in health facilities
  - Ensure availability of reagents in all health facilities for diagnosis and monitoring of HIV/AIDS/STI and major OI
  - Strengthen and establish monitoring of drug resistance for ARV, Anti TB and OI treatments
- Increase number of laboratory and non laboratory staff trained on diagnosis and surveillance of HIV/AIDS/STI and major OIs
- Implement and strengthen a national quality assurance scheme
- Develop mechanism for preventive maintenance

Targets

- Quality laboratory services achieved

Indicators

- Number of laboratories built, renovated and equipped
- % laboratories with required human resource
- % of labs accredited and certified
- % and type of lab equipment serviced according to SOPs of the equipments.

Key Implementers

- MOHSW, PORALG, Regional Engineers, RLO DLO, National HIV Reference Laboratory

Intervention Area 2: HIV Testing and Counselling (HTC) services

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, support and treatment programs and enables persons to confidently 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 is high suggesting a need to provide a wide variety of models of HTC including PITC. The existing public system cannot handle the high demand for this service. However the opportunities for support for HTC service provision from a number of partners exists.

Situation analysis

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

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.
- The National Counsellor Training Curriculum was reviewed to equip counsellor with necessary skills to provide services of recommended quality.
- National guidelines were developed
  - VCT
  - PITC
- 1,027 VCT sites had been established and some have been accredited.

Challenges

Aspects	**Challenges for HIV Testing and Counseling**
Availability	• Irregular supply of HIV test kits • Lack of appropriate infrastructure for HTC
Equitable access	• 10.5% of people aged 15 to 49 in urban areas had been tested in the past year against 3.4% in rural areas • A few trained counselors are in place compared to need, • Lack of skills to provide counselling to special groups, for example, the deaf and the children,
Acceptability	• Patients and clients visiting the health facilities might not ask for an HIV test because of fear and stigma • VCT services are often provided in small and poorly furnished rooms, which compromise privacy and confidentiality. • 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)
Quality	***Programme management*** • VCT services being partially included in the Council Comprehensive Health Plans (CCHPs), • Inadequate coordination of VCT services at all levels, • A weak referral and networking system • Inadequate supervision and support to counsellors, • Existence of different HTC standards ***Quality improvement (M&E and supportive supervision)*** • Poor/lack or incomplete and inconsistent reporting • Poor/lack of motivation • Heavy workload (some counsellors attending between 30 and 50 clients a day),

Emerging Issues

- Private for profit partners find it uneconomical to conduct HTC-related activities due to factors such as
  - Reduced costs for laboratory service without adequate compensation,
  - Transporting samples for quality control without compensation of costs involved,
  - Perceived additional work to their health care providers without remuneration and
  - Different reporting systems .

Equity, Gender and sustainability considerations

- Low and skewed coverage affecting rural and vulnerable populations
- More women are accessing the HTC. There is need to address male involvement.
- Inadequately negotiated exit plans by implementing agents without involving stakeholders at all levels

Strategic objective

To improve access to and use of quality HIV testing and counselling (HTC).

Strategies

- Strengthen existing and promote the establishment of HTC including services for children
- Develop and disseminate appropriate standard operating procedures (SOP) for HTC to all health and non health services.
- Strengthen and support HTC as an integral component of HIV/AIDS/STI/TB prevention, control and care
- Develop Guidelines
  - Comprehensive HTC Guidelines
  - Standard guidelines for peer educators and counselors

Targets

- Increased utilization of HTC services

Indicators

- % of people counselled and tested
- Number of HTC services established
- % of people tested referred to other services

Key Implementers

MOHSW, PORALG, RHMT, RACC, DACC , CHMT, CACC, ZTC

Intervention Area 3: IEC, BCC programming and Stigma Reduction Activities

A. *Behavioural Change Communication (BCC)*[1]

Preamble

Information and knowledge are necessary but not sufficient conditions for behavior change. Behavior 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.

[1] This section heavily borrows from FHI (2002), Behavioural Change and Communication for HIV/AIDS: A Strategic Framework

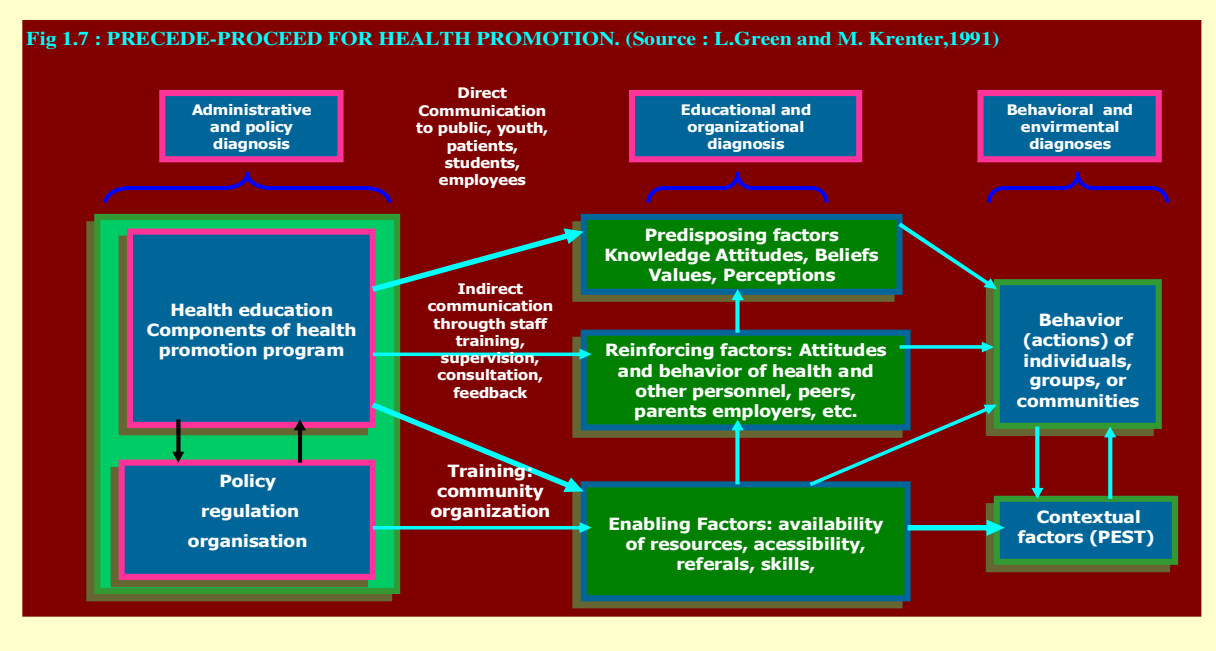


Figure 5: Precede-Proceed Model for Health Promotion

Situation analysis

Though the primary education net enrolment rate has improved to 90.5% in 2004 compared to 58.8% in 1990, illiteracy is a challenge especially among women. Overall, 25% of females and 20% of males have never been to school. Consequently the use of print media for sending HIV and AIDS messages to the general public will have a limited intended impact. Therefore, there is need to explore other innovative approaches in order to improve the impact of these messages on the target audiences including those who are unable to read and write.

Below are the achievements and challenges in the implementation of 2003-2006 plans:

Achievements

- 47% of men and 42% women used condoms in their last high risk sexual encounter
- Age at first sexual contact among female and male adolescent has increased by one year.
- Decline in proportion of people have sex with two or more partners (females from 8% to 5% and males from 27% to 20%)
- 15% of Tanzanians aged 16-49 years have ever been tested for HIV.

Challenges

Aspects	Challenges with BCC Programming
Availability	• Non inclusion of 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
Equitable access	• Current messages are not contextualised to local settings
Quality	• IEC has often resulted in the production of discrete communication materials. • No monitoring tools are available to establish effectiveness of the BCC programs inadequate linkages and coordination at all levels

B. Information Education and Communication (IEC)

Preamble

IEC materials are extremely important in transmitting messages that are crucial for creating awareness on HIV/AIDS/STIs prevention, care and treatment in the general population. These materials are some of the strategies used to promote behavioural change.

Achievements

- Awareness of HIV and AIDS in Tanzania is 99%
- Developed IEC materials
  - Print material: 100, 000 wall calendars, 200,000 brochures, 200,000 booklets, 100, 000 posters and 235,000 newsletters were produced.
  - Audio visual: TV and radio programs (film, spots & live talk shows)
  - There are some IEC materials produced by local NGOs.

IEC materials produced and distributed through print materials, TV and Radio programs covered the following topics:

• Stigma and discrimination • Nutrition • Anti retro viral treatment (ART) and Anti-retro-viral (ARV)	• Home Based Care • Voluntary Counseling and Testing • Care and Treatment Centers (CTC)	• Opportunistic infection • Tuberculosis and HIV • Adherence • Condom promotion HIV and AIDS situation in Tanzania	• Eligibility criteria for ARV treatment and the WHO Criteria • Prevention and Mother To Child Transmission program • Sexual Transmission Infections

Challenges

Aspects	**Challenges in IEC materials production**
Availability	• No locally specific communication strategies • No evaluation done on impact of different types media used for channelling messages to the public
Equitable access	• Centralized and inadequate production of IEC materials. • Regional media and other communication channels are rarely used
Quality	• The IEC materials are not sensitive to gender, economic dimensions political-legal context which influence sexual relations

C. Stigma and Discrimination

Preamble

Stigma is a mark of shame or discredit on a person or group. 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 is often felt by PLHIV, men who have sex with men (MSM), sex workers (SWs), 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**.**

Situation analysis
Below are achievements and challenges encountered when implementing 2003-2006 plan:-

Achievements
- Development of training materials on stigma and discrimination for health workers

Challenges

Aspects	Challenges in Stigma Reduction among HCW
Availability	• Stigma in health care setting is still exists • Stigma and discrimination prevent uptake of available services
Equitable access	• There is no clear law to minimize stigma and promote respect for Human Rights of persons living with HIV and AIDS

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

Strategic Objective
Contribute to the production of culturally sensitive IEC strategies that promote behaviour change and support stigma reduction

Strategies
- Promote production and distribution of cultural and context specific IEC materials at national, region, and district levels
- Produce training materials and train for/in reduction of stigma and discrimination among HCW
- Promote and monitor behavioural change and communication activities

Targets
- Culturally sensitive IEC strategies in place at all levels

Indicators
- % of regions and districts with culturally sensitive IEC materials

Key Implementers
- MOHSW, NGOs, CSO, Communication strategists, BCC Programmers, Academic institutions

Intervention Area 4: Condom promotion and use

Preamble
Condom promotion and use has been recognised to be an important aspect for prevention of sexual transmission of HIV and STIs in the general population. Their promotion and social marketing has been given high priority in the National Policy on HIV/AIDS. Despite the concerted efforts towards condom promotion, their wider acceptance and use is still a challenge. There are myths and misconceptions surrounding their use especially by some religious groups. There is a strong need to continue with rigorous efforts and/or campaigns to minimize these barriers towards condom use.

Situation analysis
Achievements
- 41.7% of youth aged 15-24 years used condom at their last higher risk sex.
- The total number of condoms supplied in 2006 was 85M for male and 0.75M for female.
- Distribution of condoms in health facilities
- Partnering with NGOs with community based agents

Challenges

Aspects	Challenges in Condom Distribution
Awareness	• In health facilities, condom use is usually only promoted for family planning and for STI patients
Acceptability	• 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, 2004)
Availability	• Condom outlets are limited in number and variety (health facilities, shops, youth clubs). • Specific outlets where young people can go without feeling embarrassed are few. • Condoms stock outs • While the cost of condoms is comparatively small, it is not affordable for certain sectors of the population.
Affordability	• 1/6 of male condoms are free, 5/6 are sold through social marketing (2005) @ TZS. 100 for a pack of 3. • Female condoms are relatively expensive @ TZS. 350 each
Equitable access	• 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. • Inadequate of condoms for vulnerable groups • Inadequate number of penile and pelvic models for condom demonstration

Equity, Gender and sustainability considerations

Accessibility of female condoms is a challenge primarily because of cost. Similarly distribution of condoms through health facilities has created access problems because such outlets are few and mainly used by the sick.

Strategic Objective

To contribute towards the promotion, distribution and use of condoms

Strategies

- Improve accessibility of condoms through private-public partnership and other alternative distribution outlets
- Train service providers for comprehensive information and education about condoms for HIV and STIs prevention

Targets

- Additional potential partners identified
- New outlets for condom distribution identified

Indicators

- No. of potential partners
- No. of new condoms outlets identified
- No. of HCW identified and trained
- No. of non health service providers identified and trained
- No. of functional alternative sources and outlets of free condoms in the health sector

Key implementers

- MOHSW, NGOs, CSOs

2.4. Thematic Area 4: 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 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 problems and other routine activities.

In order for the system to produce the expected outcomes (outputs, effects or impacts), 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 X. 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

<table>
<tr><th rowspan="2">Support Systems (Factory or base)</th><th rowspan="2">Inputs</th><th rowspan="2">Process or interventions, activities</th><th colspan="3">Outcomes</th></tr>
<tr><th>Outputs</th><th>Effects</th><th>Impacts</th></tr>
<tr><td>What inputs are the systems producing? (<u>Stewardship-leadership)</u></td><td>Resources <u>(Resources created by a functioning health or support system)</u></td><td>Tasks & responsibilities.

<u>(Delivering good services in all fairness)</u></td><td>Direct product of process

<u>(fairness)</u></td><td>Indirect effects on the clients

<u>(responsiveness</u></td><td>Wider community

<u>(fairness)</u></td></tr>
<tr><td rowspan="2">Programme management system</td><td>General strengthening of existing institutions</td><td rowspan="8"><u>Prevention</u>
PMTCT
Prev. Sexual Transmission
Health Care Settings
Vulnerable Populations
Positive Prevention & stigma

<u>Treatment, care and support</u>
Facility based (OIs, ART, TB/HIV)
Community based services

<u>Cross-cutting issues</u>
Laboratory
HIV Testing & Counselling
IEC,BCC & Stigma
Condom promotion
Operations research</td><td rowspan="8"></td><td rowspan="8">Changes in client knowledge, attitude, behaviour

<u>(good and healthy practices)</u></td><td rowspan="8">Reduced prevalence</td></tr>
<tr><td>Specific new infrastructure for HIV and AIDS programme expansion or scale up</td></tr>
<tr><td>Human resource for health system</td><td>Skilled HWs as a whole</td></tr>
<tr><td></td><td>Specific HWs hired</td></tr>
<tr><td>Procurement and supply management</td><td>System for all commodities</td></tr>
<tr><td></td><td>Specific drugs for HIV and AIDS</td></tr>
<tr><td>Quality improvement (Strategic information</td><td>General QI and strategic system for health sector</td></tr>
<tr><td></td><td>Specific M&E for HIV and AIDS programmes</td></tr>
<tr><td>Financing system</td><td>Health sector budget</td></tr>
<tr><td></td><td>Allocation to HIV and AIDS programmes</td></tr>
</table>

It is recognised that health systems constraints are at the root of the disappointing 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 (e.g. affordability, stigma) 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 and the way the service delivery is traditionally organized.

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 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 HIV and AIDS programmes will be addressed in this thematic section.

Intervention Area 1: National Strategic Planning and Programme Management

Preamble

As indicated in the introduction, that HIV and AIDS control programmes 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 sector units
- Options for delivering HIV interventions at community and household levels through partnerships and involvement of community-based agents and PLHIV.

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

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 the major commodities (i.e. ITNs, antimalarial medicines, diagnostics) at all levels;
- improving 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 is on going. Within the framework of the ongoing local government reforms, the district authorities have responsibilities for delivering health services. The responsibilities under MoHSW are technical guidance and evaluation of health services within the councils.

- *At regional, district and facility levels*
  - Existence RHMTs to provide technical support to DHMTs or CHMTs
  - There are autonomous District Health Boards under the PORALG.
  - Existence of most accessible primary health care services which include reproductive health services, STI, TB etc.
  - Existence of some services that are linked with each other, households and communities
    - For example reproductive and antenatal care services, serve as pivotal entry point for the delivery of interventions for the prevention and control of HIV in pregnant women and their children.

Planning, financing and quality improvement at all levels

- strategic plans exist
- resource mobilization is done including funding of HIV and AIDS interventions at all levels
- documents on modalities of channelling funds are available

Program mangement for specific HIV and AIDS interventions

- *At national level*

Direct management and planning for the HIV and AIDS programme is lodged in the National AIDS Control Programme (NACP). NACP has

- Developed and harmonized HIV related guidelines and capacity-building
- Been facilitating and providing technical assistance to other stakeholders at all levels.
- Established linkages with other departments of the MoHSW, other government agencies, NGOs, development partners, technical experts, and community resources.
- Been strengthening the capacity of Regional Teams to supervise, monitor, and assist the districts in planning and implementing interventions (RACCs)
- Partnerships and collaboration among relevant programmes or interventions which are a prerequisite for joint planning and implementation of effective integrated services have been enshrined in the NACP
- A plan for gradual initiation of ART beginning with referral hospitals and followed by regional and district hospitals
- Promoted scaling up of HIV and AIDS interventions include:
  - 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
  - Initiating HIV drug quality and adherence to antiretroviral treatment, including establishing drug resistance surveillance programmes.
  - Strengthening management of strategic information
  - Initiated integration of HIV and AIDS interventions into existing services

At district level and facility level

- Strengthened management capacity in HIV and AIDS programmes
  - Infrastructure improvements, including purchase and installation of essential equipments and supplies.
  - Coordinate partnerships between public, NGOs and private (for profit or not-for-profit) actors

- Coordinate partnerships between elements of HIV and AIDS programme

Challenges Specific to the General Health Sector Strategy

	Challenges for general health system strengthening
Availability	• Inadequate mainstreaming of HIV and AIDS into MoHSW departments at all levels • Difficulties in identifying HIV and AIDS as a priority despite prioritization guidelines. • Inadequate budget for HIV and AIDS interventions as part of MTEF at council level. • HIV and AIDS budget is subject to ease reallocation in competing priorities
Equitable access	• At district level financial resources are insufficient for routine operations • Budget allocations for HIV and AIDS at Councils levels does not trickles down to village levels..
Quality	• It is difficult to implement activities suggested by national guidelines and standards developed by NACP (MOHSW) at council (PORALG) level because they belong to different ministries.

Challenges Specific to scaling up of HIV and AIDS interventions

	Challenges for specific HIV and AIDS scale up
Availability	• Limited HIV and AIDS services in rural areas and vulnerable populations • Poor infrastructure and lack of space to accommodate the increasing numbers of patients
Equitable access	• NACP directly implementing some HIV and AIDS interventions at lower levels. • The creation of vertical structures that drain the limited resources within the health care delivery system
Quality	• Poor linkage of vertical programs leading to inefficiency and at times artificial shortages of drugs and other commodities 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 coordination between HIV and AIDS programmes and actors. • No proper feedback loop on quality improvements issues • Inadequate documentation and dissemination of best practices at all levels.

Equity, gender and sustainability considerations

- Combined 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 combined 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.

Strategic Objective

To strengthen managerial capacity and adoption of integrated approaches to planning, resource allocation and utilization for HIV and AIDS programming at all levels.

Strategies

- Explore various appropriate arrangements that would strengthen HIV and AIDS programme management at all levels
- Strengthen mechanisms for collaboration and joint integrated planning that will support HIV and AIDS service delivery.
- Strengthen and implement system of quality assurance of HIV and AIDS service delivery

Targets

- Innovative management arrangements established
- Strengthen mechanisms for collaboration and integrated planning
- Quality improvement in service delivery assured and institutionalised

Indicators

- Existence of an innovative management system
- Number of integrated plans done collaboratively
- Quality assurance scheme institutionalised

Key implementers

- MoHSW, PORALG, POSMS

Intervention area 2: Procurement and supply management Systems for HIV and AIDS medicines, laboratory supplies and other reagents

Preamble

Procurement and supply management of commodities, reagents and drugs is an important element for the HIV and AIDS response. 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. TFDA has in place a pharmacovigilance system for all medicines whereby health workers voluntarily 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.

Situation analysis

Achievements

General health reform activities at all levels

- Procurement and supply management Systems for HIV and AIDS medicines, laboratory supplies and other reagents
  - Presence of infrastructure for procurement, storage, supply and distribution
  - Established computerized inventory system covering the whole country
    Indent and Integrated Logistics Management (ILS) system for ordering supplies is in place
  - The system of allocating funds at MSD and HFs drawing supplies against them has worked relatively well over the years.
  - Mechanisms of selecting and reviewing medicines for the management of HIV and AIDS are in place through the National Essential Medicine List (NEMLIT).

- *Medicines Registration System*
  - Existence of mechanisms for fast tracking registration of HIV and AIDS medicines (ART)
  - Some of the registered ART are manufactured in country

- *Pharmacovigilance and quality assurance*
  - Monitoring Adverse Drug Reaction (ADR) for HIV and AIDS medicines has been established.
  - 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.

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 is a problem
  - Erratic supplies especially of HIV diagnostics tests and laboratory commodities
  - Improper utilization of maximum-minimum ordering concept leading adhoc order placement.
  - Inefficient fall back opportunities at facility level to use alternative methods of acquiring supplies when MSD has stock outs.
  - No central tool for commodity forecasting for HIV and AIDS commodities
  - No regular consumption feedback of HIV and AIDS commodities from end users
  - Poor coordination and communication about available stocks and demands from end users

- *Pharmacovigilance*
  - There is gross under reporting of ADR.
  - Poor coordination of the dissemination of ADR in terms of onward transmission of information and feedback

Equity, Gender and sustainability considerations

Rural areas have few supplies and other commodities. Procurement of supplies for HIV and AIDS is heavily donor dependent and so alternative funding sources should be sought.

Strategic objective

To have secure and functional procurement and supply management systems for HIV and AIDS medicines, diagnostics and other commodities

Strategies

- Strengthen procurement and supply management systems for HIV and AIDS medicines, diagnostics and other commodities
- Facilitate regular revision of NEMLIT and ensure availability of HIV and AIDS, STI and OIs related medicines.
- Strengthen a mechanism for tracking and providing feedback on ADR associated with HIV and AIDS, STI and OIs medication.

Targets

- Uninterrupted supply of STI, OIs, HIV and AIDS medicines, diagnostics and other commodities

Indicators

- Availability of supplies
- Revised NEMLIT
- Number of ADR reported

Key Implementers

- MoHSW, MSD, TFDA, Health facilities

Intervention area 3: Human Resource

Preamble

Implementation of the NMSF for HIV and AIDS for the year 2007 – 2012 will to a large extent depends on the number and quality of health workers at all levels in the health system. Tanzania has serious human resource crisis. The establishment requires 55,404 different cadres of HCW while only 21, 248 HCW (15,403 public and 5,845 private) are in place. The country has several important health policies whose implementation at all levels depend on only 38% of the required human resource.

Situational analysis

Below are the achievements and challenges with regard to human resources

Achievements

General health reform considerations

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

Specific HIV and AIDS human resource issues

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

Challenges

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

Human resource planning and management

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

Health workers training

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

Health workers retention schemes

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

Career development

- A large number of existing work-force need upgrading.
- Lack of opportunities for continued education for workers in rural areas.
- No mechanism for mentoring newly qualified HCW especially in rural areas.

Specific HIV and AIDS human resource issues

- Inadequate staffing at all levels
- Bureaucratic hiring procedures which affects availability of required human resources at all levels

- 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 shift policy.
  - 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).
- 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

Equity, Gender and sustainability considerations

- There are imbalances in the distribution of available human resources between rural and urban areas and type of health facilities 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 worsen 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.

Strategic objective

To build human capacity at all levels to manage and sustain a comprehensive health sector response

Strategies

- Strengthen the institution responsible for managing the response at national level with the optimum number of human resource mix
- Strengthen regions so that they have the human resource capacity for providing technical support to council and district levels
- Develop human resource training master plan for the staff required for managing the HIV and AIDS response

Targets

Strengthened human resource capacity required for managing the HIV and AIDS response

Indicators

Number of required human resource

Key implementers

- MoHSW, PORALG

Intervention area 4: Strategic information

Preamble

Tanzania AIDS commission (TACAIDS) is responsible for organisation and coordination of a national HIV/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 a health sector M&E plan. At the NACP there is a unit which 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 M&E unit is responsible for standardization of M&E of HIV and AIDS intervention through development of protocols, training materials, and supervision guide. It also develops, prints and distributes data collection tools to all facilities, train regional and district trainers as well as coordination of 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 AIDS chronic care, VCT, HBC and sexually transmitted infections.

Data is collected and summarised at service provision points using standardised forms and it flows to the district, regional and national levels where a national summary is generated and disseminated.

A) Monitoring & Evaluation system

Situation analysis

Below are the achievements and challenges with regard to M&E

Achievements

- Scaled up of surveillance of HIV/AIDS/STI from 10 region in 2003 to 21 regions in 2006
- Regular availability of HIV/AIDS/STI data for national and international use
- Implementation of HIV drug resistance surveillance
- Presence of agreed national monitoring systems for PMTCT, VCT, STIs and C&T.
- Data use at sub-national levels facilitated
- High involvement and support from partners.
- Availability of electronic database system.
- Integrated surveillance through Health Management Information System (HMIS) is ongoing in all districts

Challenges

Aspect	Challenges of monitoring and evaluation
Availability	• Inadequate coverage of all programs i.e effectiveness of IEC messages not done. • Inadequate capacity to intensify surveillance activities at district level. • No surveillance activities targeting the most-at-risk sub populations (MARPS)
Equitable access	• Need to scale up monitoring systems by paper and strengthening electronic database. • Lack of capacity (human resource, infrastructure, communication) for M&E at regional and district level
Quality	• Unclear flow of data and inefficient reporting – incomplete, under reporting • Doubtful use of data at all levels – • Lack of integrated supervision and adequate feedback at the facilities level to ensure improved quality of services. • Lack of harmonized M & E system (each program with a database and M & E) • Lack of information or documentation on best practices

Emerging issues:

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

Equity, Gender and sustainability considerations

There is need to strengthen M&E infrastructure in rural areas and small health facilities

Strategic objective

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

Strategies

- Develop a harmonised M&E framework that links different HIV and AIDS programmes
- Institute a supportive supervision which will assure the quality of data and services, data flow and use at all levels.

Targets

- Strengthened HIV and AIDS, STI and OIs monitoring and evaluation system

Indicators

- Availability of different types of survey data and reports

- Availability of annual, midterm and end-term reports

Key implementers

- MoHSW, Health care facilities –private and public, RACCs, DACCs, Academic and research institutions

B). Biological and behavioural surveillance on STI, HIV and AIDS

Situation analysis

Transmission of HIV is not limited to biological factors only. Human behaviour plays a significant role as far as HIV infection is concerned. Surveillance of the trend in HIV/AIDS needs to include both biological and behavioural aspects.

Achievements

- Sentinel surveillance of HIV and STI has been scaled up to all 21 regions
- A BSS has been conducted in collaboration with partners - in Kilimanjaro, Dodoma , Mtwara, Mbeya and Lindi.

Challenges

	Challenges
Availability	• The surveillance activities on the epidemic concerning biological and behavioural surveillance on STI and HIV are inadequate • Inadequate capacity to intensify surveillance activities at district level.
Equitable access	• No surveillance activities targeting the most-at-risk sub populations (MARPS) • Absence of testing facilities or infrastructure diagnosis of HIV in children ;
Quality	• Use of RPR test in STI surveillance pauses difficulties in remote areas due to the cold chain requirement

Emerging issue

- There is uncertainty on the relevance AIDS case reporting in the era of HIV care and treatment

Equity, Gender and sustainability considerations

Need to have information from hard to reach areas and vulnerable populations

Strategic objective

Strengthen and expand surveillance activities to monitor the dynamics of the epidemic and the impact of interventions.

Strategies

- Strengthen biological surveillance system for HIV and AIDS and STI
- Contribute to the strengthening of behavioural surveillance system for HIV and AIDS and STI

Targets

- STI, HIV and AIDS trends monitored

Indicators

- Number of biological surveillance surveys carried out

Key implementers

- MoHSW, Academic and research institutions, Reference Laboratories

C). HIV, STI and TB drugs resistance and drug side effects

Situation analysis

As the HIV and AIDS programmes 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 CTC, already there were clients on ARVs. These had used the ARVs without the benefit of any guidelines! Therefore, there is a fear of having a pool of people with resistant organisms.

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

Achievements

- There are internationally validated indicators for early identification of HIV drug resistance which the country has adopted.
- Tanzania has initiated and implemented surveillance of HIV drug resistance in one region.
- Activities on HIV drug resistance monitoring have been initiated
- Availability of pharmacovigilance system for all pharmaceutical products

Challenges

	Challenges
Availability	• Surveillance activities on the epidemic concerning drugs resistance monitoring (for STI and ARV) are inadequate. • There is no sufficient capacity to carry out STI drug susceptibility monitoring • Insufficient capacity to correctly identify and report on side effects of HIV drugs
Quality	• The staff in health facilities have not been empowered to carry out pharmacovigilance activities for ARVs

Equity, Gender and sustainability considerations

The cost involved in conducting regular surveillance activities and coverage of all facilities especially in rural areas is big**.**

Strategic objective

To strengthen and sustain HIV drug resistance activities, STI drug resistance monitoring and pharmacovigilance of HIV drugs

Strategies

- Conduct STI drug and TB drug susceptibility monitoring
  - Carry out HIV Drug resistance prevention activities,
  - HIV Drug resistance surveillance and monitoring

- Strengthen a mechanism for tracking and providing feedback on ADR associated with HIV and AIDS, STI and OIs medication.
  - Train health personnel on ARV adverse drug reactions (ADR)

Targets

- 4 Zonal laboratories to perform STI drug resistance testing
- 1 special hospital and 1 referral hospital perform TB drug resistance testing
- HIV drug resistance monitoring activities to be done in all health facilities providing ART services
- HIV drug resistance surveillance testing in 1 HIV Reference lab

Indicators

- Number of STI susceptibility monitoring done
- Number of HIV drug surveillance,
- Number of monitoring and reports of ADRs

Key Implementers

- MoHSW, Academic Inst, Reference and Zonal lab

Intervention area 4: Priority HIV and AIDS and STI research.

Preamble

Research is a support function in the health sector strategy. Research is expected to:

- provide the evidence- base needed to respond to the myriad of complex issues arising from the epidemic itself and the attempts to control it.
- facilitate the identification and understanding of determinants of HIV spread
- support the national response against HIV/ AIDS/ STI s and TB.

Situation analysis

The National Health Policy on HIV/AIDS has provisions for promoting and supporting multi-disciplinary operations research on HIV and AIDS. In order to produce information relevant for solving the complex questions existing in the epidemic operational research is considered.

At the present time there are some partners and agencies who are still interested in supporting operations research on HIV/AIDS.

Achievements

- The existence of two national institutions coordinating research namely, The National Institute for Medical Research, an institution within the MOHSW and The Tanzania Commission for Science and technology (COSTECH) and The Tanzania Commission for Science and Technology.
- Existence of" Research priorities on HIV/AIDS /STDs for the HIV and AIDS Health sector strategy".
    - The research gaps in biomedical Research, Surveillance and Epidemiological Research, Social Behavioural and Communications Research, Care and Treatment and Health Services Research, HIV/AIDS in children and infant Research, have been identified.
- Collaborative working initiatives between biomedical researchers and Traditional Healers have been implemented by partners especially the Institute of Traditional Medicine at the Muhimbili University College of Health Sciences (ITM-MUCHS).
- Most of the research that has been carried out falls within the priority area and only 25% is outside the priorities

Challenges

Aspects	**Challenges of Priority HIV and AIDS and STI research**
Availability	• Limited understanding of the nature and driving forces of the HIV epidemic at the sub-national level and among sub-populations • Paucity of research projects that address equity and gender dimensions in HIV and AIDS • Inadequate dissemination of the results of research locally, to policy makers , programmes managers and the beneficiaries • Very little has been done in the area of Paediatrics HIV/AIDS.
Equitable access	• Most funds provided by partners are committed to specific research areas. This tendency leaves little room for research managers to come up with new research agenda or research questions. In such a situation conducting and supporting operational research becomes difficult and little or no funds are set aside for it.
Quality	• Lack of research policy on HIV and AIDS • Weak research coordination within NACP thus limited capacity to co-ordinate

Aspects	Challenges of Priority HIV and AIDS and STI research
	research projects • studies and research conducted on HIV/AIDS related aspects have not been well coordinated and are not based on a nationally-agreed HIV research agenda • The mandate to clear research proposals has been fully transferred to NIMR and research findings may not necessarily trickle down to NACP..

Equity, Gender and sustainability considerations

- All studies have to respect equity in terms of urban and rural areas.

Strategic objective

To strengthen the national capacity for HIV and AIDS related research and development

Strategies

- Develop coordination and recording services for research on HIV and STI at one focal point
- Conduct Operation Research (OR) in HIV and AIDS and use evidence Programming and Policy making
- Ensure adequate dissemination of the findings

Targets

- The national response against HIV/AIDS/STIs is supported in the Country
- OR conducted in new HIV and AIDS research priority areas
- Innovative methods of mobilizing and involving individuals and communities in HIV/AIDS/STDs control are developed;

Indicators

- Studies are adapted to the needs felt at the local, district, regional and national level
- Research studies give the information needed in the field and allow adjusting programs and actions according to them;
- Information on STI and HIV are available: Prevention and Treatment are adjusted
- Identified new OR priority areas in HIV and AIDS research
- New OR conducted and relevant research outputs
- Disseminated and evidence of use of OR findings in HIV and AIDS programming and policy making

Key implementers

- MoHSW, COSTECH, NIMR, Academic and Research institutions

3.0. 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 in all its structures with the oversight of the MHOSW 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 NGOs, 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 Ministry of Health 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 of the ministry of Health. The Health Sector HIV/AIDS Strategy has defined the interventions to be implemented at district level. The implementation of these will be under the District Councils. 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 (CHMT) will be responsible for implementation, monitoring and evaluation of the district health sector based HIV/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 budgeted for funding under the MTEF of the President's Office, Regional- Administration and Local Government and also supported through the activities of the community based organizations.

In supporting districts to operationalize the Health Sector Strategy, the Ministry of Health will sub-contract some NGOs where they exist to help the districts incorporate the interventions suggested in the Health Sector Plan.

In addition to supporting the councils in planning, the Ministry of Health will continue to undertake quality assurance for the response at district level as well as advocating for the health sector HIV and AIDS response to the districts. It will play this role through its Zonal Training Centers, RHMTs, and CHMTs.
The following prioritization criteria is proposed to be used:

3.2. Priority Activities For Operationalization Of The Health Sector Strategy For HIV and AIDS

In order to demonstrate the stewardship role of MOHSW with regard to this health sector response, the following proposed activities will be conducted:

Table 9: Priority Activities For Operationalization HSHSP

ACTIVITIES	TARGETS	OUTPUTS	OUTCOMES	RESPONSIBLE	TIME LINE
Adopt the HSHSP 2008-2012		Meeting report HSHP Document	Stakeholders DP, Private adopt the new health sector strategy		2007
Launch the HSHSP			Strategy formally disseminated	PS-MOHSW	
Conduct an orientation meeting for NACP staff		Meeting report, Package for briefing MOSWH, Directors	The NACP staff understand their roles and be able to brief MOH Directors	NACP Manager	
Conduct a 2 days orientation meeting for MOH Directors		MOHSW, Directors ready to implement their part of the strategy	Concept of integration of HIV activities, role of NACP and role of MOH clarified	CMO, NACP staff and facilitators	
Orient MOH institution heads on HSHSP			Institutional heads clearly understand the role of the health sector and their roles	CMO, NACP staff and facilitators	

ACTIVITIES	TARGETS	OUTPUTS	OUTCOMES	RESPONSIBLE	TIME LINE
Build capacity of zonal training centers and other partners yet to be identified to backstop RHMTs and DHMTS			ZTCs and other partners capable of building RHMT and CHMTs capacities		
Conduct simultaneous zonal dissemination and orientation meetings for RHMTs and DHMTs			RMOs, DMOs and DACCs are able to integrate HIV activities in their DHPs	Zonal Training Centres, Partners, NACP staff, PORALG and resource people	
Disseminate to and orient non-health sectors			Non-health sectors understand their roles and agree on modality of collaborating with MOHSW	TACAIDS and NACP	

3.3. 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.

3.3.1. National level

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

- Strengthening of the institution responsible for HIV and AIDS response within the organizational structure of the Ministry of Health and Social Welfare.
    - This will involve a Ministry of Presidents Office Public Service Management (POPSM) approval and posting of additional staff with the requisite skills.
    - This would bring the institution to an optimum level in terms of the quality of its professional staff to enable it perform its role effectively.
    - In order for the national institution responsible for the HIV and AIDS response in the health sector to implement its diverse mandate effectively, it is proposed that a study be done 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 ;
- 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 PORLAG on the other hand.

3.3.2. 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. The ZTCs will assume responsibility for providing technical capacity strengthening to the RHMTs and CHMTs. The MOHSW should strengthen the capacity of the ZTCs and the identified NGOs in order for them to adequately play their assigned roles.

3.3.3. District level

At the district level the thrust will be towards strengthening the capacity of DMOs/CHMTs/District Heath Boards (DHBs), working within the statutory committees of the Councils, Wards and Villages to plan, and integrate HIV/AIDS interventions as part of their general health plans, and ultimately in their district 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. RHMTs, CHMTs and Health Boards will be oriented in their roles in moving forward the HIV and AIDS agenda within the health sector.

The health sector DACC should be the right hand person of the DMO and function more or less in the same specialised function as the NACP at the MOHSW. This is not intended to be an HIV and AIDS operational

plan for districts. Rather the activities and interventions proposed here are meant to constitute important inputs when districts formulate their plans. This plan and the activities/interventions it specifies for the district level do not do away with the need for districts to review the HIV and AIDS situation and response in their areas and to decide on the activities/interventions which provide a good match.

A fair amount of advocacy with the districts in favour of this plan will have to be undertaken, by NACP. This is in line with the spirit of decentralization and respect for districts' autonomy while giving them the information necessary for them to make informed choices. Some specific activities include at district level are shown below

3.3.4. Community level

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

3.4. Financing The Response

3.4.1. 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***

3.4.2. Resource Management

There is a continued emphasis on **mobilising** financial resources into 2008 -2012 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 actions and **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.

3.4.2.1 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
	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2007/08-2012
Scenario 1: 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**
Scenario 2: 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**
Scenario 3: 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.

3.4.2.2 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/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/AIDS spending	84.9	86.8	91.5	88.0	85.2
Total HIV/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/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/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 overal 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: Showing 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 allocaction 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 HIVand AIDS.

Given the findings discussed above the suggested allocation of the resources for the health sector response to HIV and AIDS is as shown 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%	**20%**
II	Treatment, Care, Support	50%	50%	50%	50%	50%	50%	**50%**
III	Cross cutting	15%	15%	15%	15%	15%	15%	**15%**
IV	Health system Strengthening	15%	15%	15%	15%	15%	15%	**15%**

3.4.2.3. 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 as 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.

3.4.5. 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 current Health sector strategy for HIV and AIDS will be operating within the existing government health infrastructure. This provides administration and management of the plan in an integrated manner.

3.4.5.1. 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 has already established NACP to oversee the implementation of the Strategy.

3.4.5.2. 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 as wide a participation of community members particularly traditional groups who may not have a voice such as women and children orphaned and made vulnerable by HIV/AIDS. Partnerships between different sector both public and private, 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.

3.4.5.3. Financial Sustainability

National level

The government of Tanzania has committed to long-term funding to support the implementation of the Health Sector strategy for HIV and AIDS 2008-2012. For instance it is planned that the Government's own

financial contribution to HIV and AIDS activities are expected to 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 the Community Funds, communities will learn how to mobilize resources within the community. 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.

3.5. Monitoring and Evaluation of The Plan

3.5.1. Objectives

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

- To generate information for decision for the management and relevant stakeholders on the progress of implementation of HSHSP 2008-2012
- To assess achievement of objectives
- To make recommendations on strategies to improve designs and future performance

3.5.2. M&E 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 Monitoring and Evaluation Sub-Committee will be responsible for providing advice on all matters concerning monitoring and evaluation. The following describe the main tools and approaches that will be applied in the monitoring and evaluation of the implementation of the HSHSP 2008-2012

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 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 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 the DP, other Government ministries and other key stakeholders.

DPs 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 M&E Sub Committee.

Evaluation

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 2012. MOHSW will organise a joint mid-term review (MTR) before the end of the third year of HSHSP. An independent external evaluation will be undertaken in the final year of HSHSP. 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/possible, 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 need be.

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

3.5.3. M&E Implementation role 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 Service 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 level, the RHMT and DHMT respectively will be responsible.

3.5.4. Documentation of Lessons Learned

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

4.0.SECTION FOUR:

ANNEXES

ANNEX 1: SELECTED UNIT COSTS FROM MKUKUTA BASED MDGS COSTINGS FOR THE HEALTH SUB-SECTOR

"Mkukuta Based MDGs Costings for the Health Sub-sector" Unit costs used for HIV and AIDS interventions

Subdivision or Thematic area	Intervention, strategy or health service	Activity	Cost component	Cost per case/Unit costs (US$)	Percentage of Reference in need
Prevention	Reduction of stigma and discrimination of PLHIV	Awareness creation and sensitisation of general public through media	Radio and TV programmes	0.45	10% of total population
	Promotion of safer Sex	Procurement and distribution of male condoms	Supplies	1.15	60% of sexually active pop.
		Procurement and distribution of female condoms	Supplies		
	VCT	Procurement and distribution of reagents and other medical supplies	Reagents and supplies to test sero positive	4.57	Fixed quantity of 600,000
			Reagents and supplies to test sero negative	6.18	Fixed quantity of 60,000
		Training of counsellors	Supplies and allowances	2033.33	Fixed quantity of 210
	Safe blood	Safe blood transmission	Supplies	14.53	
	PMTCT	PMTCT	Drugs and supplies	54.93	Number of births 8.80%
		Prevention of Opthalmia Neonatorum	Drugs and supplies	0.02	Number of births 100%
		Treatment of Neonatal Complications (LBW, Sepsis, etc)	Drugs and supplies	26.05	Number of births 10.00%
	Prevention of sexual transmission (STIs,	Chlamydia	Drugs and supplies	0.97	1.23% of Women in reproductive age
		Gonorrhoea	Drugs and supplies	0.56	6.29% of Women in reproductive age
		Syphilis	Drugs and supplies	2.77	5.86% of Women in reproductive age
		Trichomoniasis	Drugs and supplies	0.63	11.34% of Women in reproductive age
		Pelvic inflammatory disease	Drugs and supplies	0.64	2.53% of Women in reproductive age
		HSV 2			
Treatment, care and support	Care and treatment	Provide Antiretroviral drugs to adults, 1st line	Drugs and supplies	370.52	Fixed quantity 88,200
		Provide Antiretroviral drugs to adults, 2nd line	Drugs and supplies	3661.54	Fixed quantity 1,800
		Provide Antiretroviral drugs to children, 1st line	Drugs and supplies	955.80	Fixed quantity 800
		Provide Antiretroviral drugs to children, 2nd line	Drugs and supplies	5576.68	Fixed quantity 200

"Mkukuta Based MDGs Costings for the Health Sub-sector" –Unit Costs for Health system

Subdivision or Thematic area	Intervention, strategy or health service	Activity	Cost component	Cost per case/Unit costs (US$)	Percentage of existing health facilities requiring rehabilitation
Health facilities	Strengthening health infrastructure (Dispensary, Health centre, District , Regional and Ref. hospitals)	Construction Rehabilitation Upgrading Renewal Operation and maintenance	Buildings Instruments and equipment Furniture Communication devices and IT Transport Electricity and water		Buildings 50% Instruments and equipment 100% Furniture 100% Communication 100% Transport 100%
Human resources	Capacity building for human resources for health to have the correct skill mix in place (quantity and quality wise)	Hiring and retention	Pay package		
		Relocation	Allowances		
		In service training	School fee/fare/allowance		
		Attendance of international meetings	Allowance/fare		
	Strengthen management capacity	Hiring and retention	Pay package		
		Relocation	Allowance		
		In service training	Teaching mat./fare/fee/allowance		
		Linking health system with the community	Allowance/fare		
		Provision of equipment	IT/furniture		
	Strengthening MOHSW training centres (including zonal training centres)	Rehabilitation Installation of IT Hiring and retention In service training Operations and maintenance	Buildings Medical equipment Teaching equipment Furniture IT Pay package Utilities Communication		
	Capacity building for health systems research	Provision of funds Provision of technical assistance	Per diem		
	Management at the Ministry of Health and Social Welfare	All			

Unit costs for construction of dispensary, health centres, district hospitals, regional and referral hospitals

Component	Cost				
	Dispensary	**Health Centres**	**District Hospitals**	**Regional Hospitals**	**Referral Hospitals**
Building	$40,000	$180,000	$860,000	$1,400,000	$2,800,000
Medical Equipment and Instruments	$21,662	$57,582	$303,471	$900,000	$1,800,000
Furniture	$5,270	$20,020	$98,542		
Communication Devices and IT	$4,000	$4,000	$10,200		
Transport	$10,140	$30,280	$250,420		
Total Unit Cost for Construction	$81,072	$291,882	$1,522,633	$2,300,000	$4,600,000

Source: Mkukuta Based MDGs Costing for Health Sub-sector

Unit cost for rehabilitation and operation and maintenance (per year)			**The unit cost for upgrading and renewal dispensaries, health centers and district hospitals**		
	Health Facility Rehabilitation (in % of unit cost for construction)	Yearly cost for operation and maintenance (in % of unit cost for construction)	Health Facility	Unit Cost for upgrading	Unit cost for renewal
Dispensary	50%	5%	Dispensary → Health Centre	210,810	41,072
Health Centre	50%	5%	Health Centre → District Hospital	1,230,751	332,022
District Hospital	50%	5%	District Hospital → Regional Hospital	777,367	662,633
Regional Hospital	50%	5%			900,000
Referral Hospital	50%	5%			1,800,000

Unit cost of in-service training and of attendance of int. meetings by specialists

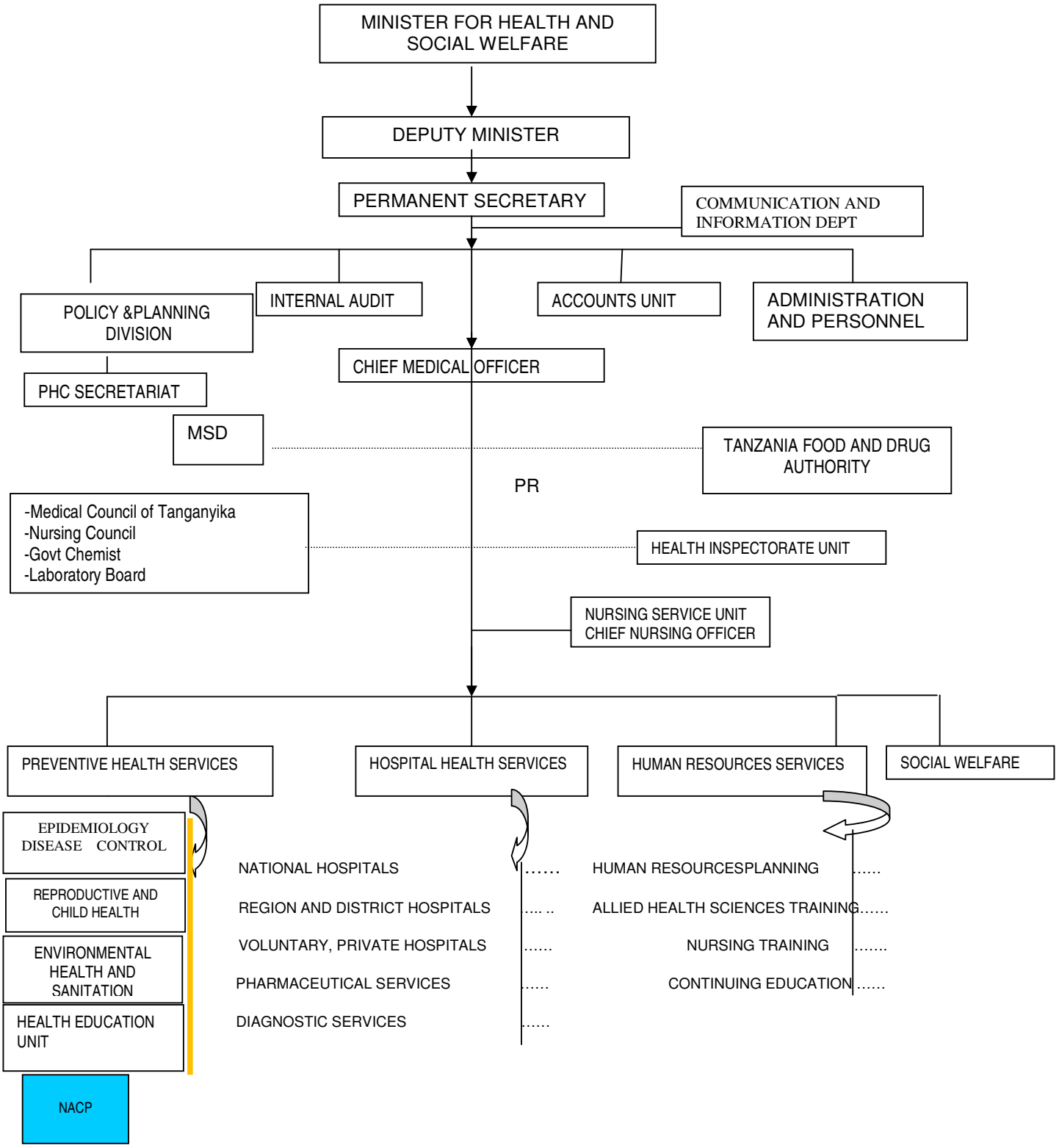
Activity	Cost Component	Unit Cost (cost per participant)
In-service-training (higher learning institutions, short course) of specialists	school fees per participant	500
	fare per participant	50
	Allowance	350
In-service-training (higher learning institutions, long course) of doctors / specializing / upgrading	school fees per participant	10,000
	fare per participant	150
	Allowance	2,400
In-service-training (higher learning institutions, short course) of doctors	Fees	1,500
	Allowance	560
In-service-training (long-course, in MoH institutions as above) of nurses (upgrading	training cost per participant	2,500
	allowance per participant	1,200
	fare per participant	150
In-service-training (short-course(on-the-job training, in MoH institutions as above) of nurses	Accommodation per participant	600
	training cost per participant	800
	allowance per participant	420
In-service-training (long-course, in MoH institutions as above) of technicians	fare per participant	50
	training cost per participant	2,500
	allowance per participant	1,200
In-service-training (long-course, in MoH institutions as above) of other medical staff	fare per participant	50
	training cost per participant	2,500
	allowance per participant	1,200
Attendance of international meetings by specialists	Allowance	1,000
	fare per participant	1,500
On-the-job training (esp. IT) of other technical staff	consultancy fees	300
	per diem	30

ANNEX 2: FRAMEWORK FOR TARGET SETTING OF SELECTED IMPACT AND OUTCOME INDICATORS

Ref No.	INDICATORS	SEX	BASE-LINE	TARGETS					
				2008	2009	2010	2011	2012	Data source/ resp. ins/depart.
GOAL:									
IMPACT INDICATORS									
Percent of infants born to HIV infected mothers who become infected		Males							
		Females							
		Total							
Percent of adults and children with HIV still alive 12 months after initiation of antiretroviral therapy									
Percent of 15-24 year olds who are HIV positive									
Percent of adults aged 15-59 who are HIV infected									
Percent of adults aged 15-59 who are HIV infected		Males							
		Females							
		Total							
OUTCOME INDICATORS									
THEME 1: Prevention of HIV									
Prevent Sexual Transmission of HIV :		Males							
		Females							
		Total							
% of 15-19 year olds who report being sexually active		Males							
		Females							
		Total							
% of 15-24 year olds who report being sexually active		Males							
		Females							
		Total							
% of 15-24yr-olds who both correctly identify ways of preventing sexual transmission of HIV & reject major misconceptions of HIV transmission		Males							
		Females							
		Total							
Median age at first sex		Males							
		Females							
		Total							
% of unmarried respondents who report at least 2 sexual partners in the past 12 months		Males							
		Females							
		Total							
% of married respondents who report at least 2 sexual non-regular partners in the past 12 months		Males							
		Females							
		Total							
STI Treatment: % of women and men with STIs at health care facilities who are appropriately diagnosed, treated and counselled according to national guidelines		Males							
		Females							
		Total							
% of facilities with observed STI treatment protocols									
PMTCT % of HIV positive pregnant women receiving a complete course of ARV prophylaxis to reduce MTCT									

THEME 2: Treatment , Care and Support							
CHBC: % of adults aged 18-59 who have been chronically ill for 3 or more months during the past 12 months and, including those ill for 3 or more months before death whose households have received, free user charges and basic external support in caring for the chronically ill person	Males						
	Females						
	Total						
ART: % of persons with advanced HIV infection receiving ARV therapy **(adults)**	Males						
	Females						
	Total						
% of persons with advanced HIV infection receiving ARV therapy (**children) or Proportion of children on ART**	Females						
	Males						
	Total						
THEME 3: Cross-cutting							
VCT: % of adult population (15-49 yrs.) counselled and tested for HIV and received their test results.	Males						
	Females						
	Total						
% of 15-49 year olds using condoms during the last sexual act with non regular sexual partner	Males						
	Females						
	Total						
THEME 4: Health System Strengthening							
Funding allocation							
Number of staff according to establishment							

ANNEX 3: ORGANOGRAM OF MINSTRY OF HEALTH AND SOCIAL WELFARE (MOHSW)



ANNEX 4: MATRICES TO THE HSHSP 2008-2012

4.1. THEMATIC AREA 1: PREVENTION

Intervention area 1: Prevention of Mother To Child Transmission of HIV (PMTCT)
Strategic objective: Reduce the transmission of HIV from mothers to their children, during pregnancy and/or breast feeding and ensure entry into care and treatment for mother and baby so as to increase the percent of HIV positive pregnant women who receive ARV

Strategy 1: Advocate for and increase awareness and commitment to addressing PMTCT and paediatric HIV prevention, care, treatment and support among key stakeholders at all levels							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop national communication strategy for PMTCT and Paediatric care	Increase awareness on PMTCT	No. of different people sensitized	Reports	MOHSW NACP			
Sensitive policy makers, partners and communities at all levels							
Sensitize on importance of nutrition							
Strategy 2: Strengthen the provision of PMTCT in all sectors and to all levels of health facilities							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Decentralize responsibility of PMTCT planning and implementation to the Zonal, Regional and District levels	Capacity for PMTCT services built and implemented at all levels	Number of facilities implementing PMTCT services	Reports	MOHSW NACP PORALG RHMT CHMT Health facilities			
Refine targets for PMTCT							
Develop and review tools and guidelines for PMTCT and referral							
Define package of services at different levels of health care and different capacities and skills							
Define criteria for and assess facility readiness for PMTCT							
Strategy 3: Improve delivery of community PMTCT and referral of HIV-infected women, their children and families							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Mobilize and build capacity of community structures	Capacity for PMTCT services in the community built and implemented	No. of communities trained	Report	MOHSW NACP PORALG TACAIDS			
Refine standard of package of intervention							
Establish district wide systems linking PMTC services to community based providers							
Build capacity of PLHIV to support PMTCT							
Promote male friendly HIV services delivery models within RCH and other SRH services							

Strategy 4: Improve programme management, coordination and supervision for PMTCT programme activities at all levels							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Integrate PMTCT programme planning with RCH, TB and other programs	PMTCT services integrated into all other programs	No of programs integrated		MOHSW NACP PORALG RHMT DHMT Health facilities			
Coordinate PMTCT programmes with other health programs using existing and new opportunities							
Redefine role of national, regional and district health management teams to supervise PMTCT services							
Strengthen capacity for forecasting for PMTCT commodities							
Institutionalize quarterly reporting of PMTCT services							

Intervention Area 2a: Prevention of Sexual Transmission of HIV
Strategic Objective To expand quality STIs services and enhance appropriate utilization of services

Strategy 1: To expand quality STIs services to all health facilities in districts in the country and make services youth friendly							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Establish quality STI services in all of the districts of the county	% of patients with STIs at selected health care facilities who are appropriately diagnosed and treated according to national guidelines increased from 67% to 70%	% clients served by public, FBOs and private health facilities providing STI care	Reports Activity implementation reports	NACP RHMT CHMT RCH Unit MSD Private sector Zonal Referral Hospitals			
Establish user friendly youth reproductive health services in all regions of the country		Number of youth friendly reproductive health clinics established					
Make quality STI services available to specific vulnerable groups like Sex Workers, IDUs and MSM	40% of FBOs and NGOs including private health facilities also provided with STIs services	Number of special STI clinics for vulnerable groups established					
Assure constant /uninterrupted supplies of STI drugs and supplies in public and private health facilities	Public and private health facilities managing STIs able to get uninterrupted supply of STI drugs and supplies	% clients served by public, FBOs and private health facilities providing STI care that have a current supply of essential STI drugs and report no stock-outs lasting longer than one week in the last 12 months					

Strategy 2: Guideline, curriculum development and training for STI prevention and management at facility and community levels							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Training and re-training of all HCWs on public and private sectors	STI case management by syndromic approach integrated into the curricula of pre-service training medical institutions including universities, in-service as well at community levels	Number of STI TOTs trained					
Revise national STI guidelines and training curricula according to WHO guidelines.							
Develop, print and distribute the new STI guideline and curriculum		Number of districts with STI guidelines					
Conduct training of regional STI TOTs on planning guidelines							
Conduct training of all CHMTs on comprehensive STI planning		Number of Councillors & CHMT sensitized					
Improve coordination of STI at all levels							
		Number of districts implementing the communication package					

Intervention Area 2b: Prevention of Sexual Transmission of HIV
Strategic Objective: To promote safe, socio-culturally accepted male circumcision as a preventive measure against HIV transmission

Strategy 1: Conduct operational research by rapid assessments to determine key providers, assess acceptability, estimate costs and evaluate the quality of safe male circumcision services provided by health care workers.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop operational research protocol Implement the protocol in sampled regions	Promote awareness of male circumcision where traditionally this is not done	Proportion of male children and youth circumcised	Reports	NACP NIMR	JIPEGO		
Disseminate findings							
Develop national policy guidelines							
Design and implement communication strategies	Communication strategies in place						
Develop and implement a national plan including monitoring and evaluation	Monitoring and evaluation in place						
Develop tools for training and supervision of safe male circumcision in the country	Tools for training and supervision in place						
Phased implementation of male circumcision	Phased implementation initiated						

Intervention Area 3a: Prevention of transmission in health-care settings
Strategic objective: Reduce the risk of HIV transmission through blood and blood products

Strategy 1: Strengthen the distribution capacity of NBTS and regional distribution units							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Scale up the use of NBTS services to district level	Increased low risk blood donations in public and private hospitals	Number of NBTS distribution units established		MoHSW Tanzania Red Cross	CDC WHO AABB Bergen University		
Create awareness on NBTS among key players of blood transfusion:							
Disseminate and ensure compliance of public and private hospitals with National Blood Safety guidelines		% of blood units transfused that have been screened for HIV, syphilis and hepatitis according to National guidelines					
Develop curricula, materials and train of health care staff on NBTS							
Ensure availability of quality and adequate supply of reagents	All donor blood in public and private hospitals to be screened for HIV, syphilis and hepatitis before transfusion.						
Strategy 2: Promote community awareness for blood donation							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop and disseminate IEC and BCC materials for community mobilization	Increased low risk blood donations in public and private hospitals	% donations from voluntary donor					
Recruit low-risk-non-remunerated donors							
Educate donors and promote voluntary blood donation with involvement of cultural groups in community campaigns							
Strategy 3: Establish an efficient and appropriate M&E system and a Quality Assurance scheme for NBTS							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Review current NBTS M&E system	Strengthen Monitoring and Evaluation	% of NBTS centres & health facilities transfusing blood monitored					
Develop M&E tool							
Establish Quality Assurance scheme for NBTS	All NBTS branches enrolled in External Quality Assurance Schemes	Annual frequency of participation in EQAS					

Intervention Area 3b: Workplace Interventions
Strategic Objective: To Implement Comprehensive Workplace Interventions In The Health Sector Focused On The Prevention, Care, Treatment And Support Of Employees And Their Families

Strategy 1: Scaling up of Health Sector workplace HIV interventions							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop Health Sector workplace HIV interventions advocacy package material	Comprehensive Health Sector Workplace HIV intervention implemented in all levels	Number of health facilities with IPC-IS and PEP guidelines	Reports	MoHSW Health care facilities HCW CHMT Traditional healers Trade unions	WHO ILO CDC JSI UNFPA		
Scale up training of health workers on Infection Prevention & Control and Injection Safety	All health care facilities with English and Kiswahili versions of IPC-IS and PEP guidelines						
	All health facilities have record system for exposures to contaminated materials						
	All health care facilities have appropriate disposal methods for medical waste	Number of regional and district hospitals that have functional incinerators					
	All health facilities equipped with appropriate personal protective gear						
Expand the availability of PEP kit to all health facilities and ensure implementation of guidelines	All health facilities have PEP kits	Number of HCW who had sharp injuries that have used PEP					
		Number of facilities with records for sharp injuries					
Provide information at community level on the risks of HIV through traditional practices and involve practitioners in reducing the risks							

Intervention Area 4a: Vulnerable Population Groups: Targeted Youth Programmes
Strategic Objective: To develop effective interventions to reduce HIV infection among youth

Strategy 1: Develop effective communication packages for HIV risk reduction interventions targeting youth							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Conduct evidence-based advocacy to policy/decision makers, planners, community and other key sectors	Enhanced capacity of partners especially CSOs to implement IEC and BCC on SRH/HIV targeting young people.	Number of consultative meetings	Reports	NACP, Drug Control Commission MOHSW, TACAIDS, NGOs, CBOs, CHMT	WHO, CDC, Red Society PSI & T-MARC other partners		
Conduct evidence-based advocacy to regions down to lower levels							
Develop and avail training materials for HIV prevention in ASRH		% of regions and districts with IEC and BCC interventions targeting youth integrated in their plans					
Printing and dissemination of SRH and HIV training materials							
Build capacity of partners especially CSOs to implement IEC and BCC on SRH/HIV targeting young people.							

Strategy 2: Establish linkage between HIV and AIDS and ASRH services.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Conduct Training of Trainers (TOT) on SRH/HIV friendly service provision	Joint planning of SRH/HIV interventions targeting young people with key stakeholders at central, regional/district and community levels	Number of SRH/HIV training tools disseminated					
Conduct orientation/training for health service providers on SRH/HIV friendly services provision							
Advocate for the District Council to integrate in District Multisectoral HIV/AIDS plans peer education and peer counselors							
Formalize the ASRH coordination group.							
Link the ASRH subgroup with HIV prevention task forces, National RCHS working group and other related SWAPs Working group		Number of members of the national ASRH coordinating group					
Conduct quarterly and annual meetings on ASRH/HIV/AIDS		Number of meetings on ASRH/HIV and AIDS					

Intervention Area 4b: Preventive Interventions for Vulnerable Population Groups (CSW, MSM, Mobile Workers, Prisoners, IDUs)
Strategic Objective: To Contribute To The Reduction Of Risk Of HIV Infection Among Vulnerable Population Groups.

Strategy 1: Develop effective HIV risk reduction interventions for vulnerable populations including IDUs							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop programmes to promote increased access to services and interventions (IEC, condom access, peer education, friendly VCT and STIs services, care and support, impact mitigation) for these groups	National policy guidelines on vulnerable population groups developed	Number of districts and partners receiving national policy guidelines	Report containing detailed information on Vulnerable Population groups Reports on activities implemented	NACP, Drug Control Commission MOHSW, TACAIDS, NGOs, CBOs, CHMT	WHO, CDC, other partners The Tanzania Red Society PSI T-MARC Salvation Army		
	Introduce and expand HIV interventions and rehabilitation services	Number of rehabilitation and psychosocial centres established and strengthened					
	Harm reduction for injecting drug users, focusing on risk reduction information and education	% injecting drug users reporting sharing of injecting equipment					
		% of drug injectors using condoms at last sex					
Study social-cultural milieus and determinants for each specific group and develop interventions in a participatory approach (Conduct specific studies with highest respect for ethical issues and human rights of the researched group)	Existing data on vulnerable groups identified Mechanism/ coordination system will be developed	Number of print materials printed and distributed to appropriate population groups					
Strategy 2: Establish partnership with appropriate stakeholders							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Support NGOs, CBOs and other agencies	Contribute to the reduction of new HIV infections among the vulnerable populations Joint planning and implementation of HIV interventions targeting vulnerable groups with key stakeholders at all levels	Number of skilled support groups established	Reports	Drug Control Commissio n MOHSW,			
Lobby for de-criminalization							
Establish partnership with NGOs and self-help groups in order to support their work and provide quality back-up medical services							
Create a conducive environment for HIV/AIDS prevention and control, including the general increase of tolerance for behavior							

Intervention Area 5: Positive Prevention
Strategic Objective: To reduce the risk of PLHIV getting re-infection or infecting others from HIV

Strategy 1: Encourage meaningful involvement of PLHIV at all level							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Lobby for development of operational guidelines, legal review and implementation of MIPA	National guidelines for greater and meaningful involvement of PLHIV (MIPA) developed	MIPA guidelines in place	Reports on activities implemented	NACP PLHA groups NGOs SHDEPHA+ WAMATA TANOPHA	TACAIDS WHO, FHI, CHAI, JICA, CDC DP		
		% of PHLAs and other actors with National MIPA guidelines					
	Greater and meaningful involvement of people living with HIV/AIDS in national and community based programmes and activities	PLHIV involvement in community based HIV interventions					
		Community outreach and mobilization done					
Establish BCC interventions aimed to reduce discriminatory behaviour against PLHIV, with a particular focus on youth and young children	Targeted BCC interventions developed and implemented						

Strategy 2: Support individually focused health promotion to enhance disclosure of HIV positive status							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Promote disclosure among PLHIV	Public disclosure of HIV sero-status by PLHIV	Number of post test support clubs established	Reports	NACP PLHA groups NGOs SHDEPHA+ WAMATA TANOPHA			
Promote VCT and link to appropriate follow up services							
Provide Post test and ongoing counseling for HIV positive		% of PHLHIVs participating in positive prevention activities					
Provide counseling for sero discordant couples							

4.2. THEMATIC AREA 2: CARE, TREATMENT AND SUPPORT

Intervention area 1: Facility-based Care, Treatment and Support
Strategic Objective 1: To Strengthen And Scale Up Implementation Of Comprehensive Care And Treatment Strategies In Public And Private Facilities.

Strategy 1: Strengthen capacity for implementing Comprehensive Care, Treatment and Support							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen capacity of Care, Treatment and Support at NACP by recruiting additional staff.	All health facilities providing comprehensive package of care	Number of private facilities providing ART services Policy for PITC developed	Quarterly and annual reports	NACP Private and Public Health Facilities, MoHSW			Conducive policy needed for the success of this initiative Conducive arrangement needed for the success of this initiative
Develop capacity of private and voluntary hospitals to enable them to provide ART.							
Establish an arrangement with private health institutions spelling out incentives and regulations on ART delivery in these institutions.							
Provide guidance and technical support to prison authorities to establish HIV Care and Treatment clinics in correctional institutions.							
Develop policy for provider initiated testing and counseling (PITC) for health care seekers.							
Establish an arrangement between MoHSW and Private institutions							

Strategy 2: Increasing access to and delivery of ART for Adults							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Sensitize health workers and communities and create ART literacy	All health centers providing comprehensive package of care and treatment. 60% of all eligible persons put on ART 20% of patients on treatment are children All health care providers trained in HIV and AIDS care and treatment	Percentage of people eligible for ART receiving treatment Number of health centers delivering ART services	Quarterly and annual reports	Community councils MoHSW Health officials NACP			
Improve and maintain infrastructure							
Strengthen district laboratories and develop specimen referral mechanisms.							
Conduct accreditation exercises in the selected health facilities that provide ART.							
Scale up the provision of ART in existing CTC and scale out to all health facilities							
Increase male enrolment at facilities							
Develop mechanisms for patient follow-up to ensure adherence and support							

Strategy 3: Increase access to and strengthen paediatric care.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen the paediatrics section of the NACP Care and Treatment unit by recruiting staff. Establish a coordination committee at the MoHSW Adapt and disseminate guidelines for provider initiated testing and counseling Adapt and disseminate guidelines on integration of paediatric HIV care, IMCI, PMTCT and MCH services and linkage to EPI, nutrition, general health care and community HBC programs Train national, regional and district trainers on paediatric counselling, care, treatment and support Adapt and disseminate curriculum for basic paediatric HIV counseling, Care, Treatment and Support Introduce and scale up HIV and AIDS Care and Treatment services including ART at PMTCT sites in referral and regional hospitals with clinical capacity	20% of patients on treatment are children All health care providers trained in Paediatric HIV and AIDS care and treatment	Number of health centers delivering ART services for both adults and children % of eligible children receiving antiretroviral therapy Number of health care facilities providing PITC Number and percentage of PMTCT sites providing antiretroviral treatment		NACP Health facilities			

Strategy 4: Provide care, including OI management to PLHIV							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Ensure integration of cotrimoxazole prophylaxis into MCH and TB/HIV services. Ensure regular supply of drugs for prophylaxis and management of OIs in district and health centers using district funds. Provide nutrition counseling, support and assessment and refer/use wrap around funds to secure nutritional support	All health centers providing comprehensive package of care and treatment All health care providers trained in HIV and AIDS care and treatment	Number of health facilities offering cotrimoxazole prophylaxis Number of HIV exposed infants given cotrimoxazole up to 18 months	Quarterly and Annual reports	NACP MoHSW Health Facilities			

Strategic objective 2: To improve the quality of care for both PLHIV and TB patients by strengthening the collaboration between these programs.

Strategy 1: To establish and implement mechanisms for collaboration between TB, HIV and AIDS related services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen and support the joint NACP/NTLP committees at all levels Finalize development of TB/HIV policy and disseminate documents Adapt TB/HIV integration and TB/HIV co-morbidity management guidelines Strengthen monitoring and evaluation of TB/HIV collaborative activities Identify and adapt best practices from the TB/Leprosy Control program	All CTCs screening PLHIV for TB All TB clinics screening patients for HIV co-infection All TB clinics at regional and district hospitals providing HIV care and ART	Policy on TB/HIV integration developed and disseminated Number of districts with TB/HIV coordinating committees TB/HIV co-morbidity management guidelines adapted		NACP NTLP			
Strategy 2: To strengthen the capacity of health care workers to ensure adequate and appropriate screening for prophylaxis or early treatment of TB in PLHIV							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Training health care workers in both TB and HIV care services on collaboration TB/HIV activities and TB/HIV co-morbidity management at regional and district level Establish a mentorship program to maintain the quality of TB/HIV care	All CTCs screening PLHIV for TB All TB clinics screening patients for HIV co-infection	Health care workers trained in managing TB/HIV co-morbidity					
Strategy 3: To reduce the burden of HIV in TB patients							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen provider initiated testing and counseling at TB treatment sites Train HCW in HIV testing and counseling Scale up cotrimoxazole preventive therapy f Scale up ART services to TB patients Scale up community support for DOTS Introduce HIV clinical staging and ART Surveillance of tuberculosis as a manifestation of Immune Reconstitution Syndrome	All CTCs screening PLHIV for TB All TB clinics screen patients for HIV co-infection All TB clinics at regional and district hospitals providing HIV care and ART	% of TB patients tested for HIV % of TB patients with HIV co-infection that are treated for TB and HIV Percentage of HIV infected patients screened for TB					

Strategy 4: To reduce the burden of TB in PLHIV							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Scale up and support TB screening at the care and treatment clinics Sensitize HBC workers and PLHIV support groups to promote TB screening Introduce Isoniazid preventive therapy in accredited institutions Conduct surveillance of TB as a manifestation of Immune Reconstitution Syndrome (IRIS)	All CTCs screening PLHIV for TB All TB clinics screening patients for HIV co-infection All TB clinics at regional and district hospitals providing HIV care and ART	% of TB patients tested for HIV % of TB patients with HIV co-infection that are treated for TB and HIV. Number of hospitals with TB clinics providing cotrimoxazole prophylaxis and HAART % of HIV infected patients screened for TB		NACP NTLP			

Strategic objective 3: Provide quality HIV and AIDS care and treatment to PLHIV to reduce morbidity, mortality and improve the quality of life.

Strategy 1: To establish a system of different levels of care packages for primary, secondary and tertiary health care facilities							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop standard packages of care for different levels of health care facilities i.e. for primary, secondary and tertiary health care facilities. Develop mentoring programs Conduct regular supportive supervision.	All HIV care and treatment health facilities provided with mentoring and supportive supervision and mentoring Accreditation of health facilities offering HIV and AIDS care and treatment services Standard packages of care developed for different levels of care	Standard packages of care developed for different levels of Care Mentoring programs developed and implemented					

Strategy 2: To strengthen and scale up HIV Care and Treatment related training to enhance skills of health care providers							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Adapt and implement focused training curricula for paediatric care, palliative care including pain management and TB/HIV integration and management of TB/HIV co-morbidity.	All HIV care and treatment health facilities provided with mentoring and supportive supervision and mentoring Health providers trained	Number of health care providers trained Mentoring programs developed and implemented		MoHSW (NACP) RHMT DHMT	Partners		
To conduct training for paediatric care, palliative care including pain management, TB/HIV co-morbidity for zonal master trainers, regional trainers and district health care workers.							
To conduct IMAI training for HCWs in health facilities in the district and at primary health centre level.							
To conduct regular supportive supervision and mentoring.							
To conduct regular review of guidelines and disseminate them through training.							
To conduct training in management skills for HCW.							

Strategy 4: To develop a system of Quality Assurance of HIV Care and Treatment Services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen the NACP Quality Assurance unit	Quality of service provision improved	Care standards documents developed and disseminated Accreditation of health facilities offering HIV and AIDS care and treatment services		NACP			
Develop national quality of HIV care standards and indicators							
Develop a tool for and implement quality of HIV care auditing on a regular basis							
Strengthen accreditation and re-assessment of health facilities							

Intervention area 2: Community based Care Services
Strategic Objective 1: To strengthen and scale up the implementation of comprehensive care, treatment and support services in community settings

Strategy 1: Scale up the accessibility and availability of comprehensive community home based care and support services for PLHIV							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Assist districts to prioritize HBC	121 districts with plans, inventory	# of districts reporting HBC services	Quarterly and annual reports	NACP DMOs, CHMT			
Conduct an inventory of HBC services		List of inventories					
Mobilize resources for HBC services.	One CSO providing HBC services per district	# of CSO reporting HBC services					
Develop regionalizing services.	121 districts conduct assessment	# of CSO reporting HBC services					
Develop clear roles and responsibilities for civil society in community HBC services		# of CSO reporting HBC services					
Conduct an assessment on the current status of the Village Health Workers	121 CSO initiate home based HIV Counseling and Testing	Number of VHW identified					
Initiate home based care counseling and testing services at community level.		# of trained lay counsellors					
Develop and implement community awareness activities about ART literacy	121 districts implement community awareness activities	# of people counselled					
Involve local leadership in securing funds and harnessing community resources with the aim of ensuring sustainability.		# of districts reporting funding for HBC					
Strategy 2: Improving care and management of pain and other common symptoms of chronic diseases including HIV and AIDS							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Collaborate with the TPCA in developing a module for training in Palliative care, including pain management	All districts currently implementing HBC services	Training module	Training and Assessment reports	TPCA ORCI NACP, DMOs, CSO MSD, MEMS FBO hospitals			
Conduct an assessment to identify gaps in the current supply systems for HBC supplies and drugs.		Number of districts assessed					
Develop an appropriate supply chain management							
Assess the effectiveness of current programs that provide oral morphine in the country							
Institute a process towards advocacy for policy that will allow for gradual scaling up the provision of oral morphine in the community							

Strategy 3: Strengthening the integration of TB, HIV and AIDS services at community level							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Build skills of community HBC service providers to identify and refer PLHIV patients for TB screening	24,000 HBC service providers	Number of PLHIV referred for TB screening by HBC workers	Quarterly and annual reports	NACP NTLP CHMT DMO			
Establish effective linkages between TB clinics and community HBC service providers for implementing and reporting community DOTS	24,000 HBC service providers	Number of PLHIV referred for TB screening by HBC workers					

Strategic Objective2: To Improve the Quality of Life and Reduce Morbidity and Mortality of PLHIV through the Provision of Comprehensive HIV and AIDS Care and Treatment Services in the Community

Strategy 1: Strengthen the capacity for appropriate management of common OIs and STIs in PLHIV							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Train CHW in the diagnosis and management of common OIs and STIs	24,000 HBC workers	# of patients managed	Quarterly and annual reports	NACP CHMT DMO			
Establish referral systems	121 CHMT	# of effective referrals reported					
Provide a comprehensive care package that includes cotrimoxazole, bed nets, safe water and condoms	121 CHMT	# of patents receiving services					

Strategy 2: Establish and disseminate service standards for all institutions and individuals providing home based care services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Conduct periodic review of existing service standards and protocols and disseminate them.	Reviews every 3 years	Number of Reviewed Documents	Review reports	NACP	Development partners		
Conduct periodic assessments and surveys to inform change and re-focusing of interventions.	Annual event	Number of assessments and surveys conducted	Annual reports				
Support the CHMT and DHMT in the provision of regular supportive supervision to maintain the provision of quality services.	121 CHMT	Frequency of Regular supportive supervision visits	Quarterly and annual reports	NACP, RHMT, CHMT			
Establish accreditation systems for the certification of CSOs, FBOs and NGOs working in the community.	CSO Accreditation tools	Approved CSO Accreditation tool	Annual reports with # of CSO accredited				

Strategy 3: Develop and implement capacity building strategies to increase technical skills of community home based care service providers							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen the Care and Social Support Unit at NACP with additional staff to improve coordination and supportive supervision functions.	CSSU	# and type of staff added	Annual reports	NACP	Development partners		
Training community volunteers in care and support services including risk reduction, adherence counseling and prevention with positives.	24,000 community workers	# of CHWs trained	Training and progress reports	NACP, CHMT			
Review and adapt as necessary existing training materials and disseminate.	Reviews every 3 years	Number of Reviewed Documents	Review reports	NACP			
Build capacity among community based health workers to facilitate training, monitoring and supervision of community volunteers	Two HBC focal persons per health care facility	# of facility based HBC focal persons trained	Programme progress reports	NACP, RHMT CHMT			

Strategy 4: Strengthen the supervision, monitoring and evaluation capacity for civil society organizations and public institutions							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Standardize protocols for monitoring, evaluation and reporting of HBC services.	121 CHMT	# of protocols developed, # of CSO reporting use of protocols	Programme progress reports	NACP, CHMT, RHMT			
Train relevant CHMT staff to monitor, evaluate and report on HBC services.	121 CHMT	# and type of staff trained	Training and Programme progress reports				
Establish mechanisms for effective data collection, storage and use at district and national level.	121 CHMT	# CHMT sharing reports with stakeholders, # of CHMT with functional data collection and reporting systems	Programme progress reports				
Establish mechanisms to enable HBC providers to function efficiently within the community e.g. provision of bicycles and kits	24000 CHBC workers	# of CHBC workers provided with bicycles and kits	Programme progress reports				

Strategic Objective 3: To strengthen community based support to establish effective linkages and referrals between civil society organizations and public institutions to ensure the provision of comprehensive services across a continuum of care for PLHIV and orphans and most vulnerable children (MVC)

Strategy 1: Develop mechanisms to enhance community ownership, participation and involvement in home based care services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Involve PLHIV, households and communities in the planning and implementation of community based care, treatment and support initiatives	Enhanced community ownership, participation and involvement	# of projects developed with involvement of PLHIV and community leaders # of post-test clubs established # of affected households receiving external support # of volunteers retained # of CHMT reporting stakeholders who addressed harmful practices beliefs in the communities # home care givers educated	Programme progress reports	CMAC CSO PLHIV groups CMAC			
Support resident community based volunteers and PLHIV support groups in encouraging peers to know their HIV status and establish post-test clubs.							
Support communities to provide essential services to affected households and individuals.							
Establish mechanisms for communities to support and motivate community volunteers							
Sensitize communities to identify and address risk factors within their communities and be open to challenging harmful beliefs, practices and traditions that increase the spread of HIV/AIDS.							
Advocate for and educate communities to make them more responsive to the needs of PLHIV and their families.							
Strategy 2: Establish mechanisms for effective referrals and networking among all key stakeholders in community home based care services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**resources**	**Remarks**
Develop district and community level inventories of institutions	Effective referrals and linkages established and functional	# of institutions invented # of public and non public institutions with functional referral system # of HBC providers trained # of treatment partners with functional patient follow up system # of PLHIV from community program linked to CTCs Referral guideline developed	Inventory checklist Programme progress reports	CMAC			
Establish effective referral systems							
Highlight the role of HBC in care and treatment interventions and ensure that all care and treatment partners develop plans for patient follow-up and adherence using HBC service providers.							
Assist all HBC programs to develop effective referrals and linkages to and from CTC services.							
Assist the CHMTs in developing referral guidelines to ensure that HBC and CTC services are fully linked.							

Strategy 3: Develop effective strategies to mitigate the impact of HIV/AIDS in communities and households with MVC							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**resources**	**Remarks**
Identify and establish linkages with appropriate institutions through which support resources for MVC may be sought.	MVC properly supported	# of institutions supporting MVC	Programme progress reports	CMAC PLHIV groups CSO			
Identify and enhancing support for orphans and other vulnerable children in the communities.		# of MVC served					
Strengthen local systems to provide health care and nutrition care for families caring for vulnerable children.		# of institutions providing nutrition care to MVC households					
Strengthen community based psychosocial support for OVC most in need Strengthen local systems to ensure that MVC receive appropriate EPI services.		# of MVC reached with psychosocial support					
Improve access of MVC to essential health services through local support mechanisms.		# of MVC accessing health care through community support					
Scale up identification of HIV positive MVC and youth, most at risk of infection or showing signs of infection, and link them to care, treatment and support services.		# of HIV+ MVC identified					
Assist communities to address stigma and discrimination against infected or affected MVC.		# of CHCWs trained in stigma reduction					
Promote the participation of MVC and child interest groups in any interventions that affect their lives.		# of institutions involving MVC in their programming					

4.3. THEMATIC AREA 3: CROSS-CUTTING

Intervention area 1: Laboratory Services
Strategic objective 1: Strengthen diagnostic services to support prevention, care and other interventions for HIV and AIDS/STIs and major OIs

Strategy 1: To ensure nation-wide access to quality and timely delivery of laboratory services
- Ensure availability of appropriate laboratory infrastructure and equipment in health facilities
- Strengthen and establish monitoring of drug resistance for ARV, Anti TB and OI treatments
- Ensure availability of reagents in all health facilities for diagnosis and monitoring of HIV/AIDS/STI and major OIs

Activities	Targets	Indicators	Means of verification	Key actor	Partners or collaborators	Resources	Remarks
Renovate all referral, regional and districts laboratories	Labs in 5 referral, hospitals renovated	No. referral labs renovated		MOHSW NTLP NACP Referral hospitals Kibong'oto hospital PORALG RHMT CHMT CACC Health facilities RLO DLO			Need to identify partners on the ground as per the regionalization of NCTP
	Labs in 21 regional hospitals renovated	No. regional labs renovated					
	Labs in 114 district Hospitals renovated	No. district labs renovated					
Build new laboratories by	New laboratories built	No. of laboratories built					
Equip all referral, regional and districts laboratories	Provide labs in 5 referral hospitals with PCR facilities	No. referral labs with PCR facilities					
	Provide labs in 21 regional labs with ELISA facilities	No. regional labs with ELISA facilities					
	Provide labs in 21 regional labs with haematological and biochemical analysers	No. regional labs with haematological and biochemical analysers					
	Provide labs with 114 district labs with haematological and biochemical analysers	No. district labs with haematological and biochemical analysers					
	Provide labs with 114 district labs with CD4 machines	No. district labs with CD4 machines					
	Conduct situational analysis to assesses distances between health centres and facilities with CD4, haematological and biochemical analyzers	Report on situational analysis					
	Identify health centres with access to CD4, haematological and biochemical analyzers identified	% of health centres with access to CD4, haematological and biochemical analyzers identified					
	Establish/Strengthen 5 referral and Kibong'oto lab capacity to do TB culture and sensitivity	Capacity to do TB culture established/strengthened in 5 referral and Kibong'oto labs					

Strategy 1: To ensure nation-wide access to quality and timely delivery of laboratory services o Ensure availability of appropriate laboratory infrastructure and equipment in health facilities o Strengthen and establish monitoring of drug resistance for ARV, Anti TB and OI treatments o Ensure availability of reagents in all health facilities for diagnosis and monitoring of HIV/AIDS/STI and major OIs							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Establish monitoring of ARV resistance in two referral labs	Two referral lab monitoring for ARV resistance	2 referral lab with established monitoring for ARV resistance					
Strengthen and develop capacity for monitoring of Anti TB resistance in HIV infected persons in one referral and Kibong'oto lab	One referral lab and Kibong'oto hospital perform TB cultures and monitor anti-Tb resistance	No. of designated laboratories performing TB cultures and sensitivity testing					
Establish monitoring of antimicrobial resistance of STIs in 5 referral labs	Five referral labs monitoring antimicrobial resistance of STIs	No of referral labs with established monitoring of antimicrobial resistance of STIs					
Review Public Procurement Act to allow easy processing of laboratory supplies	To have complimentary system of procuring laboratory supplies	Public Procurement Act reviewed to allow easy access to laboratory supplies					
Negotiate procurement of reagents at Zonal MSD	Reagents procured at Zonal MSD facilities	No. of councils procuring reagents from Zonal MSD facilities					
NACP negotiates with MSD for councils to be able to purchase HIV and AIDS/STIs related laboratory supplies when MSD stocked out	Reagents procured from alternative sources during stock outs	No. of councils procuring reagents from alternative sources during stock outs					
Train laboratory staff on logistic management, forecasting of laboratory supplies to meet care and treatment expansion demands	At least one laboratory staff per facility trained on logistic management and forecasting of laboratory supplies	No. of health facilities with at least one laboratory staff trained					
Strengthen logistics to ensure timely delivery of laboratory supplies to all health facilities	All laboratory facilities use reporting and requisitioning (R&R) form when ordering laboratory supplies	No. of laboratory facilities ordering lab supplies using R&R form					

Strategy 2: Increase number of laboratory and non laboratory staff trained on diagnosis and surveillance of HIV/AIDS/STI and major OIs							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Scale up pre-service training of lab staff	Review curriculum to include HIV and AIDS/STIs and major OIs for laboratory trainees	Curriculum reviewed	Report s	MOHSW Colleges of Allied Health Sciences Universities ZTC Health facilities PORALG RHMT CHMT CACC DLO RLO			
	Include curriculum into Colleges of Allied Health Sciences	Curriculum includes training in diagnosis and surveillance of HIV and AIDS/STI and OI					
	Do situational assessment of the College of Allied Health Sciences to offer pre-service training on HIV and AIDS/STIs and major OIs for laboratory trainees	Situational assessment conducted					
		No. of trainees enrolled per intake in Colleges of Allied Health Sciences					
Scale up in-service training of lab and non-lab staff	Increase intake of laboratory trainees in Colleges of Allied Health Sciences Develop ZTC capacity to train TOT in laboratory diagnosis and monitoring of HIV and AIDS/STIs and major OIs	No. of TOT trained					
		No. of lab and non lab staff trained					
Recruit more lab staff to perform duties related with diagnosis and surveillance of HIV and AIDS/STI and major OIs	TOT locally train lab and non lab staff in laboratory diagnosis and monitoring of HIV and AIDS/STIs and major OIs	% of available lab staff as per establishment					
Motivate lab and non lab medical staff	Recruitment of more lab staff to perform duties related with diagnosis and surveillance of HIV and AIDS/STI and major OIs	System for motivation developed and implemented					
	Develop a plan for recognition and appreciation of laboratory staff						
	Develop plan for refresher training for all lab and non lab medical staff	No. and types of refresher courses conducted No. of staff trained					

Strategy 3: Implement and strengthen a national quality assurance scheme and and develop mechanism for preventive maintenance							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen regular supportive supervision of laboratories	Biannual supportive supervision of 5 referral and 21 regional laboratories by central level staff	% of supportive supervision sessions conducted in a year	Reports	MOHSW (Diagnostics) NACP RACC DACC MOHSW			
	Quarterly supportive supervision of all district labs by referral l and regional level staff	%. of labs offered supportive supervision					
Provision of QA materials	Bi-annual QA materials sent to 5 referral, 21 regional, 114 district labs	% QA materials sent to labs biannually					
Accreditation and certification of laboratories	Accreditation and certification done for 5 referral, 21 regional, 114 district labs	% lab accreditation and certification done					
Enforce use of SOPs for diagnosis and monitoring HIV and AIDS/STIs and major OIs and in HIV testing	All lab and non lab staff adhere to SOPs	% lab testing procedures performed as per SOPs					
Improve sample transfer to labs performing any HIV/STI and major OI laboratory diagnosis	All sample transferred to labs for performing HIV/STI and major OI diagnosis	% of facilities with access to functional laboratory services					
All QA samples requiring processing in other labs transported in timely) and appropriately to destination (according to SOP	All QA samples transported timely and appropriately to destination	%of QA samples transported in timely and appropriately to destination					
Strengthen regular preventive maintenance scheme of lab equipment as per SOPs	Preventive maintenance of all equipment according to SOPs	% and type of equipment serviced according to SOP					
	Train 21 regional engineers to do regular preventive maintenance of lab equipment according to SOP	No of regional engineers trained in preventive maintenance of equipment					

Intervention area 2: HIV Testing and Counselling
Strategic objective 1: Improve access to and use of quality HIV Testing and Counseling (HTC)

Strategy 1: Strengthen existing and promote the establishment of HTC including services for children							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Strengthen existing VCT services in the country. Promote VCT services in all health facilities.	To provide quality VCT services health facilities	No. of health facilities providing quality VCT services.	Reports	MOHSW (NACP) (Diagnostics, NTLP) PORALG RHTMs RACCs CHMTs CACCs DACCs			
To accredit/certify all VCT services	No and % of facilities offering VCT accredited/ certified	No and % of health facilities linked to at least two home based and family CT.					
Establish mobile VCT services in remote hard to reach areas and groups at high risk.	To establish mobile VCT services targeting hard to reach areas and population at high risk in 30% of the 114 districts.	No. and %. of districts with mobile VCT services					
Establish Home-Based Counseling and Testing (CT) to include family CT To provide at least 2 home based and family counsellors linked to health facilities	To introduce home based CT in 50% of 114 districts.	No. and % of districts that have introduced home based CT including family CT services. No and % of health facilities linked to at least two home based and family CT.					
Finalize PITC guidelines and develop curriculum.	PITC guidelines and curriculum developed and included in and pre- and in-service training.	PITC guideline and curricula in use. in and pre-and in-service training.					
Develop capacity of the ZTC to train in PITC	To train 2 TOTs in each of the 8 ZTC in PITC	No. of TOTs trained in PITC					
Train health care staff in PITC.	To train all pre-service health care staff in PITC.	No. of pre-service health care staff trained.					
	To train 50% of in-service health care providers in PITC	No. of health care providers trained in PITC.					
Establish PITC service in all health facilities.	To establish PITC services in all health care facilities.	No. of health care facilities with established PITC services.					
Develop, pilot and implement HTC guidelines for children.	Introduce HTC for children in 5 referral, 21 regional and 10% of 114 district hospitals	% of referral, regional and district hospitals offering HTC for children					

Strategy 1: Strengthen existing and promote the establishment of HTC including services for children							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Train HCW on the provision of quality HTC services for children.	Train HCW from 5 referral, 21 regional and 10% of 114 district hospitals on HTC for children	% of referral, regional and district hospitals with trained HCW					
Provide supportive supervision to facilities and HCW providing HTC for children	Provide bi-annual supportive supervision to facilities offering HTC services	% of referral, regional and district hospitals biannually supervised					
		No. of supervisory and feedback reports					

Strategy 2: Develop and disseminate appropriate standard operating procedures (SOP) for HTC to all health and non health services.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop and disseminate SOPs for HTC to all health and non health facilities.	To develop and disseminate SOPs for HTC in all health and non health facilities.	No. of health and non health facilities with HTC SOPs	Reports	MOHSW (NACP) PORALG RHTMs RACCs DACCs CHMTs CACCs DACCs Partners			
Train and retrain HCW in HIV testing techniques and approaches that meet national standards.	Train all HCW in HIV testing techniques and approaches that meet national standards.	% of HCW trained in HIV testing techniques and approaches that meet national standards.					
		% of HCW using HIV testing techniques and approaches that meet national standards					
Conduct follow up supportive supervision to ensure that HCW adhere to HIV testing techniques and approaches that meet national standards.	Conduct bi-annual supportive supervision in all HTC providing facilities	% of facilities receiving HTC biannual supportive supervision from the next higher level.					
		No. of supervisory and feedback reports produced					

Strategy 3: Strengthen and support HTC as an integral component of HIV and AIDS/STI/TB prevention, control and care							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
To harmonize and integrate HIV intervention programs with other health related programs	Promote harmonization of various HIV intervention programs with other health related programs e.g. RCH at all levels	Availability of harmonized programs Strengthened referral to other programs	Reports				
To strengthen linkages between HIV programs with other health and non health related programs	Strengthen linkages between HIV programs with other health and non health related programs						
To strengthen referral mechanism between HIV programs and with other health and non health related programs	Strengthen referral mechanism between HIV programs and with other health and non health related programs						

Strategy 4: Develop a comprehensive HTC guidelines (Guidelines to include all contexts where HIV Testing and Counseling happens)							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Introduce and implement standard guidelines for peer educators and counselors.	Implement comprehensive HTC to include all contexts where HIV Testing and Counseling happens	No. of villages with at least two person trained in peers education and counseling services	Reports	MOHSW (NACP) PORALGs RHTMs RACCs CHMTs CACCs DACCs FBOs CSOs			
Train peer educators and counselors on quality peer education and counseling services.							
Biannually supervise peer educators and counselors		No. of supervisory and feedback reports					
To develop guidelines on Comprehensive HTC		Guidelines and SOPs on Comprehensive HTC developed and in use					
To develop SOPs for use of the Comprehensive HTC							
To pilot SOPs for use of the Comprehensive HTC							
To train on use of the Comprehensive HTC guidelines and SOPs							

Intervention area 3: Promote BCC programming, production of IEC materials and support stigma reduction
Strategy Objective1: Contribute to the production of culturally sensitive IEC strategies that promote behaviour change and support stigma reduction

Strategies 1: Promote production and distribution of cultural and context specific IEC materials at national, region, and district levels							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Produce and distribute calendars, posters, leaflets and newsletters covering different aspects of HIV and AIDS/STIs and major OI	To produce a total of 300, 000 wall calendars, 600,000 brochures, 600,000 booklets, 300,000 posters and 700,000 newsletters	No. and types of IEC materials produced	Reports	MOHSW (NACP, RCH) MOHSW (NACP) Service delivery units NGOs CSOs	Media companies		
	To distribute IEC materials to all referral, regional, district, HTC and CTC services at all levels	No. of referral, regional, district, HTC and CTC services with IEC materials					
Promote lower level production and reproduction of IEC materials	To promote lower level production and reproduction of IEC materials	All IEC materials posted in accessible and printable formats					
		All 21 RHMT access and reproduce IEC materials for local consumption					
Produce and air films and talk shows on different issues on HIV prevention, care and treatment	To produce and air 6 films and monthly talk shows	No. and types of films and talk shows produced and aired					

Strategies 2: Produce training materials and train for/in reduction of stigma and discrimination among HCW							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Production of training materials for reduction of stigma and discrimination *(Interpersonal communication)*	Train health care staff in reduction of stigma and discrimination	50% Stigma reduction within health care	Reports	MOHSW (NACP) ZTC MOSTHE Academic institutions			
Pre-service stigma reduction training	Develop curriculum for pre-service trainees	Curriculum for pre-service trainees developed					
	Pre-service curriculum adopted by training institutions						
	Stigma reduction training among pre service trainees	90% of pre-service health care staff trained in reduction of stigma and discrimination					

Strategies 3: Promote and monitor behavioural change and communication activities							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop HIV communication and behavioural change strategy for the health sector	To improve HIV communication and behavioural Change within the health sector	HIV communication and behavioural Change within the health sector improved	Reports	MOHSW (NACP) BCC Programmers NGOs CSOs			
To promote BCC programming	HIV and AIDS related BCC programming promoted	HIV and AIDS related BCC programming within the health sector in place					
To train health and non health care workers in BCC programming in at all levels	Health and non health workers trained in BCC programming	No. of staff trained					
Conduct monitoring of behavioural change and communication activities	Behavioural surveys done according to schedule	No. done					

Intervention area 4: Condom promotion and use
Strategic Objective 1: To contribute towards the promotion, distribution and use of condoms

Strategy 1: Improve accessibility of condoms through private-public partnership and other alternative distribution outlets							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Identify potential partners who will distribute condoms in especially remote hard to reach areas and among risky populations	Additional potential partners identified	No. of potential partners	Survey and mapping reports	MOHSW (NACP, RCH)			
Increase condom distribution outlets to include non health facilities	New condoms outlets identified	No. of new condoms outlets identified					

Strategy 2: Train service providers for comprehensive information and education about condoms for HIV and STIs prevention							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Identify and train service providers for comprehensive information about condoms for HIV/STIs prevention	To train at least one HCW per health service delivery point.	No. of HCW identified and trained	Reports	MOHSW (NACP, RCH) PORALG NGOs CSOs FBOs			
	To train non health service providers	No. of non health service providers identified and trained					
Identify alternative sources and outlets (e.g. automated machines) of free male and female condoms in the health sector		No. of functional alternative sources and outlets	Report	MOHSW (NACP, RCH)			

4.4. THEMATIC AREA 4: HEALTH SYSTEM STRENGTHENING

Intervention area 1: National Strategic planning and programme Management
Strategic Objective: To strengthen managerial capacity at all levels and adopting integrated district based approaches to resource utilization in conjunction with disease programmes

Strategy 1; Explore various appropriate arrangements that would strengthen HIV and AIDS programme management at all levels							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop Terms of Reference to study the current management arrangements	Innovative management arrangements established	Existence of appropriate program management arrangements at all levels	Report	MOHSW PORALG			
Conduct the review							
Disseminate the findings on the management arrangements							

Strategy 2 To strengthen technical integrated planning and programme management at all levels that will support HIV/AIDS service delivery							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Facilitate the planning at national and district levels	Integrated planning and capacity building of local actors built in	Plans showing integrated planning and capacity building.. MTEF plans showing priority health sector HIV and AIDS interventions Report of mapped HIV/ and AIDS interventions.	Copy of plans and reports	MoHSW PORALG NGOs FBOs DMOs, RMOs, CMACs, VMACs MOHSW PORALG			
Strengthen district/ local managerial capacity.							
Incorporate priority health sector HIV/AIDS interventions annual MTEFs plans							
Map existing and planned HIV/AIDS interventions, identify needs, gaps, overlaps and inefficiencies and draw lessons from best practices and success stories.							
Harmonize annual planning and budget allocations to priority interventions							

Strategy 3: Strengthen and implement quality assurance of HIV and AIDS interventions services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Document and disseminate best practices	Best practices documented	Availability of documents	Report	MOHSW PORALG			
Conduct regular supportive supervision to improve quality.	Supportive supervision conducted						
Explore and develop sustainable measures by mobilizing alternative sources of funding	Alternative measure for resource mobilization	Availability of different funding modalities					

Intervention area 2: Procurement and Supply management
Strategic Objective: To have a secure Procurement and Supply Management systems for HIV and AIDS medicines, diagnostics and other commodities

Strategy 1: Strengthen procurement and supply management systems for HIV and AIDS medicines, diagnostics and other commodities							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop a diagnostics and reagents catalogue.	Strengthened procurement and supply management system	Existence of a catalogue a budget. % of diagnostics and laboratory supplies, HIV/AIDS, STI and OIs commodities available. Availability of MSD forecasting tool. Presence of SOPs and Quality Assurance documents.	Reports				
Develop a budget for national diagnostics and laboratory reagents.							
Optimise the availability of diagnostics and laboratory supplies							
Manage out of stock situation by forming a commodity management committee.							
Review the current MSD forecasting tool.							
Institute quality Assurance system including SOPs at MSD in all sections.							
Put in place public relations Officer at MSD.							

Strategy 2: Facilitate regular revision of NEMLIT and ensure availability of HIV and AIDS, STI and OIs related medicines.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Review and nominate membership of the National medicines and therapeutic committee.	A revised and updated NEMLIT & STG in place once every three years	Existence of lists and duties of member	Reports and minutes	MoHSW MSD			
Update NEMLIT & STG once in three years		A revised and updated NEMLIT & STG					
Convene medicines and therapeutic committee meetings regularly		Existence of minutes					
Conduct regular review of medicines kept in the register to ensure availability and affordability	Local manufacturing of HIV/AIDS, STIs and OIs should be increased from 20% -50% to 75%.	100 % of HIV/AIDS, STI and OIs kept in the register					
Promote local manufacturing capacity for HIOV/AIDS, STIs and OIs medicines		Number of HIV/AIDS, STI and OIs locally manufactured.					
Develop information system for medicines use to promote compliance by users	Information protocols for medicines use to promote compliance by users developed.	Number of booklets given to patients					

Intervention area 3: Human Resource
Strategic Objective: To build human capacity at all levels to manage and sustain a comprehensive health sector response.

Strategy 1: Strengthen the institution responsible for managing the response at all levels with the optimum number of human resource mix**.**							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Establish a coordinated mechanism of recruiting and deploying staff in the health sector.	Strengthened human resource capacity required for managing the HIV and AIDS response	A report on how to coordinate recruitment and deployment of staff	Report	MoHSW, PORALG, POPSM, NGOs, FBOs			
Develop short and long term strategies for increasing the HR mix in the health sector.		A report on short and long term strategies					
Improve the motivation of Health Workers		Documents HW motivation					
Improve the working environment							

Strategy 2: Develop human resource training master plan for the staff required for managing the HIV and AIDS response							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Improve capacity building in planning and management at all levels	Curriculum in training institutions with leadership modules in place	Short and Long term HR projections available. Updated staffing levels document A new establishment in place	Reports Registers	MoHSW, PORALG, NGOs, FBOs, Training Institutions including Universities			
Strengthen workforce planning practices							
Develop management and leadership skills at all levels in the health sector							

Strategy 3: Improve capacity in delivering and managing training at all levels in both public and private sector							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Develop a training master- plan for the health sector	Innovative ways to support all training institutions to deliver and manage training		Report	MoHSW; MHEST, PORALG POPSM			
Improve capacity of the training institutions							
Strengthen quality assurance in training institutions							
Facilitate Zonal training centres to effective linkage between training and services							
Harmonize continuous professional development							
Promote and recognize innovative distant learning programmes							
Strengthen QA system in all HFs							
Actively involve health professional bodies, association and private training institutions							

Strategy 4: Increase human resources required for HIV/AIDS related activities through task shifting without compromising quality of Health Care services							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Establish a regulatory framework (where necessary) to enable some work to be delegated to low cadre workers in the HFs – Task Shift Policy	Regulatory framework to enable some work to be delegated to low cadre workers in the HFs	Document of Regulatory framework	Copy of the document and list Survey reports	MOHSW; POPSM, PORALG, NGOs FBOs TFDA			
Develop an incentive package for implementing task shift policy plan	Incentive package for implementing task shift policy plan in place	Incentive package document					
Identify HIV/AIDS activities from existing HCW which can be delegated to lower cadre workers in their respective categories	HIV/AIDS activities delegated to lower cadre workers in their respective categories	List of activities delegated to lower cadre workers.					
Identify HIV/AIDS activities at dispensary and health centre levels which can be delegated to other people in their respective catchment areas.	Activities of HIV/ AIDS at dispensary and health centre levels which can be delegated to other people identified	List of HIV/ AIDS activities at dispensary and health centre levels delegated					
Train identified low cadre workers in their expected roles and responsibilities	Training of identified low cadre workers done	Training report of low cadre workers trained					
Include HIV and AIDS activities in the ADDO programmes	HIV/AIDS activities included in the ADDO programmes	Number of HIV and AIDS activities included in the ADDO programme					
Expand ADDO programmes to all districts in Tanzania mainland	ADDO programmes rolled out to all districts	Proportion of districts implementing the ADDO programme					

Intervention area 4: Strategic information
Strategic objective 1: Strengthen and institutionalize monitoring and evaluation system for it to provide relevant comprehensive information in a timely manner for programme management and planning.

Strategy 1: Develop a harmonised M&E framework that links different HIV and AIDS programme							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners**	**Resources**	**Remarks**
Assess the needs for new tools	M&E systems strengthened at all level New tools are adapted	Existence of unified M&E system Assessment done Availability of news adapted tools All supervisors & HW have been trained Number of computers and software installed	Reports	MOHSW HCW Health facilities		Funds for training, dissemination of the tools	
Design adapted new tools to harmonize data and test them							
Train supervisors, Health workers or special staff							
Build capacity for electronic data handling at facility & district level							
Strengthen data collection system							
Complete & make functional operations manual, outlining roles & responsibilities of public & private sectors, civil society							
Strengthen capacity to ensure provision of necessary information for national M&E system							
Align the Joint annual programme review							
Ensure integration of national financial management monitoring with programme monitoring for all HIV/AIDS programmes							

.**Strategy 2:** Institute a supportive supervision which will assure the quality of data and services, data flow and use at all levels.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners**	**Resources**	**Remarks**
Conduct regular supervision visits to monitor and evaluate all services provided in HIV/AIDS/STI issues	All HIV and AIDS Programmes evaluated Mid-term M&E of HIV/AIDS, STI and related programmes conducted Data used for decision making	Number of programmes monitored Mid-term report on M&E of HIV/AIDS, STI and related programmes conducted Number of activities implemented according to the finding	Reports	NACP MoHSW PORALG RACC DACC CACC Academic and research institutions			
Monitor the availability & utilisation of financial resources							
Conduct regular programmes evaluation, mid- term and reviews							
Build the capacity at NACP M&E unit							
Conduct supportive supervision and provide timely feedback to the facilities		Number of supportive supervision visits done					

Strategic objective 2: Strengthen and expand surveillance activities to monitor the dynamics of the epidemic and the impact of interventions.

Strategy 1: Strengthen biological surveillance system for HIV and AIDS and STI							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners**	**Resources**	**Remarks**
Conduct annual sentinel Surveillance of HIV infection on ANC and PMTCT	STI, HIV and AIDS trends monitored	Number of biological surveillance surveys carried out	Reports	MoH NACP HCW			
Collect prevalence data in blood donors and VCT services							
Screen for syphilis in patients attending HF and women at ANC							
Collaborate with the diagnostic unit of MOHSW to evaluate new syphilis tests and identify RPR replacement							
Strengthen laboratory services & train staff to perform HIV testing							

Strategy 2: Contribute to the strengthening of behavioural surveillance system for HIV and AIDS and STI							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners**	**Resources**	**Remarks**
Conduct behavioural surveillance surveys among youth aged 15-24 years	STI, HIV and AIDS trends monitored	Number of behavioural surveys carried out	Reports	MOHSW NACP Academic institutions			
Incorporate behavioural surveillance surveys among general population							
Conduct behavioural surveillance surveys among most at risks groups	Behavioural surveillance surveys among most at risks groups done						

Strategic Objectives 3: To strengthen and sustain HIV drug resistance activities, STI drug resistance monitoring and pharmacovigilance of HIV drugs

Strategy 1: Conduct STI drug and TB drug susceptibility monitoring							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners**	**Resources**	**Remarks**
Establish monitoring of ARV resistance in two referral labs	Two referral lab monitoring for ARV resistance	No. of referral lab with established monitoring for ARV resistance	Reports	MOHSW PORALG Health facilities			
Strengthen and develop capacity for monitoring of Anti TB resistance in HIV infected persons in one referral and Kibong'oto lab	One referral lab and Kibong'oto hospital perform TB cultures and monitor anti-Tb resistance	No. of designated laboratories performing TB cultures and sensitivity testing					
Establish monitoring of antimicrobial resistance of STIs in 5 referral labs	Five referral labs monitoring antimicrobial resistance of STIs	No of referral labs with established monitoring of antimicrobial resistance of STIs					
Strengthen capability of laboratories to make diagnosis of STI drugs resistance	National and zonal hospital able to identify STI drug resistance						
Build capacity of the National & Zonal hospital to diagnosis HIV resistance to ARVs	National and zonal hospital able to detect HIV resistance to ARV therapy						
Train health care workers on diagnosis of STI and ARV drugs resistance		Health care workers are able to diagnosis ARVs resistance					

Strategy 2: Strengthen a mechanism for tracking and providing feedback on ADR associated with HIV and AIDS, STI and OIs medication.							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
ADR monitoring forms to be available at HFs levels	ADR monitoring forms available at HF levels	Proportion of HFs with ADR forms	Reports	TFDA			
Train HW to recognize and report all ADR related to HIV/AIDS, STIs and OIs medication.	HW sensitized to recognize and report all ADRs related to HIV/AIDS, STIs and OIs medication.	Proportion of HWs sable to recognize ADR related to HIV/AIDS, STIs and OIs medication.					
Form a national committee on ADR for HIV/AIDS, STIs and OIs medicines.	National committee on ADR for HIV/AIDS, STIs and OIs medicines formed.	List of national committee members on ADR for HIV/AIDS, STIs and OIs medicines.					

Intervention area 5: HIV, STI Priority Research
Strategic objective 1: To strengthen the national capacity for HIV and AIDS related research and development including Operations Research

Strategy 1: Develop coordination and recording services for research on HIV and STI at one focal point							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Establish links with research institutions Strengthen the research capacity of stakeholders & institutional Implement appropriate ethical review Promote research in traditional and alternative remedies Encourage collaboration and coordination between local and international researchers	Research work well coordinated	Number of research institutions having cooperation agreement	Reports	NACP MoHSW Academic and research institutions			

Strategy 2: Conduct Operation Research (OR) in HIV and AIDS and use evidence for programming and policy making							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Encourage operational research in HIV and STI to address the emerging challenges at located settings Enable researchers to consider news areas for operational research	Innovative methods of mobilizing and involving individuals and communities in HIV/AIDS/STDs control are developed;	Number of Operational research done					

Strategy 3: Ensure adequate dissemination of the findings							
Activities	**Targets**	**Indicators**	**Means of verification**	**Key actor**	**Partners or collaborators**	**Resources**	**Remarks**
Organise HIV/AIDS research dissemination seminars where all new biomedical and social research related to HIV /AIDS will be disseminated Give feedback to the community where the study was done Use various media to disseminate the findings to the public via medical journalist	Research findings used in programming and policy making	Number of research published and disseminated in Tanzania Number of research findings disseminate		NACP MoHSW Media Academic and research institutions			

ANNEX 5: REFERENCE AND NOTES

[i] TACAIDS. A New Look at the HIV and AIDS Epidemic in Tanzania. December 2005

[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 us 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/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/AIDS Strategy for Tanzania, 2003-2006. February 2002, p. 5.

[vi] THIS 2003/2004

[vii] Siegfried et al. Lancet Infect Dis 2005

[viii] WHO, UNFPA, WB, UNAIDS. *Statement on Kenyan and Ugandan trial findings on circumcision and HIV*. Press Statement 13 December 2006

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[x] DHS 2004/5. This indicate no change since the DHS 1999

[xi] 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...]

[xii] Tanzania Demographic Health Survey (DHS) 1999

[xiii] 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/AIDS in Mtwara Rural and Makete Districts, p. iv*; Muhondwa 1999)

[xiv] DHS 2004/5

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