THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

NATIONAL MULTI - SECTORAL STRATEGIC FRAMEWORK ON HIV AND AIDS (2008 – 2012)

Dar es Salaam
May 2007

5th and Final version

National Multi - Sectoral Strategic Framework on HIV and AIDS 2008 – 2012 Tanzania

Note: This is the 5th and Final Draft of the NMSF 2008 – 2012 produced by the Consultant Team based on consultation meetings and comments received by stakeholders in May 2007.

This Draft needs final approbation by the concerned authorities in Tanzania. The final version of the NMSF should be carefully edited as agreed with TACAIDS.

Editing Note:

In general in the text "HIV" is used when "HIV and AIDS" is concerned; HIV AND AIDS are used when specific reference is made to both aspects; "PLHIV" is used as the acronym for persons living with HIV and AIDS.

For the Consultant Team
Montevideo, May 24, 2007

Ulrich Vogel, Lead Consultant (Int.)
ulrichfvogel@gmx.net

TABLE OF CONTENTS

LIST OF ABBREVIATIONS III

FOREWORD VI

EXECUTIVE SUMMARY VI

CHAPTER 1: BACKGROUND 1

1.1 SOCIO-ECONOMIC AND POLITICAL ASPECTS OF TANZANIA 1

1.2 RELATION OF THE NMSF TO OTHER NATIONAL DOCUMENTS, PLANS AND INTERNATIONAL COMMITMENTS 3

CHAPTER 2: THE HIV AND AIDS EPIDEMIC(S) IN TANZANIA 7

CHAPTER 3: ANALYSIS OF THE NATIONAL RESPONSE TO HIV AND AIDS (2003 – 2007) 12

CHAPTER 4: THE NATIONAL MULTI-SECTORAL STRATEGIC FRAMEWORK ON HIV AND AIDS 26

4.1 Priorities, Approaches and Guiding Principles 26
4.1.1 Priority setting 26
4.1.2 Approaches 27
4.1.3 Guiding Principles 28

4.2 Vision, Goals, Indicators and Targets 29

4.3 Thematic Areas: Goals, Strategic Issues, Strategic Objectives, Strategies, Indicators and Targets 31
4.3.1 Thematic Area: Enabling Environment related to the entire National Response 31
4.3.2 Thematic Area: Prevention 39
4.3.3 Thematic Area: Care, Treatment and Support 55
4.3.4 Thematic Area: Impact Mitigation 61

CHAPTER 5: MONITORING, EVALUATION, RESEARCH AND REVIEW OF THE NMSF 70

CHAPTER 6: ORGANISATIONS AND INSTITUTIONAL ARRANGEMENTS FOR THE IMPLEMENTATION OF THE NATIONAL RESPONSE AT CENTRAL, REGIONAL AND LGA LEVELS 78

CHAPTER 7: FINANCIAL, HUMAN AND TECHNICAL RESOURCE FRAMEWORK OF THE NATIONAL RESPONSE **88**

CHAPTER 8: FROM STRATEGIC FRAMEWORK TO OPERATIONS AND IMPLEMENTATION **94**

ANNEX 1: PROCESS OF ESTABLISHING THE NMSF **97**
- Annex 1a: Members of the Steering Committee for the NMSF Review 104
- Annex 1b: List of Local and International Consultants 105
- Annex 1c: List of Stakeholders Consulted during the Review of the 2003 - 2007 NMSF 106

ANNEX 2: KEY REFERENCES RELATED TO THE NMSF **104**

ANNEX 3: MEMORANDUM OF UNDERSTANDING BETWEEN THE GOVERNMENT OF TANZANIA AND THE DEVELOPMENT PARTNERS **113**

List of Abbreviations

ABC	Abstain, Be Faithful, Condom use
ABCT	AIDS Business Coalition in Tanzania
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ARCAN	African Region AIDS Care Capacity Network
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral Drug
ASAP	AIDS Strategy and Action Plan (World Bank / UNAIDS)
ATE	Association of Tanzania Employers
BCC	Behaviour Change Communication
CARF	Community AIDS Response Fund
CBO	Community Based Organization
CHAC	Council HIV and AIDS Coordinator
CMAC	Council Multi-sectoral AIDS Committee
CMO	Chief Medical Officer
COPTA	Community Participatory Training Approach
CSO	Civil Society Organization
CT	Consultant Team
CTI	Confederation of Tanzanian Industries
DACC	District AIDS Control Coordinator
DPGA	Development Partners Group on HIV and AIDS
DP	Development Partner
EAC	East African Community
FBO	Faith Based Organization
GFATM	Global Fund to fight AIDS, TB and Malaria
GLIA	Great Lakes Initiative on HIV and AIDS
GOT	Government of Tanzania
HAART	Highly Active Antiretroviral Therapy
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HSS	Health Sector Strategy for HIV and AIDS
ICT	Information Communication Technology
IEC	Information, Education, Communication

ILO	International Labour Organization
IMTC	Inter-Ministerial Technical Committee on HIV and AIDS
LGA	Local Government Authority
M&E	Monitoring and Evaluation
MDA	Ministry, Department and Agency
MDG	Millennium Development Goal
MKUKUTA•	Mkakati wa Kukuza Uchumi na Kuondoa Umaskini
MoCDGC	Ministry of Community Development, Gender and Children
MoEVT	Ministry of Education and Vocational Training
MoF	Ministry of Finance
MoHEST	Ministry of Science and Technology & Higher Education,
MoHSW	Ministry of Health and Social Welfare
MoLYDS	Ministry of Labour, Youth Development and Sports
MoU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NATP	National AIDS Treatment Plan
NBTS	National Blood Transfusion Services
NEPAD	New Partnership for Africa's Development
NGOs	Non-Governmental Organizations
NMSF	National Multi-sectoral Strategic Framework
NPES	National Poverty Eradication Strategy
O&OD	Obstacles and Opportunities in Development
ODA	Overseas Direct Assistance
OI	Opportunistic Infection
PEP	Post-Exposure Prophylaxis
PEPFAR	United Sates of America Presidential Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PLHIV*	People Living with HIV and AIDS
PMO	Prime Minister's Office
PMO-RALG	Prime Minister's Office Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PO-PSM	Presidents Office, Public Services Management
PS	Permanent Secretary

• Swahili acronym for the National Strategy on Growth and Reduction of Poverty (NSGRP)

* This abbreviation is preferred in Tanzania over the more commonly used PLWH

RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RFA	Regional Facilitation Agencies
RFE	Rapid Funding Envelope
RH	Reproductive Health
RS	Regional Secretariat
SADC	Southern Africa Development Community
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
SW	Sex Worker
TACAIDS	Tanzania Commission for AIDS
TAC	Technical AIDS Committee
TAF	Tanzania AIDS Forum
TAPAC	Tanzania Parliamentary AIDS Commission
TCCIA	Tanzanian Chamber of Commerce and Industry
TDHS	Tanzania Demographic Health Survey
THIS	Tanzania HIV/AIDS Indicator Survey
TIENAI	Tanzania Informal Economy Networks on AIDS Initiative
TMAP	Multi Country AIDS Programme for Tanzania (World Bank)
TNCM	Tanzania National Coordination Mechanism (GFATM)
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
ToR	Terms of Reference
TRCHS	
TUCTA	Tanzania Confederation of Trade Unions
TWG	Technical Working Group
UMASITA	UMOJA wa Matibabu wa Sekta Isiyo Rasmi Dar es Salaam
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counselling and Testing
VMAC	Village Multi-sectoral AIDS Committee
WMAC	Ward Multi-sectoral AIDS Committee
WB	World Bank
WHO	World Health Organisation
WPP	Work Place Programme on HIV

Foreword

(to be produced by TACAIDS / authorities of Tanzania)

Executive Summary

The new National Multi-sectoral Strategic Framework (NMSF) on HIV and AIDS covers the period 2008 to 2012. It is the second of its kind. It builds on the achievements and strength of the National Response to the HIV epidemic in the last five years (2003 – 2007) and proposes measures and strategies to overcome past barriers and constraints.

The NMSF 2008 – 2012 guides the approaches, interventions and activities which will be undertaken by all actors in the country regardless of whether they are coming from the public or private sector, the civil society groups, the business communities or the bilateral and international partners of the government of Tanzania.

The NMSF 2008 – 2012 was developed through an extensive review and consultation process between February and May 2007. Six national and six international consultants reviewed documents and studies and engaged stakeholders at national, regional, district and community levels in consultations, workshops and during field visits. Past experiences of the National Response to HIV and AIDS were analysed and Technical Working Groups of local and international experts working in Tanzania consulted in developing the new framework. Several drafts of the framework were produced, reviewed and amended by the consultancy team and through consultations and written comments by stakeholders and experts from inside and outside the country.

The HIV epidemic in Tanzania still poses a major threat to the national development and has been declared a national disaster. Its impact causes widespread suffering among individuals, families and communities across the country. However, there are signs of hope. Based on latest available data, the HIV prevalence is stabilising and even slightly decreasing in many parts of the country. Prevention efforts seem to work and the availability of effective treatment appears to reduce the impact of AIDS among the infected people. However, there are still over 1 million Tanzanians infected with HIV and new infections are occurring in the country every day. The magnitude of the epidemic and its cumulative effects over the past twenty years still provide major challenges to the country which can only be overcome through accelerated multi-sectoral efforts.

The Vision and Goals of the NMSF

The vision of the new NMSF is stated as follows:

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

In order to achieve this overarching vision, the NMSF proposes four **general goals** that need to be achieved in the coming five years covering the four thematic areas of the National Response. The indicators for these goals will measure the degree of progress achieved and are part of the National M&E framework.

Enabling Environment:

1. Create a political, social, economic and cultural environment for the national response to HIV based on a human rights and gender sensitive approach with transparency and accountability at all levels, broad public participation and empowerment of PLHIV, women and youth.

Prevention:

Reduce the HIV transmission in the country.

Care and Treatment:

Reduce morbidity and mortality due to HIV and AIDS.

Impact Mitigation:

Improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children

The strategy further proposes four additional goals which will provide overall institutional, financial, human, operational and management directions in the implementation of the framework.

Monitoring and Evaluation:

Use relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision-making.

Organisations and Institutional Arrangements for the Implementation of the National Response at Central, Regional and LGA Levels:

Provide well – coordinated, effective, transparent, accountable and sustainable leadership and management structures based on the "Three Ones Principle" at central, regional and LGA levels to deliver the National Response as well as involving stakeholders from the public, private and civil society sectors.

Financial, Human and Technical Resource Framework of the National Response:

7. Provide the necessary and appropriate financial, human and technical resources for the implementation of the National Response to the HIV epidemic through combined, coordinated and sustained efforts by the Government of Tanzania, the private and civil society sectors and the Development Partners.

From Strategic Framework to Operations and Implementation:

8. Translate the NMSF into well-defined operational plans at national and LGA levels under the leadership of the PMO (TACAIDS) and PMO-RALG involving all stakeholders through a participatory approach and implement the plans effectively and efficiently.

These goals are translated into objectives, strategies and indicators in the NMSF providing direction for various interventions. However, the Strategic Framework doesn't spell out in detail what to do, how to do it and where and when to do it. This task is reserved for the different operational - or action-plans which need to be developed and implemented by the different actors across the country based on local priorities and capacities.

Three major Priorities of the NMSF

The National Response to HIV has to balance measures which address the two main dimensions of the epidemic: the 7% of the sexually active population who are infected and the many more (families, communities, entire sectors of the society) who are affected by the impact of AIDS on the one hand and the 93% of the adult population who are not infected with HIV and who should be protected from infection in the future on the other hand.

While care and treatment for those infected with the virus is important and life-saving, in the medium- and long-term perspective, the country can only hope to reduce the burden of the epidemic by reducing the HIV transmission and increasing the percentage of Tanzanians who are not infected with the virus.

Therefore, the NMSF postulates as Number 1 priority for the country to increase HIV prevention efforts.

HIV is mainly transmitted through sexual contacts. Prevention efforts need to be focused on the entire population starting from very young children to adults and older persons who are still sexually active. In order to educate persons on sexual health and support the development of a responsible and positive sexual behaviour and relationship, it is best and most promising to start with the young people as they are begin their active sexual life. Recent surveys show that many young people are already adopting positive measures like delaying the onset of sexual activities or reducing the number of sexual partners as well as using condoms during sexual intercourse.

In a society like Tanzania where HIV has been prevalent for the last twenty years and has spread to nearly all communities of the country ("generalised epidemic") it is a highly complex affair to develop plans to reduce HIV transmission and mitigate the negative impacts of AIDS. Many aspects need to be considered and there is no "magic bullet" or short-cut in successfully dealing with the epidemic. It is for this reason that the NMSF provides a very comprehensive and extensive set of objectives and strategies covering four main thematic areas: enabling environment, prevention, care and treatment and impact mitigation. In addition, monitoring and evaluation, the organisation of the national

response as well as the resources needed to implement the response are also of prime importance and need to be taken into consideration by the different actors. Only when a synergy is established among all these key elements will success in the fight against AIDS be achieved.

Therefore, the NMSF proposes as Number 2 Priority to make sure that the entire population will be reached with quality and sustainable services for prevention, care and treatment and impact mitigation.

Given the diversity of the epidemic and the large size of the country, it is not envisioned that all objectives and strategies will and need to be implemented in a uniformed way across the country. For example, in regions and districts heavily affected by the epidemic, it is envisioned that more networks of counselling and treatment centres will be established compared with regions and district where the epidemic is less pronounced.

Therefore, the NMSF proposes as Number 3 Priority that the selection of priorities for interventions in the thematic areas of the enabling environment, prevention, care and treatment as well as impact mitigation should and must be based on the local situation when the strategic framework is translated into operational plans.

In implementing the NMSF, all actors' and stakeholders' support and interventions need to be guided by a set of common **approaches and principles** which apply to all intervention activities. As HIV is mainly transmitted through sexual contacts, openness about sexuality is required in the prevention efforts. The sexual relations between men and women are structured through social, economic, political and cultural imbalances between the sexes and this inequality needs to be addressed across all intervention initiatives. Capacity building and community participation should be prime elements in empowering people in the development of community based response at all levels and must be part and parcel of the wider government agenda to fight poverty and develop the country.

All plans, programmes and projects must be based on principles of human rights and respect the dignity and cultural integrity of people. As such, they should empower them, and be based on best available practises while being ethically and scientifically sound. Collaboration by all parties and continuous political commitment by government leadership at all levels is equally and necessarily important.

Achievements and challenges:

The last five years of the National Response to HIV were guided by the first National Multi-sectoral Strategic Framework on HIV and AIDS (2003 – 2007). During these years, a number of **achievements** have been attained which have contributed to strengthen the National efforts. Among the major achievements in the four thematic areas the following were observed:

Enabling environment (cross-cutting issues):

- Most MDAs started some HIV interventions for their employees and their sector;
- HIV and AIDS were integrated in the long-term poverty reduction strategy (MUKUTA);

Prevention:

- The coverage of STI treatment in the country increased to all hospitals, health centres and 60% of dispensaries;
- Substantially more (male) condoms were available in the country (from 50 to 150 million);
- The number of Voluntary Counselling Centres increased more than 3 times;
- PMTCT was scaled up from a pilot programme to more than 12% of health facilities;
- From different surveys there were indications that young people started to change their sexual behaviour (increased delay of sexual activities, fewer sexual partners etc.) and school-based health promotion programmes were expanded;
- The private and informal sectors became more actively involved, providing prevention and care programmes to its employees and members respectively.

Care and treatment:

- The roll-out plan for ART was implemented and more than 70.000 PLHIV are reported to be under treatment by the end of 2006;
- Home-based care projects were expanded mainly by CSOs;

Impact Mitigation:

- Increased support was provided to orphans and most vulnerable children

Progress was also achieved in:
Monitoring and Evaluation:

- Further expansion of the HIV sentinel surveillance system;
- Regular studies on HIV and behaviour (inclusion of HIV and AIDS in the Demographic and Health Survey (DHS)); and the Tanzania HIV Indicator Survey (THIS);
- Consolidation of the reporting on HIV and AIDS in the health system;
- Development and initiation of a comprehensive monitoring system for non-health activities (TOMSHA).

And in:
Management and Institutional arrangements of the National Response:

- TACAIDS became operational as the central coordinating structure for the National Response;
- Focal persons were appointed in all MDAs and AIDS Commitees established;

- Multi-sectoral AIDS Commitees were esr\tablished in all districts and in some wards, and villages and training was provided to committee members;
- Regional Facilitating Agencies were established covering all regions and providing substantial support for districts and communities;
- The portfolio of a Deputy Minister for Disasters and HIV and AIDS was created in the PMO;
- The Tanzania Parliamentarian AIDS Coalition was established;
- Many more Civil Society Organisations became involved in HIV providing a tighter net of coverage across the country, including more groups of PLHIV
- The funding for HIV and AIDS activities increased substantially from government and donor resources and far more funds reached communities;

However, in the overall response substantial **challenges** remain and need to be addressed in the coming years. Among these include the following:

- Continual lack of high level political commitment and accountability for the HIV response;
- Weak and insufficient HIV programmes by the MDAs especially at regional, district and community outreach levels;
- Overburdened national coordination structure (TACAIDS);
- Difficulties in applying the "Three Ones" principle at central and district levels;
- Insufficient participation of CSOs and PLHIV especially at district and community level in planning and implementing HIV responses;
- Continual delays and difficulties in providing timely funding to districts and communities;
- Stigma and discrimination remained high in many areas and parts of the country;
- Prevention efforts did not sufficiently address sexuality matters and often lacked continuity;
- Gender inequalities were not sufficiently and comprehensively addressed;
- Correct and consistent condom use remained problematic, and access was limited in most rural communities;
- Coverage of prevention efforts in rural areas was insufficient;
- Access to ART remained largely concentrated in urban centers.

The NMSF 2008 – 2012 maintains the four Thematic Areas of the first NMSF and tries to address the shortcomings of the past years. The Objectives of the Thematic Areas have been expanded and updated to provide an appropriate framework for national and lower level operational planning. Below is the summary of the Thematic Areas and the Strategic Objectives (the related strategies and indicators are presented in Chapter 4. 3).

The Four Main Thematic Areas and their Objectives

1. *Enabling Environment consists of 5 sub-themes:*

Advocacy and Political Commitment:

- Maintain and strengthen political commitment, transparency, accountability and popular support for HIV interventions using a human rights and gender sensitive approach.
- Deepen public awareness, acceptance and understanding of the needs and concerns of PLHIV and other vulnerable and marginalized groups through sustained advocacy at all levels.
- Recognize the special needs of specific groups such as women, youth, people with disability and those living in rural areas.
- Conduct a situation analysis of HIV and AIDS advocacy to identify achievements to date and outstanding challenges and gaps with a view to implementing effective and sustainable advocacy mechanisms and strategies that will counter stigma, discrimination and denial.

Fighting Stigma, Denial and Discrimination:

- Human rights of PLHIV and their families are safeguarded through non-discriminatory attitudes in their communities and through improved access to user-friendly and gender sensitive HIV services.
- High level leadership (political, traditional and community based) is maintained to engage in anti-discriminatory and stigma reducing activities.

Regional, District and Community Response:

- Communities develop local responses to the challenges of HIV, based on local knowledge of the epidemic, on creativity and local competence through a wide range of partnerships involving the civil society and public sectors.
- Communities' responses to HIV are 'anchored' in the existing government structures and committees at LGA level with adequate resource support.
- Communities receive technical assistance by regional organisations and institutions in developing the local responses.
- Regional organisations and institutions provide the necessary coordination and supervision of local responses.

Mainstreaming HIV and AIDS:

HIV concerns are mainstreamed in key sectors of Tanzanian society in line with NMSF priorities

HIV and AIDS, Development and Poverty Reduction Policies:

- Ensure full integration of the challenges related to the HIV epidemic into the country's major long-term development plans and policies taking into account the particular effects on PLHIV, their affected families and communities as well as gender and poverty related issues.

2. Prevention consists of 9 sub-themes:

Promotion of abstinence, delayed sexual debut, partner reduction and consistent condom use among young people in and out of school:

- Empower young people with knowledge and skills to dialogue about sexuality, to adopt attitudes and practices that protect them against HIV-infection and to access reproductive health services

Reduction of risk of HIV infection among the most Vulnerable populations:

- Reduce risk of infection among those most vulnerable due to gender inequality, sexual abuse, socio-cultural factors and involvement in illegal practices (women in relationship without control to practice safe sex, women engaging in commercial and transactional sex, sexually abused children, widows and divorcees, men who have sex with men (MSM), prisoners, refugees and displaced persons, people with disabilities and intravenous drug users)

Expansion of workplace interventions, with special attention for mobile and migrant workers:

- Increase the proportion of public and private sector enterprises and informal sector operators developing and implementing comprehensive workplace interventions with special attention for mobile and migrant workers.

Prevention, treatment and control of other sexually transmitted infections (STI):

- Expand quality, gender sensitive and youth friendly STI services including counselling and condom promotion to all health facilities in the country and enhance appropriate utilization of services

Promotion and expansion of HIV testing and counselling services:

- Increase the number of people in Tanzania who know their HIV status and who adopt appropriate measures to protect themselves and/or their partners from infection and re-infection.

Prevention of mother to child transmission of HIV:

- Reduce the transmission of HIV from mothers to their children, during pregnancy, birth and/or breast-feeding and ensure entry into care and treatment for mother and baby

Promotion and distribution of condoms:

- Increase the proportion of the sexually active population, especially in the rural areas, who use condoms consistently and correctly and promote and expand the availability of female condoms as a female controlled and dual protection method.

Prevention of HIV transmission through blood transfusion, exposure to contaminated body fluids and contaminated instruments:

- Reduce the risk of HIV transmission through blood, contaminated instruments and non-observance of universal precautions in health care settings as well as through the use of contaminated instruments in traditional practices such as scarification, male circumcision and female genital cutting.

Introduction of new prevention interventions:

- Emerging prevention intervention are introduced and scaled up based on international scientific evidence and on results of assessment of local acceptability, demand, operational and regulatory issues as well as stakeholder consultations.

3. Care, Treatment and Support consist of three sub-themes:

The Continuum of Care, Treatment and Support:

- Increase equitable access for PLHIV to a continuum of care, treatment and support

The dual Epidemic of HIV and TB:

- Improve the quality of care for both PLHIV and TB patients through closer collaboration between the two programmes.

Home-Based Care and Support:

- Scale up availability and accessibility of quality community and home-based care services

4. Impact Mitigation consists of three sub-themes:

Most vulnerable children:

- Community-based support for MVC through a multi-sectoral response is enhanced, supported by expanded service delivery.

The Affected:

- The ability of individuals, families, and communities to respond to the impacts of HIV and AIDS is strengthened.

People Living with HIV and AIDS:

- People living with HIV and AIDS (PLHIV) and other stakeholders are empowered to respond effectively to PLHIV needs and rights, taking into account the different situations and needs of women and men.

The Monitoring and Evaluation Framework of the NMSF

For measuring progress in the National Response to HIV, a comprehensive and effective monitoring and evaluation system is necessary to provide continuous data on programme performances and identify weaknesses which need to be addressed.

The NMSF 2008 – 2012 has for the first time a very detailed and comprehensive M&E framework built on progress of indicator development and harmonisation of the last

years in the health and non-health related areas. There is a growing awareness among all partners that only a common M&E system which captures the entire dimension of the NMSF will deliver sufficient information for all actors to provide a clear picture on the overall progress in the implementation of the NMSF. The framework spells out in detail how this system will function and what the requirements are. It also provides the orientation for monitoring and evaluation of the NMSF itself.

A major part of the M&E work will be the development of a national research agenda related to the main areas and challenges of the NMSF, especially in providing more insights into the different driving forces that lead to the diversity of the HIV epidemic(s) at regional and district level in order to facilitate better and more effective regional and lower level planning of priorities in the fight against AIDS.

Organisations and Institutional Arrangements for the Implementation of the National Response at Central, Regional and LGA Levels

Strategies, interventions and activities have to be delivered and implemented. The major challenges of a successful National Response to HIV are still in the area of organisation and implementation of strategies and interventions. What has to be done in the fight against AIDS is largely known and the NMSF provides this strategic vision. However, in Tanzania and in most countries in Africa which facing a severe HIV epidemic, implementation of intervention strategies is generally hampered by many obstacles and shortcomings.

The NMSF 2008 – 2012 calls for political leadership, commitment and accountability at all government institutions levels charged with guiding and supervising the National Response. The PMO and the office of the Deputy Minister on Disaster and HIV and AIDS where the responsibility of the Government is anchored, will play a key role in assuring that the government at all levels is more responsive to the this 'national disaster".

Parliament and political parties need to strengthen their oversight and advocacy role; while TACAIDS continues to provide coordination and strategic guidance in the overall implementation of the NMSF. The MDAs on the other hand, need to expand and deepen their role in developing strong sector specific programing in addressing the challenges of HIV among their respective workforce.

Civil society organisations across the country are important implementation partners and complement the government driven intervention initiatives. Through relevant capacity building CSOs are envisioned to continue providing quality services as they organise themselves in a more effective way as partners of the National Response. In particular, PLHIV are expected to improve their self-organisation at central and local levels to enable them assume a major role in planning of HIV interventions and service delivery. Similarly, the private sector is expected to expand its workplace programmes

on HIV and supports medium- and small enterprises as well as the informal sector to respond effectively to the HIV challenge.

The major challenge in the execution of the above initiatives is the continuous strengthening of decentralised HIV programming and implementation, involving communities in participatory planning, implementation, monitoring and evaluation of community specific interventions in a transparent manner, through open communication and accountability of all partners. With increased understanding about the local dimensions and driving forces of the HIV epidemics, the responses to HIV and AIDS will become stronger and more effective. Capacity building as well as continuous technical assistance to district and communities are key areas of the institutional and organisational framework. In all interventions, programmes and projects the different needs and capacities of women and men will be taken into account.

The main guiding principle for all national, local and external partners is the 'harmonisation and alignment' of all programmes and projects implemented under the framework along the "Three Ones" Principle: having one coordinating structure, one implementing plan and one monitoring and evaluation system at central, regional and LGA levels.

Financial, Human and Technical Resource Framework of the National Response

The implementation of the NMSF needs resources. Tanzania, being still one of the most resource constrained country needs to mobilise substantial financial resources - both internally and externally to implement the NMSF. Along these efforts, the government and the Development Partners need to ensure that these resources are used efficiently and well accounted for.

The "human resource crisis" inside and outside the health sector for delivering services and interventions needs innovative approaches, changes in labour regulations and involvement of more private sector actors. Similarly, actors at all levels need to be equipped with the necessary and appropriate logistics to effectively deliver their tasks and services. Bottlenecks in the procurement procedures including supply chain management and related infrastructural necessities need to be addressed.

From Strategic Framework to Operations and Implementation

The NMSF 2008 – 2012 provides the broad orientation and the principles which will guide the National Response to HIV in Tanzania in the coming five years. It also sets the indicators and targets to be achieved.
However, the MNSF is not an operational plan which indicates for all actors and stakeholders what to do, when, where and how to do it.

It is absolutely necessary for the National Response to become reality to move from the 'strategic' orientation to concrete plans, programmes and projects.

In order to do so, two main developments are necessary:

1. The NMSF 2008 – 2012 must be brought to the attention of the responsible persons, actors and stakeholders in the entire country, from the central level down to the districts and communities so that everybody who is concerned about HIV knows and understands what the National Response is all about and what needs to be achieved. Therefore, under the guidance of TACAIDS, and with the support of the regional structures, a detailed dissemination and promotion plan for the NMSF 2008 – 2012 has to be established and implemented.
   This will also include the translation of the document into Swahili to facilitate the appropriation of the document in the districts and communities.
2. Operational Plans have to be developed and implemented. Given the complexity of Tanzania, the multiple sectors and the many regions and districts involved, the NMSF will not be translated into ONE National Operational Plan. It is envisaged, that based on the guidance of the NMSF 2008 – 2012:
   a. Key MDAs and Sectors develop and implement their national plans reaching down to the districts and communities and,
   b. All districts will develop and implement integrated Development Plans which incorporate the HIV and AIDS concerns of their communities based on best available local knowledge and capacities.

As the different national district plans will be costed, the harmonisation with the financial resources from the government and from the DPs needs to be undertaken to integrate these plans fully in the planning cycle with the start of the fiscal year 2008-2009.

Chapter 1: Background

1.1 Socio-economic and political Aspects of Tanzania

The United Republic of Tanzania is located in Eastern Africa. It shares borders with Kenya and Uganda in the north, Rwanda, Burundi and the Democratic Republic of Congo in the west, and Malawi, Zambia and Mozambique in the south. The Indian Ocean forms the border to the east.

The United Republic of Tanzania comprises of Tanzania Mainland and Zanzibar. This document refers to Tanzania Mainland only.

Tanzania is administratively divided into 21 regions and 122 district, municipal and town councils.

Tanzania's population is estimated to be around 37 million people (2005) of which about 30 % live in urban centres and 70 % reside in the rural areas. The population is concentrated in the Lake Zone along Lake Victoria in the north, around Dar es Salaam, the main business and trading centre along the coast, and in the southern highlands around Mbeya. Large areas of the country are sparsely populated. The population growth rate is estimated at 2.8%; and life expectancy at birth is 47 years for men and 49 years for women.

Tanzania is among the poorest countries in the world with a per capita Gross National Income of US $ 660. Tanzania is ranked at position 162 out of 177 countries on the Human Development Index of UNDP (2004).

Poverty is widespread. Tanzania has embarked on an ambitious poverty reduction programme widely known by its Swahili acronym MKUKUTA. It aims at reducing poverty by 50% by the year 2010. According to estimates in 2000/2001, 36% of the population continued to live below the nationally established "Basic Needs Poverty Line", only 3% less than 10 years earlier[1]. Due to population growth, the absolute numbers of poor people has increased in the last ten years.

Although the overall economic growth rate ranged between 5.7% and 6.7% from 2001 to 2004, the growth rate in the agricultural sector has been lower than in other parts of the economy. While poverty may be reduced significantly in Dar es Salaam, the rural areas are most likely to miss the target specified in MKUKUTA.

Development is very uneven across the country and with regard to different indicators. A few districts have less than 15% of households below the basic needs poverty line, while in others the percentage may be as high as 60%.[2] But even some of the poorest districts

---

[1] REPOA, 2005 Brief 1 Poverty and Human Development Report 2005

[2] ibid

have done very well in reducing under-five mortality rate or the net primary school enrolment rate[3].

Economic development has generally not trickled down to the rural areas. However, there are many ambitious projects in infrastructure, telecommunication, mining and tourism sectors in the country and the entire East African Region which may provide new opportunities for formal and informal employment and income but also may incorporate new challenges as mobility will increase and with it movements of mostly single men out of their families and communities for (temporary) work.

[3] ibid

1.2 Relation of the NMSF to other National Documents, Plans and International Commitments

HIV and AIDS Policies and Laws

The policy response to HIV dates back to the mid 1980s with the formation of the National AIDS Control Programme (NACP) within the Ministry of Health and Social Welfare (MOHSW). At that stage, HIV was seen mainly as a health issue. In 1999, the President of the United Republic of Tanzania declared AIDS to be a "national disaster" and that set in motion a multi-sector response which was later incorporated into the National Policy on HIV and AIDS[4] in 2001. The policy reiterated the Government of Tanzania"s (GOT's) commitment to HIV and AIDS as a priority area and called for strong political commitment and leadership from all levels of government and civil society to ensure sustained and effective interventions. The National Policy set the context for the 2003 – 2007 National Multi-sectoral Strategic Framework (NMSF) and with the passing of legislation in 2001[5], the Tanzania Commission for HIV and AIDS (TACAIDS) was constituted in the Prime Minister's Office (PMO) to coordinate and operationalise the multi-sector response. The new NMSF for 2008 – 2012 builds on that policy document and the last NMSF.

Despite progress in the policy environment there is an incomplete legal framework to support it. The new HIV and AIDS Prevention and Control legislation[6] is at the beginning of a process within and outside government and will need fast tracking to enhance the response. The HIV and AIDS policy review in 2008 will further guide the GOT and civil society's inputs in the national response.

Legislative review will be an important component of the 2008 – 2012 NMSF. Reviews of the following laws and regulations are needed:

Laws / Regulations governing	Effect
Scope and Practice of Health Professionals	To allow lay counsellors and traditional healers greater involvement in the HIV response.
Health Services	To allow for distribution of condoms, VCT kits, etc, through multiple service providers.
Public Finance	To ring fence the HIV funds; ensure that no budget is approved without HIV plans and activities; allow easier access

[4] National Policy on HIV/AIDS. United Republic of Tanzania, Prime Minister's Office. Dar es Salaam. September 2001

[5] Act No. 22 of 2001 that set up the Tanzania AIDS Commission.

[6] Proposal to Enact the HIV/AIDS Prevention and Control Act 2006. Attorney General's Chambers. Ministry of Justice and Constitutional Affairs. March 2006.

	of CSOs to public sector funds.
Public Service Commission & Labour	To ensure workplace programmes are in place for government and private sector employees and their families; promote anti-discriminatory regulations for PLHIV.
Land and Housing	To allow women, children and orphans greater access to security of tenure.
Human Rights	To enhance a rights-based approach to the HIV response and provide the instruments to support a 'rights-based' approach to decrease stigma, discrimination and denial; to ensure rights and responsibilities of PLHIV.
Socio-cultural (circumcision, mourning days, wife inheritance)	To enhance the prevention response in HIV.
Welfare of children particularly orphans and other vulnerable children	To enable effective impact mitigation activities.
Protection of Workers	To safeguard employment and avoid discrimination at the workplace
Marriage Laws Laws regarding gender-based violence Sexual Offenses Act	To empower and protect women and girls

National Development Policies

The country's overall development framework and long-term social and economic development goals are laid out in the National Vision 2025 document. The National Poverty Eradication Strategy (NPES) provides the long-term framework for guiding poverty eradication efforts in order to reduce absolute poverty by 50 percent by 2010 and eradicate absolute poverty by 2025.

The MKUKUTA is the National Framework which accords high priority to poverty reduction in Tanzania's development agenda. Spanning a five-year cycle (2005/06 – 2009/10), it aims to achieve the Vision 2025 and the Millennium Development Goals (MDGs). While MKUKUTA recognised the effect and influence of HIV and AIDS on poverty, it did not incorporate the last NMSF into all its activities[7]. Issues on impact assessment and the effects of HIV and AIDS on the macroeconomic situation as well as on households and families need to be factored into the next review of MKUKUTA. HIV can be both a consumption factor (consuming services) as well as an investment activity (greater donor support, enhancing human capacity, creating employment and delivering services). At a local level, HIV activities need to be mainstreamed into the economic and development projects at the district, village and community level with greater transparency to and involvement of CSOs. HIV programmes should also be linked to governance and accountability with enhanced and sustained commitment by political

[7] Linkages and gaps between MKUKUTA and the NMSF 2003 – 2007. Pg 10.

leaders and opinion makers. The Poverty Monitoring system of MKUKUTA should also develop linkages with the Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and enhance the overall monitoring and evaluation process in both frameworks.

Joint Assistance Strategy for Tanzania (JAST)

The JAST is part of the overall development framework between donors and the GOT[8]. It is intended to deepen Tanzania's ownership and leadership in donor relations by enhancing harmonisation and alignment to the GOT's national priorities, development goals, systems and processes under MKUKUTA and Vision 2025. It also seeks to reduce the high transaction costs of multiple and overlapping processes of delivering, managing, monitoring and evaluating development assistance.

Overall 40% of the budget of the GOT is through donor assistance. Of particular significance, is that 80% of the HIV budget is from donor sources with the majority of funds from three donors (the United States government (USG), the Global Fund to fight AIDS, TB and Malaria (GFATM) and the World Bank (WB))[9]. The HIV and AIDS response lends itself to being a thematic area under JAST and the formation of Development Partners Group-AIDS (DPGA) give credence to such a theme. With the advent of JAST, the support to non-state actors will also need review to ensure their continued funding, support and sustainability. On the other hand, greater equity and coverage across Tanzania will be enhanced as donor assistance will follow a demand driven approach with local communities at the centre of the response. The JAST also makes provision for technical assistance and this should be utilised to the fullest by all structures in the HIV response to strengthen capacity and implementation and reduce bureaucratic obstacles.

The Memorandum of Understanding (MoU)[10] between the Development Partners (DPs) and the GOT which supports the implementation of joint planning, resource mobilization and monitoring and evaluation is a very significant input in the national response. It is in line with the JAST and the principle of the "Three Ones" which guides the NMSF.

International Commitments

The GOT is signatory to a range of international agreements, declarations, treaties and conventions which deal with HIV eg., Bejing Platform of Action, United Nations General Assembly Special Session on HIV and AIDS (UNGASS), New partnership for Africa's Development (NEPAD), Southern African Development Community (SADC), MDGs, Great Lake Initiative on HIV and AIDS (GLIA), East African Community (EAC) and Africa Region AIDS Care Capacity Network (ARCAN). MDGs and UNGASS goals and indicators have been incorporated into the new NMSF. These commitments and ratification protocols need to be costed, adequately resourced (human and technical) and managed by sector specific Ministries Departments and Agencies (MDAs) with support from TACAIDS where necessary. The NMSF 2008 - 2012 should review these

[8] Joint Assistance Strategy for Tanzania. November 2006.
[9] NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.
[10] See Annex 3

commitments and ensure that continued provision is made for their activities within the various MDAs and/or TACAIDS.

Chapter 2: The HIV and AIDS Epidemic(s) in Tanzania

Tanzania is facing a 'generalized[11]' epidemic of HIV. The national HIV prevalence rate among the sexually active population (defined as the population between 15 and 49 years of age) is reported to be 7.0 %, with females having a slightly higher rate (7.7%) than males (6.3%).[12] To date, it is estimated that 1.3 million people including adults and children are living with HIV or AIDS. There are signs that the overall national figures are stabilizing and even going down slightly in the last five years[13].

The first three cases of AIDS were reported in 1983. Since then, HIV infection has spread to all regions and districts of the country. However, the HIV prevalence rates show important variations within the country. 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 regions like Iringa, Mbeya or Dar es Salaam which have seen infection rates well above 20% in the mid-late 90s and which have now dropped to about 11-18%, still presenting the more affected parts of the country. Other regions such as Kigoma, Kagera and Kilimanjaro report HIV prevalence rates among ante-natal attendees of only 3-5% have never seen a major explosion of the epidemic and have stayed with relatively low infection rates over the past twenty years[14]. But even inside the regions there are substantial differences: in Mbeya region for example there are districts like Kyela which has an HIV prevalence rate of 19.8 % and Ilembo with only 5.1%[15].

The variations between the regions and districts result from different factors fuelling the HIV epidemics. The specific factors are, however, largely unknown. Despite a wealth of studies on aspects of the HIV epidemic(s) in the country, a sound understanding of the heterogeneity of the epidemic is still lacking. The existing surveillance system is not decentralised enough to provide enough local data on the epidemics and studies analysing the local 'drivers' of HIV transmission have not been undertaken. The NACP plans to extend the HIV surveillance system to all regions and more districts and to undertake studies focussing on different epidemiological 'scenarios' of the country.

Urban areas report generally higher infection rates than rural areas. The highest infection rates are found in women of the age-group 30 -39 years and in men of the age-group 35-44. However, in this age-group the infection is cumulating. It cannot be interpreted as being the age-group with the highest incidence rates.

---

[11] "generalised" in the classification of the HIV epidemics of UNAIDS means "HIV prevalence consistently over one percent in pregnant women".

[12] HIV/AIDS Indicator Survey 2003/4

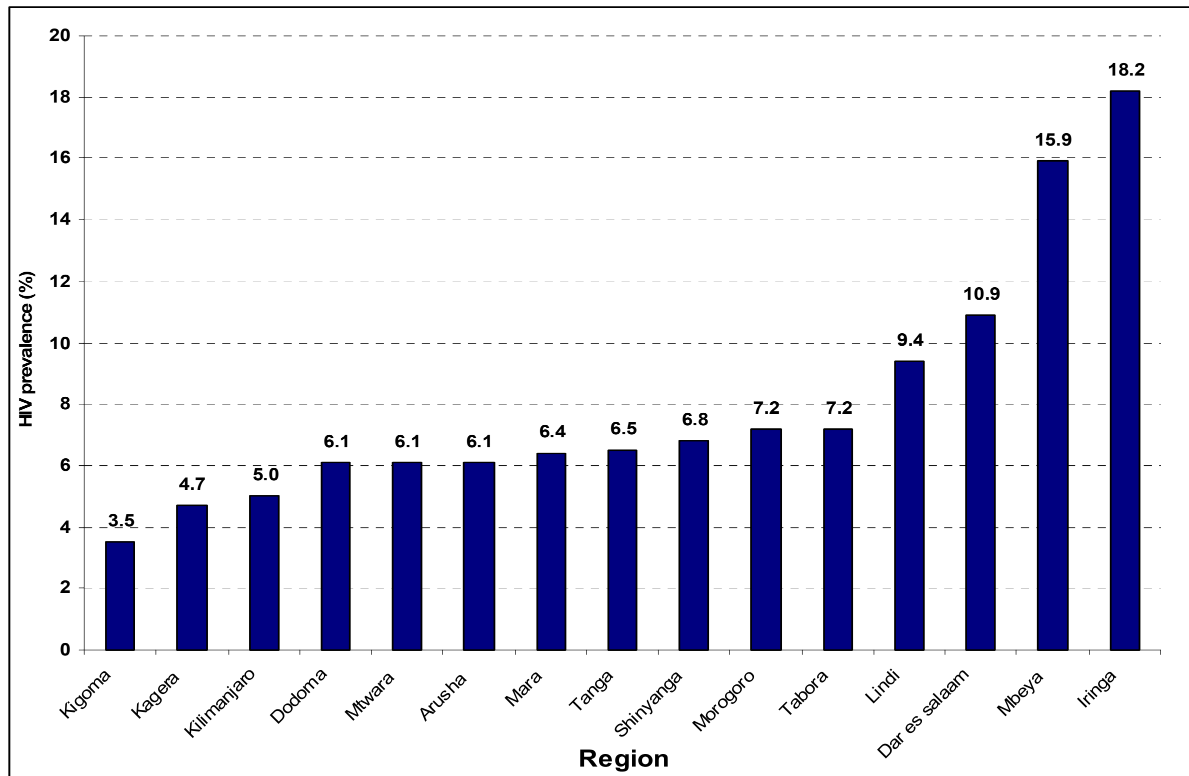
[13] The last HIV Surveillance Report of the NACP concluded: "In general, there is a significant downward trend in HIV infection over the three survey rounds since 2001/02." p.7

[14] For a regional panorama, see Figure 1 of the NACP Surveillance Report which shows rates from 15 of the 21 regions (the remaining six regions are not yet integrated into the surveillance system as of 2006)

[15] All figure here are from the "Surveillance of HIV and Syphilis Infections Among Antenatal Clinic Attendees 2005/06, Report Number 3" published in 2007 from the National AIDS Control Programme, Ministry of Health and Social Welfare, Dar es Salaam.

In contrast to most HIV epidemics in the southern part of Africa, there is no important difference in infection rates between young women (19-24 years old) and young men of the same age group (4% and 3% respectively)[16].

Fig 1: Prevalence of HIV infection among ANC attendees by region, Tanzania 2005/06



Source: "Surveillance of HIV and Syphilis Infections Among Antenatal Clinic Attendees 2005/06, Report Number 3"

Calculations based on the findings from the Tanzania HIV/AIDS Indicator survey (2003/4) show 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[17]. The picture also shows that, for both men and women, HIV prevalence increases with level of education. Adults with some secondary education are more likely to be infected with HIV than those with no education (i.e. with no education, males 4.2% and females 5.8%, while with some secondary education the rates are 7.3% for males and 9.3% for females[8]. HIV prevalence among separated/divorced/widowed is significantly higher (men 15% and

[16] HIV/AIDS Indicator Survey 2003/4
[17] Tanzania Commission for AIDS. A New Look at the HIV and AIDS Epidemic in Tanzania. December 2005
[8] HIV/AIDS Indicator Survey 2003/4

women 19.8%) than among those currently in union/married (men 7.8% and women 6.9%) and those never in union (men 3% and women 3.8%)[18]. HIV prevalence also seems to increase with wealth (prevalence rates among the poorest men 4.1% and women 2.8% while among the richest men 9.4% and women 11.4%)[19].

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. The dimension of these infection routes is not known.

The dynamics and determinants of the HIV epidemics in the country are multiple. They are shaped by the sexual relations of the people which are related to numerous social, cultural and economic factors. Overall, the determinants are probably not much different from other parts of Africa with generalised epidemics. Among the more important aspects are:

- Promiscuous sexual behaviour
- Low and inconsistent condom use
- Intergenerational sex
- Concurrent sexual partners
- Lack of knowledge of HIV transmission
- Presence of other sexual transmitted infections, especially herpes simplex 2 virus

The **contextual factors** which shape the epidemics in the country include :

- Poverty and transactional sex with increasing numbers of commercial sex workers
- Male irresponsible sexual behaviour due to cultural patterns of virility
- Social, economic and political gender inequalities including violence against women and girls inside and outside relationships (marriage)
- Substance abuse especially the consumption of alcohol
- Local cultural practises (like widow ‘cleansing’ or initiation rites)
- Mobility in all its forms which leads to separation of spouses and the increased establishment of temporary sexual relationships
- Lack of male circumcision

However, as said above, these factors are general knowledge affecting the transmission of HIV. It will be very important when developing more appropriate responses, to identify at regional and district level the main drivers and determinants of the HIV transmission which may or may not be different from the overall national picture. Also, there is a wealth of studies looking into those factors which has not been sufficiently exploited and analysed. Increased understanding of the different epidemic in the country is vital for developing appropriate and relevant responses and priorities at local level.

Impact of the AIDS Epidemic

[18] Ibid
[19] Ibid

The exact impact of the AIDS epidemic in the country is unknown and difficult to establish.

Impact on Demography and Human Resources[20]:

Studies linking HIV and AIDS with the country human capital development process are lacking. Kessy reports from different sources, which estimate that without AIDS the annual number of deaths in 2015 would be 40 percent less. Majority of the AIDS deaths is expected to fall on the 15-49 years age group, the most sexually active and in the prime of their productive years (43 percent). The annual AIDS deaths are also increasing from about 99,000 deaths in 2000 to about 175,000 deaths in 2015. However these projections may have to be revised in the light of the ART roll-out programme which will have a major impact on deaths related to AIDS in the coming years.
Other studies reports that in Tanzania, there is a loss of 8 years in life expectancy

Orphans

World Bank studies estimated the number of children orphaned by AIDS to be increasing from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2000. The latest estimate by UNAIDS[21] put the number of orphans due to AIDS at 1.100.000[22]. Another study by UNAIDS projected that by the year 2010 there will be 4.2 million AIDS orphans in Tanzania (UNAIDS, 2001).

Household Level

A recent study of households affected by death from AIDS[23]in Tanzania analyses the gaps in consumption growth between households affected by death from AIDS and non-affected households and estimates that there is a growth gap of nearly 20%. The impact of female adult death is found to be particularly severe.
The situation of female- and child-headed households needs special attention as far as breaking the poverty cycle is concerned.

Health and Education Sectors

The concrete impact of HIV and AIDS on the health and education sectors in terms of additional morbidity and mortality (days and years lost) is not known. It is estimated from anecdotal evidences that the rate of HIV infection among employees of health and education 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 AIDS opportunistic infections, increased demand and sometimes reallocation of resources from other equally important health problems, and decreased number of health workers.
From anecdotal evidence it is known that death toll has been high among the teaching community from primary to university levels. In 2004, the Ministry of Education and Culture conducted a baseline study. The report however relied heavily on NACP reports for data on HIV infections and AIDS and assumed that primary school pupils, secondary

[20] The following paragraphs rely much on a comprehensive study undertaken by Dr Flora Kessy of the Ifakara Health Research and Development Centre: Social and Economic Impacts of HIV and AIDS in Tanzania, Inventory of Studies, 2007
[21] UNAIDS, Report on the Gloabl AIDS Epidemic, 2006, p. 509
[22] For the difficulties with estimates concerning orphans and most vulnerable children, see Chapter 4.Impact Mitigation
[23] K. Beegle et al, Adult Mortality and Consumption Growth in the Age of HIV/AIDS, 2006

school students and teachers follow the same trend as their respective cohorts in the general population. The study also did not embark on a thorough socioeconomic impacts analysis on the sector. The government has recently revealed that the education sector is in danger of losing more than 27,000 teachers to AIDS by 2020.

Chapter 3: Analysis of the National Response to HIV and AIDS (2003 – 2007)

Introduction

The National Response to HIV in Tanzania has evolved since 1985. Under the responsibility of the Ministry of Health and Social Welfare (MoHSW) and its National AIDS Control Programme (NACP) supported by World Health Organisation's (WHO) Global Programme on AIDS (GPA) one short-term (STP) and 3 medium-term plans (MTPs) were developed and implemented between 1985 and 2002

During the implementation of the STPs and MTP I 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 the above efforts, HIV infection rates continued to increase in the country, reaching a peak in the mid 90s. The MTP II (1992 - 1996) aimed already at mobilizing a broader national response involving sectors like education, labour, and agriculture for the first time, while intensifying collaboration with local and international NGOs, bilateral and international agencies. Efforts towards multi-sectoral response to the epidemic which was vividly underscored in MTP III was given a unique boost in 1999, when the President of the United Republic of Tanzania declared AIDS to be a national disaster24 calling for a concerted multi-sectoral response to address it. This was followed by the establishment of an enquiry into the factors that were behind the slow multi-sectoral response to the epidemic[25].

Among the recommendations of the Shellukindo enquiry was the development of the National Policy on HIV and AIDS[26] in 2001 and an establishment of supra-ministerial body to coordinate the multi-sectoral response. It was in light of these recommendations that the President of the United Republic of Tanzania formally established the Tanzania Commission for AIDS (TACAIDS)[27] under the Prime Minister's Office which was later ratified by government Act No. 22 in 2001 to coordinate the multi-sectoral response and provide strategic leadership.

The inception of TACAIDS was followed by the development of the first National Multi-sectoral Strategic Framework (NMSF) (2003 – 2007). Through this framework, the public and private sectors, local and international NGOs and institutions were urged to initiate interventions aimed at addressing the four major thematic areas: prevention, care

---

[24]. http://www.publicintegrity.org/aids/country.aspx?cc=tz

[25] Shellukindo, W.H. et al. "Towards Advocacy for HIV/AIDS Response Within Government, Political; and Civil Leadership in Tanzania" A Consultancy Report submitted to NACP, April 2000.

[26] National Policy on HIV/AIDS. United Republic of Tanzania, Prime Minister's Office. Dar es Salaam. September 2001

[27] Act No. 22 of 2001 that set up the Tanzania AIDS Commission.

and treatment, impact mitigation and the enabling environment (cross-cutting issues). The MoHSW was the first to respond to the call for multi-sectoral response in 2002 by developing the Health Sector Strategy for HIV and AIDS (2003-2006). This was 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.

National Responses along Thematic Areas

Thematic Area 1: Cross Cutting Issues Related to the Entire National Response (Enabling Environment)

The 2003 – 2007 NMSF envisioned to address a number of broad cross-cutting issues (enabling environment) to enhance successful implementation of the various strategies outlined under each thematic area in the framework. These included the following:

- **Advocacy**

Coping with a "national disaster" like AIDS calls for a strong leadership, commitment and accountability. The retired Tanzanian President Benjamin William Mkapa led his high- level political leadership in the official launches of the TACAIDS, the National HIV and AIDS policy in 2001 and the NMSF 2003 – 2007. Through his advocacy in and outside the country, Tanzania managed to the secure support from the Global Fund to fight AIDS, Tb and Malaria (GFATM) of anti-retroviral treatment (ART) to PLHIV. This was later followed with the establishment of Benjamin William Mkapa National HIV and AIDS Fellowship Program to support training of health workers for care and treatment of people living with HIV.

The advocacy tone set by the President is reported to have reverberated from the national to the regional and district levels where majority of Civil Society Organisations (CSO) (93%) and members of Council Multi-sectoral AIDS Committees (CMACs) (92%) reported some levels of advocacy by political, government and religious leadership at different forums. Similar efforts were noted among the parliamentarians who decided to establish the Tanzania Parliamentarian's AIDS Coalition (TAPAC) in 2002 with advocacy as one of its mandates.

Although some progress was noted in the growing number political leadership involvement in advocacy activities related to HIV, much of it is reported to be based on the need to fulfill their public responsibilities rather than real commitment and accountability to the national response efforts. Further, the low level of advocacy had been attributed to lack of advocacy skills both among the political leadership and key stakeholders involved in HIV interventions. In an effort to enhance and broaden more effective advocacy by key stakeholders including media institution, TACAIDS successfully developed and launched the National Communication Strategy in November 2005 which was immediately followed with the drafting of Media Advocacy Strategy.

- **Fighting Stigma, Denial and Discrimination**

Through advocacy activities, CSOs and the networks of PLHIV have made the public more aware about the issues associated with stigma, denial and discrimination and their

implications for PLHIV. PLHIV have been recognized as a force in the overall national response against the epidemic and are now represented in key HIV Committees tasked with coordination of multi-sectoral initiatives in the country.

Stigma and discrimination against PLHIV, however, are still a major challenge marginalizing infected individuals at the level of the family, workplace and the community and are creating unnecessary suffering. PLHIV are still being discriminated in accessing health care and other social services in violation of their basic human rights. The absence of an effective, national level PLHIV umbrella organisation in Tanzania may have worked against efforts to fight stigma and discrimination and reduce denial among the PLHIV. Although TACAIDS has for the past few years tried to support efforts towards the formation of a National Council of PLHIV, these efforts have been derailed by personal interests of some members of these organisations.

- **Regional, District and Community Response**

The government has through the PMORALG established an HIV response structure through its "Decentralization by Devolution" policy covering the entire country with multi-sectoral committees on HIV at district, ward and village levels. This initiative was based on the understanding that the "fight against AIDS" has to be organised and coordinated by appropriate structures which are close to the communities and which can respond to the specific threats and opportunities.

Since TACAIDS does not have regional and district offices, 11 Regional Facilitating Agencies (RFAs) were established, each covering two regions, as an extended arm of TACAIDS to provide technical and financial support to community based initiatives.

However, limited managerial and technical skills among the key local players in planning, implementing, monitoring and evaluating community specific programmes have become a major impediment in providing effective local responses to HIV. Further, while all the councils have established functional CMACs and training was provided to council members, the respective committees are yet to be established in some wards and villages. Finally, the 'Three Ones' Principle which has been a guiding the National Response appears to be compromised in some regions and LGAs due to lack of relevant technical capacity and limited experiences by actors to form partnerships and collaboration between sectors .

- **Mainstreaming HIV and AIDS**

Few Ministries Departments and Agencies (MDAs)s have developed a situation and impact analysis of the effects of HIV on their sector and few have developed appropriate interventions to counter the negative effects of the epidemic on their workforce (internal mainstreaming) and 'target-group' (external mainstreaming).

Lessons learnt from mainstreaming efforts by the public and private sectors show lack of comprehensiveness and sustainability due to lack of leadership and commitment, inadequate technical skills to execute the programmes, and limited human and financial resources.

- **HIV and AIDS and Development and Poverty Reduction Policies**

The MKUKUTA strategy on poverty reduction has recognized the implications of HIV to its success and has taken steps to incorporate it in its goals and objectives to address the existing interdependence of HIV and poverty.

Experiences from the district response initiatives show lack of integrated planning in the execution of district, ward and village level responses to HIV. Non-health and health planning officers appear to be working in isolation both in analysing and monitoring the impact of the epidemic and its implications to development. This has been one of the reasons for the low progress in mainstreaming of HIV in MKUKUTA.

Thematic Area 2: Prevention

The thematic area prevention of the 2003-2007 NMSF aims at reducing the spread of HIV in the country through two goals (i.e. reduce the prevalence of STI and increase the knowledge of HIV transmission in the population) and nine major intervention areas. Considerable progress has been made in addressing this thematic area as follow:

- **Sexually Transmitted Infection (STI) Control and Case Management**

Significant progress has been made in expanding STI services in the country. By the end of 2006, services for STI syndromic management were available in all hospitals, all health centres and about 60% of dispensaries. More than 400,000 patients with STI were reported to have been diagnosed and treated in health facilities in 2006, compared to 223,000 in 2003.

Despite this progress, an evaluation of the delivery of STI services in 2005 raised concerns about low utilisation by young people, frequent stock-outs of drugs and lack of systematic counselling of STI patients on condom use and on importance of testing for HIV. The syndromic management of STIs does not include herpes simplex type 2 infections (HSV-2) despite its proven significant role in facilitating HIV transmission. Further, although the MOHSW has updated relevant guidelines, manuals and curricula and carried out in-service training in STI syndromic management, such training is yet to be integrated in the pre-service training programme for all health workers.

- **Condom Promotion and Distribution**

There has been a steady increase in the number of male condoms available in the country from over 50 million in 2003 to over 150 million in 2006. Unlike the male condoms whose demand is significantly high in relation to supply, the uptake of female condoms has been quite low with only about 776,000 condoms reported to be distributed in the country in 2006. The introduction of social marketing of condoms which also includes female condoms has complemented and even surpassed the free distribution of condoms through the health facilities.

There is uneven distribution of condoms between rural and urban communities, making condoms mainly an urban phenomenon. The main distribution outlet for free male condoms still remains the public sector (i.e. MoHSW health service outlets) limiting

accessibility to condoms among specific groups in the community. Further, the uptake of female condoms is quite low due to low acceptability coupled with high costs of the female condoms. Promotion of effective and consistent condom use, particularly in the rural communities, while being sensitive to the cultural context of the target population, still poses a major challenge.

- **Voluntary Counselling and Testing (VCT)**

The number of VCT sites has increased considerably during 2003 – 2007 implementation period. There were 1,027 VCT sites by the end of 2006, compared to 289 in 2003. This number includes sites in health facilities and stand alone sites. The geographic distribution of VCT sites is still inequitable, with an urban bias, although all the 125 districts have at least 4 sites. The number of clients counselled and tested has increased to 680,520 in 2006, up from about 140,000 in 2003.

Despite this considerable roll-out of service availability, the uptake of VCT in the country is still quite low. According to the Tanzania HIV/AIDS Indicators Survey (THIS) 2003/04, only about 15% of men and women are reported to have ever undertaken an HIV test. Women and men living in urban areas are two to three times more likely to have been tested than those in rural areas. One of the reasons for the low uptake is related to limited access to VCT services, particularly in the rural areas. Low public awareness about the benefits of knowing one's HIV status, insufficient human resources with skills in counselling and fear of stigma are also barriers to increased VCT utilization.

- **Prevention of Mother to Child Transmission (PMTCT)**

Based on the lessons learned from the MOHSW and UNICEF initiated pilot project, PMTCT services were scaled up to 710 health facilities in the country by end of 2006. About 12% of eligible pregnant women are reported to have received a course of ARV to reduce the transmission of HIV to their children during delivery in 2006. The National PMTCT Guidelines were revised in 2006 in an effort to promote comprehensive care and support to HIV infected mothers.

The coverage of PMTCT services has been quite low largely due to the centralized planning of the role-out of these services; stock-outs of ARV drugs due to forecasting and supply problems; the existing policy of giving ARVs late in pregnancy (at 28 weeks); and poor follow-up of mother and baby.
Male participation in PMTCT remains low mainly due to difficulties facing women to disclose their HIV test result to their partners for fear of rejection or even violence. Further, the ANC services are not currently organised in a way that encourages joint attendance by both parents ("parent friendly").

- **Health Promotion for Specific Population groups: Children and Youth, Girls and Women, Men and Disabled People**

A significant number of CSOs have played an active role in initiating and implementing interventions aimed at reaching specific population groups in the country, especially prevention interventions among young people. These initiatives have adopted a combination of information provision through edutainment, skills building and provision of youth friendly services. There is evidence that young people are changing their

behaviour, although it is not possible to attribute the findings to specific interventions. When comparing the data from the TRCHS (1999) and the Tanzania Demographic Health Survey (TDHS) (2004/5), risky sexual behaviour among the youngest age group (15 – 19), especially among young men,has clearly been going down during the period between the surveys. The proportion of young people aged 15-19 who had sex before the age of 15 has decreased (for young women from 15% to 11% and for young men from 24% to 13%); among young men the proportion who did not have sex in the past 12 months increased from 50% to 65%, while the proportion who had more than one partner in the past 12 months decreased from 20% to 10%. Evidence from other countries suggests that it is vital to change also the behaviour of older men, in order to create safer sexual environments for young people. Very few interventions have so far addressed this issue.

Health promotion for specific target groups including children and young people has seen its constraints due to limited skills among the key implementers, including CSOs, in developing balanced and culturally sensitive messages. The national communication strategy developed by TACAIDS in 2005 is yet to be effectively and widely disseminated to the stakeholders.

- **School based Prevention for Primary and Secondary Level**

The Ministry of Education and Vocational Training (MoEVT) has developed the Education Sector Strategic Plan for HIV and AIDS (2003 – 2007) as well as guidelines to implement comprehensive HIV and life skills training in schools and teachers' colleges. All secondary and about 1,500 primary schools are at different stages of implementing the strategy. In many of these schools 'carrier subject' teachers have been trained, but manuals and teaching materials are insufficient and the quality of the teaching varies considerably.

Counsellors have been selected and trained and are active in a quarter of the secondary schools. Although peer education is conducted in some schools, it appears to be limited in those schools with external NGO support. Reaching out-of-school youth still remains a major challenge, although the National Communication Strategy which is now in place is likely to provide more specific strategies for reaching them with effective behaviour change messages.

- **Health Promotion for Vulnerable Population Groups**

Although the concept of vulnerable populations used in the NMSF 2003 – 2007 turned out to be very broad, a number of key stakeholders have played significant roles in addressing some groups perceived to fall under this category.
The Ministry of Community Development, Gender and Children (MoCDGC) has developed a strategic plan on protection of women and children, including Sex Workers and single mothers. The plan is currently being implemented

Key factors that contribute to the vulnerability of specific populations in Tanzania are embedded in the socio-economic and cultural milieu of local communities. A

participatory approach to identify and address these factors, including the development or amendment of relevant legislations where appropriate is a step in the right direction.

- **Workplace Interventions (public, private and informal sectors)**

The public and private sectors have initiated limited workplace programmes on HIV. In most MDAs some workplace intervention activities have been taken place while in the private sector similar efforts are being noted. With the support and the coordination of the AIDS Business Coalition Tanzania (ABCT) enterprises in the private sector have started with prevention and care measures for their employees.. The membership of the ABCT was grown from 23 members in 2004, to 52 members in 2006. However, the coverage of workplace interventions among the private sector is still very limited as there are an estimated 800 enterprises in the private and semi – private sector. Similar workplace initiatives are being spearheaded by UMASITA and the Tanzania Informal Economy Networks on AIDS Initiative (TIENAI) in the informal sector.

Although most MDAs have developed some HIV workplace programmes for their staff, overall, the implementation level of these programmes has been quite slow due the lack of sector specific HIV and AIDS policy, lack of leadership, commitment and skills among the focal persons and Technical AIDS Committees (TACs) in implementing the planned activities.
Worryingly, some MDAs and private sector institutions are reported to have developed and adopted guidelines which include pre-employment testing contrary to the national policy on HIV, hence perpetuating stigma and discrimination in the workplace.

- **Safety of Blood, Blood – Products and Universal Precaution in Health Care and Non-Health Care Settings including Waste Management**

The National Blood Transfusion Services (NBTS), through its recruitment drive for regular, low-risk donors, provided about 10% of transfused blood in 2005, while screening of donors using rapid HIV tests continued in the hospitals not yet covered by the NBTS.
The MoHSW has developed a policy and guidelines for post-exposure prophylaxis (PEP) as well as for waste management and safe hospital waste disposal. Despite the existence of a policy on PEP, the procurement and distribution of PEP kits has been limited. Similarly, no significant efforts have been made to provide home-based care givers with guidelines and necessary gear to protect themselves while caring for their sick relatives.

Thematic Area 3: HIV and AIDS Care and Support

The NMSF 2003 - 2007 identified two key areas of intervention: treatment of common opportunistic infections including provision of ARVs; and home/community-based care and support. The demand for care and treatment services is also compounded by an increasing number of TB patients who are co-infected with HIV and vice-versa.

- **Treatment of Common Opportunistic Infections including ARVs**

The MoHSW developed and is implementing a roll-out plan for treatment of opportunistic infections (OI) and provision of ARVs. According to this strategy by 2003

about 2 million Tanzanians were living with HIV[28] out of which about 400,000 - 500,000 were in need of ART, while some 1.2 million were in need of drugs for OIs. .By the end of 2006, more than 70,000 persons were receiving ARVs through public and private hospitals, a substantial increase from about 2,000 in 2003. To effectively implement the Care and Treatment plan, the Ministry has strengthened its health care facilities, provided specialised training to the health care providers and started to recruit new staff under an emergency plan.

Despite these efforts, the health care infrastructure is currently overstretched in coping with the additional demand for treatment of OIs and the provision of ART services. The roll-out plan for ART has not been supported with adequate communication activities for PLHIV, the service providers and the community in general to promote demand for services, ensure adherence and safeguard against improper use of drugs. With the growing number of reported TB patients co-infected with HIV, the cooperation between the NACP and TB and Leprosy programmes at the MoHSW in the provision of health care services is becoming more urgent than ever before.

- **Home and Community – based Care and Support**

Home-based care (HBC) is a vital part of a continuum of care between the health care facility and the community of PLHIV. CSOs including the networks of PLHIV have been and continue providing the bulk of these services which include treatment of opportunistic infections, economic and social support for persons, families and communities affected by AIDS. As the number of people needing these services continues to grow, the MoHSW is increasingly exploring modalities of deploying non-health care workers in its roll-out programs for home-based care.

Despite impressive numbers of support projects major concerns remain about the quality of care and support provided, the availability and adequacy of supplies including drugs and the supervision of these projects. The issue of food and nutritional support for PLHIV remains a major challenge in the provision of HBC services. Further, the deployment of non-health care workers for HBC calls for more effective training and coordination between the health care facilities and the community which have so far been inadequate.

Thematic Area 4: Social and Economic Impact Mitigation

The impact of AIDS has challenged the effectiveness of traditional social networks making it difficult for communities to cope with the increasing burden of HIV infected and affected families, orphans and other vulnerable children. In this thematic area, a lot of progress has been made including the development of a National Action Plan for most vulnerable children (MVC).

- **Economic and Social Support for Persons, Families and Communities affected by AIDS**

---

[28] It should be noted that the estimated number of PLHIV in Tanzania varies substantially depending on sources. In NMSF 2008 – 2012, the figure of 1.400.000 PLVIH, as reported by UNAIDS for 2005 is generally used. (UNAIDS, 2006, Report on the Global AIDS Epidemic)

Notable steps have been taken by some MDAs in addressing the social and economic impact associated with the epidemic. The Ministry of Agriculture, for example, has developed the Agricultural Sector Strategy for HIV/AIDS (2006) which specifically aims at addressing prevention efforts against HIV infection, improvement of quality of life for affected populations and mitigating the impact of HIV and AIDS in rural households and communities. On the other hand, a substantial number of NGOs including networks of PLHIV have been established across the country and are highly active in implementing a variety of interventions to reduce the impact of HIV through advocacy to reduce stigma and discrimination, counselling and home-based care for PLHIV. Others are actively involved in income generating activities to support their members. Through advocacy, the government and the public have grown to understand and empathise with PLHIV including recognition of their right to access care and treatment.
However, PLHIV groups and NGOs are still not well organized and there are certain tensions between different networks, despite efforts by TACAIDS to coordinate the various groups into one national functional advocacy body. Further, despite efforts by PLHIV groups and CSOs to advocate against stigma and discrimination, the problem is still rife in most communities in Tanzania.

- **Support for Orphans**

The growing number of OVC in many communities has brought the government and the public in general to appreciate the magnitude of the problem and acknowledge the fact that it is no longer a problem that can be dealt with at family level alone. This acknowledgement has mobilised government organs at national and local communities to initiate national and community support mechanism for orphans and vulnerable children. Through the Department of Social Welfare a National Plan of Action is now in place with effective data management system to identify and place needy OVC under institutional support services at the village levels.

The growing number of vulnerable children needing care and support is far more than the families and existing institutions can cope with. Major legislation like the review of the Child Development Policy of 1999 and the Children's Bill which will provide the framework for further protection and support are still pending.

The Monitoring and Evaluation Framework of the NMSF

Despite efforts to integrate the newly developed UNGASS indicators and MDG goals in the NMSF 2003 – 2007 and outlining a systematic framework for M&E, achievements have been very limited. It was only in 2006/7, that a consolidated national HIV M&E framework was developed. The implementation of this framework, which now includes the monitoring and evaluation of the HIV and AIDS interventions in the non-health sectors became operational in the second quarter of 2007.
The reasons for this drawback are multiple:

- While M&E staff are in place at TACAIDS (and the MoHSW) the positions and the placement of the units kept changing and remained generally understaffed and lacking in-depth professional experience.
- There is lack of appreciation of the importance of M&E as an implementation tool by regional and district leadership in the MDAs, and this is reflected by the

inadequate human resources that are assigned to this task, funding levels available for M&E and the working facilities and equipment.

- While there is a growing acknowledgement of the importance of harmonising data and M&E systems with the national HIV M&E systems by all stakeholders, it has only been in the final months of 2006 that an HIV M&E system for the non-health aspects of the response has been established. Of equal concern in the health sector, compliance with established reporting requirements of the MoHSW by implementing partners was equally lacking. .
- Available data from surveys and routine reporting (by the health sector) was often not sufficiently disseminated to lower levels. Even when it was done, its interpretation remained poor and not well connected to improvements of ongoing interventions.

- **HIV Research**

There is a substantial number of HIV studies which have been carried out in the country by different stakeholders and presented at national and international conferences. The majority of these studies, however, are biomedical. The diversity of the HIV epidemic in the country is still not well understood due to a lack of surveillance data and research. A national research agenda with clearly defined areas whose information has a direct bearing on the operational challenges of the National Response is still lacking. The dissemination of study results also remains confined to academic circles and their use for enhancing HIV programmes is highly limited.

Institutional and Management Framework for the NMSF

- The Central Level

In line with the principle of the "Three Ones", Tanzania has developed and strengthened its institutional structures to coordinate the National Response. At a central level, the establishment of TACAIDS and a ministerial portfolio on "Disaster Management and AIDS" were most prominent. Further, the formation of an Inter-Ministerial Technical Committee (IMTC) on HIV and AIDS has added impetus to the HIV response in the country.

TACAIDS has been the key national coordinating body and assumed an ever increasing number of tasks and roles in providing guidance and technical assistance to the public, private and informal sectors in the country. Under its guidance and coordination:

- MDAs and some LGAs developed intervention plans and budgets that were integrated into the MTEF for workplace HIV programmes in the core business of the sectors.
- Together with PMORALG a decentralized response was established through the formation of HIV and AIDS committees at district (CMAC), wards (WMAC) and villages (VMAC) levels. Training was organised for the functional officers in these new structures and guidelines provided to enable them to carry out their coordination role for the response at the local level.

- ABCT was established to facilitate the scaling up of workplace programmes on HIV in the private and semi-private enterprises in the country. Similar efforts were made to support the formation of UMASITA and TIENAI to coordinate workplace HIV interventions in the informal sector.

Due to the lack of appropriate capacities and experiences in developing HIV responses at central, regional and local government levels, TACAIDS has had to assume many functions and activities beyond the coordination of the National Response. The multitude of functions and tasks overwhelmed the limited human resources in the Commission. Further, the lack of sufficient professional and technical resources, coupled with a high turn-over among the key staff, left TACAIDS in a weak position to respond effectively to these multiple challenges. As just another directorate of government answerable to the Permanent Secretary (PS) of the Prime Minister's Office (PMO), TACAIDS also lacked the institutional authority to enforce the development and implementation of HIV programmes among the MDAs.

- **The Regional and LGA Levels**

TACAIDS does not have any decentralized structure at regional or district levels. The Regional Administrative Secretariats (RAS) are mandated to provide coordination, supervision and facilitating functions to the districts and communities. However, evidence suggests that during the NMSF 2003 - 2007 implementation period, these institutions remained ill-prepared, insufficiently staffed and equipped to meet their obligations.

The creation of 11 Regional Facilitating Agencies (RFAs), each of them covering two regions, was a major innovative step in enhancing the level of technical support and financing provided to districts and communities. The RFAs are seen as the "eyes, ears and arms" of TACAIDS. They accelerated substantially the local response through capacity building and channelling of funds to CSOs. The RFAs also provided technical assistance to the RASs and CMACs. However, the RFAs found themselves, at times, in a difficult position in providing adequate coverage in their respective two regions, posing a substantial challenge in terms of logistics, time-management, as well as resource adequacy. Moreover, as the RFAs were funded as a project and were not line-structures of the government, they were at times viewed with suspicion by the less-well equipped government structures at regional level, hence regarded as alternative or competing organs.

The establishment of HIV activities at district, village and ward levels needs sustained inputs in terms of training, supervision and technical assistance. The application of the "Three Ones Principle" at district level has proved to be quite challenging to all actors due to lack of experience in participatory planning and coordination and sharing of responsibilities across sectors. The integration of the CSOs in the council plans needs to be enhanced and more trust and mutual support between the different actors need to be promoted.
At community level, there are several thousands formal and informal community-based organisations (CBOs), including faith-based organisations (FBOs). These have made

substantial contributions to the National Response, particularly where they have access to technical and financial resources through NGOs. Many of them are also involved in the ART roll-out. Despite their numbers, the capacity and the quality of services and interventions which these CBOs provide vary tremendously. Adherence to national guidelines and better integration into community and district plans are additional challenges which need to be addressed.

Financial Framework and Human Resources

- **Financial Resources**

Over the years, the funds available for HIV programmes have increased substantially both from the government and the DPs as shown in Table 1.

Table 1: Trends in Public Expenditure on HIV and AIDS (Tshs, Billions)

	Actual 2002/03	Actual 2003/04	Actual 2004/05	Actual 2005/06	Budget 2006/07
Total Public & Donor Expenditure on HIV/AIDS	47.06	61.3	148.43	290.84	406.67
Government	7.1	8.1	12.6	35	60.3
Development Partners (Donors)	39.96	53.2	135.83	255.84	346.37
Donors spending as % of total HIV/AIDS spending	84.9	86.8	91.5	88.0	85.2
Total HIV/AIDS spending as a % of:-					
Total Govt Spending	2.47	2.91	4.56	7.52	5.63
Total Revenue	3.6	4.7	8.37	14.12	11.0
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 overall total HIV and AIDS expenditure (all sources) was expected to nearly double in 2005/6, but actual releases increased by a little less than half. The government recurrent spending nearly doubled during 2005/06 and was expected to be higher in 2006/07. However, on average the government funding for the NMSF has remained at 20% level despite the scaling up initiatives, while the rest is covered by support from development partners and other agencies including the United States Government (USG), the Global Fund to fight AIDS, TB and Malaria (GFTAM) and the World Bank[29]. This arrangement poses quite a significant challenge for the financial sustainability of NMSF..

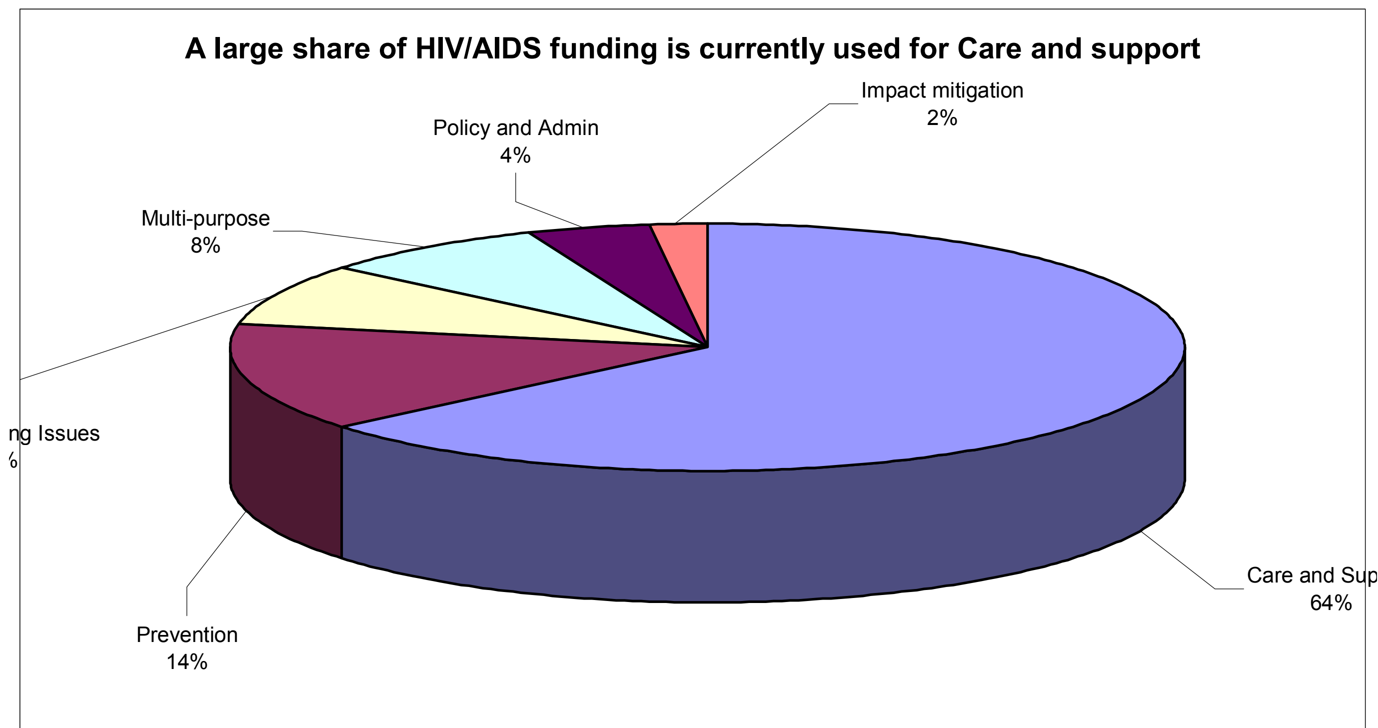
[29] NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.

Nevertheless, spending is expected to continue to grow in 2006/7 consistent with donor indications of commitments of a further 77% increase on the 2005/6 funding levels. The total expenditure on HIV and AIDS interventions in the country (including donors' off-budget spending) was equivalent to 7.5% of total Government budget spending in 2005/6 and about 14% of the total Government revenue.

The MoHSW and TACAIDS accounted for over 95% of budget and 97% of actual spending on HIV in 2005/6. Some of the TACAIDS spending represents funds transferred to other MDAs and to districts. The Thematic Area of Care and Support has received over 64% of the spending on HIV and AIDS, while prevention received only 14%. The fund allocation in the other thematic areas is presented in Figure 1. The high trends of expenditure on Care and Treatment is attributed to the roll out initiatives for ARVs and related logistics including training of health care workers, however, there is cause for concern bearing in mind the equally important role prevention interventions have in the overall National Response.

Although the government has put together financial management procedures and mechanisms to facilitate and support the process of implementation of HIV intervention at the MDAs, LGAs, CMAC and CSO levels, these mechanisms are marred with bottlenecks causing undue delay in disbursement and accountability of funds, consequently affecting the absorption capacity of key partners and the delivery of HIV programmes especially at local levels.

Figure 1: Funding for HIV and AIDS by Thematic Areas (2005/06)



Source: Deloitte and Touché study (2006).

- **Human Resources**

One of many notable achievements in the national response was the deployment of human resources through the MDAs, the LGAs, the private and informal sectors, and CSOs. According to the Civil Service Department database, for example, there are about 19,696 workers in the MDAs and local government with some skills in HIV interventions. These have been the key movers of HIV interventions in their respective sectors. The private and informal sectors on the other hand, have been implementing workplace programmes on HIV among their members while the bulk of community based HIV interventions have been carried out by CSOs and FBOs located in almost all the wards and villages in Tanzania. However, low capacity among the non-health sector workforce both in knowledge and skills in planning, implementing, monitoring and evaluating HIV interventions across all thematic areas of the NMSF remain a major challenge.

The health sector which manages a substantial part of the National Response particularly in the area of care and treatment and impact mitigation is reported to have a serious shortage of human resources. The health workforce, for example, is reported to have been declining over the years by 28% from 67,600 in 1994/95 to 48,500 in 2001/02, and by further 10% to 43,650 in 2005/06[30]. In 2002, the key cadre of health care workers including nurses, clinical officers, and laboratory technicians was reported to be at 50% or less of the agreed staffing norms in 1999[31] although the level was slightly above 60% among the doctors. Although efforts have been made both in recruiting and training health care workers under the HSS on HIV and AIDS in relation to the ART roll-out plan, this area will remain a major challenge in the future.

- **Logistics and Supply Chain Management**

Lessons learnt from the implementation of NMSF 2003 – 2007 show substantial efforts focused on addressing the 'front line' human and financial resources requirements with minimal planning of infrastructure and 'back-office' support in addressing the epidemic. By virtue of being the first sector tasked with the responsibility of coordinating the national response to the epidemic, the health sector through the NACP has managed over the years to put together reasonable logistic structures both from the national, regional and district levels responsible for delivery of relevant services and products.

However, bureaucratic procurement systems and procedures in the existing health sector structures do not appear to lend themselves to rapid implementation of the National Response. Frequent stock-outs of drugs and reagents and lack of VCT kits are some among the noted shortcomings associated with the difficulties in the procurement system. The distribution of free condoms through the health care facility outlets has been seen as 'medicalisation' of condoms, providing access to few people likely to use the health care facilities while limiting access to other specific groups.

---

[30] NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.

[31] Wyss, K. (2004), Human Resources for Health Development for Scaling up ARVs in Tanzania. WHO/Swiss Tropical Institute

Chapter 4: The National Multi-Sectoral Strategic Framework on HIV and AIDS

4.1 Priorities, Approaches and Guiding Principles

The National Multi-sectoral Strategic Framework on HIV and AIDS (NMSF) for the period 2008 -2012 articulates the broad orientations of the country to reduce further the spread of HIV and to mitigate the impact of AIDS on national development, on communities, and on families and individuals.
The NMSF builds on the Strategic Framework of the years 2003-2007 as well as on overall government development policies. It provides orientation for all stakeholders at central, regional and local level to increase their efforts and formulates concrete targets to be achieved in the coming five years. It is also in line with the international and regional commitments of the GOT with regard to HIV and AIDS.

4.1.1 Priority setting

Setting priorities for the NMSF is not an easy task. In a generalised HIV epidemic as is the case for Tanzania, the epidemic is not confined to specific population-groups on which one could and should concentrate the prevention efforts. In Tanzania about 7 % of the population 15 to 49 years of age is infected with HIV. About 93%, or the overwhelming majority of the population of the same age-group is not infected. However, the impact of HIV and AIDS is profound in the country as a whole and has touched nearly every community and family. Therefore, a Strategic Framework on HIV has to concentrate on all three priority aspects and a balance has to be found and maintained to address all three areas appropriately:

a. To ensure that those who are not infected remain uninfected.
b. To provide services for those infected by the virus and make sure that they neither re-infect themselves (as this may complicate their treatment) nor transmit the virus to their partners.
c. To support communities, families and individuals who are affected by the impact of AIDS related diseases and premature death to overcome the hardships related to these events.

The **Number One Priority of the NMSF is to prevent the further spread of HIV** among the population. It is only when this priority is effectively addressed will an end to the "AIDS – disaster" be realised. Failed prevention efforts are not only going to see an increased number of new infections, but also of an increased burden of those who will need care and treatment which will have serious human and financial implications. HIV p**revention efforts are likely to be successful among the younger generation (10 – 24 years old)** before and at the start of its sexually-active life. Promoting healthy and responsible sexual behavior among young people will ensure that they themselves and

their life-partners can enjoy their sexual life without the risk and dangers of sexually transmitted infections including HIV. Prevention efforts will, therefore, concentrate on keeping the young generation "HIV-free" and ensuring that they enter into the productive and reproductive phases of their life in good sexual health.

The **Number Two Priority of the NMSF is to make sure that the entire population will be reached with quality and sustainable services for prevention, care and treatment and impact mitigation.** The interventions and services have to cover all strategies outlined in the NMSF in a comprehensive fashion. There is no evidence so far that selecting some strategies either in the area of prevention, or care or impact mitigation will provide more effective results than concentrating on other strategies. **Medium and long-term success in the fight against AIDS will come through a comprehensive approach encompassing all strategies and interventions identified.** The "fight against HIV" will need a long-term commitment by all stakeholders over many generations to come. There are no 'magic bullets' or 'quick solutions'.

The **Number Three Priority** advocates the setting up of priorities in the four thematic areas at the moment moving from the strategic orientation to operational plans at local levels.
It should be kept in mind that the epidemic situation and the impact of AIDS varies considerably in the country as shown in Chapter 2. Therefore, **the selection of priorities for interventions in the thematic areas of the enabling environment, prevention, care and treatment as well as impact mitigation should and must be based on the local situation when the strategic framework is translated into operational plans.** To give an example: it is evident that in an area where infection rates are substantially low the net of facilities to provide counselling and treatment needs is less likely to be as tight as in an area where HIV prevalence is high. **However, it should be clear, keeping the three areas mentioned above in mind that the NMSF does not advocate channelling all resources and interventions into highly affected areas. To keep the 93% of the population which is not infected free from HIV infection necessitates continuous attention and interventions and therefore resources**.

4.1.2 Approaches

In delivering the NMSF, three general approaches have to be kept in mind which apply to many if not most strategies and interventions including M&E and the management of the response

- **Sexuality and gender imbalance:** HIV is overwhelmingly transmitted through sexual contacts. Education and understanding of sexuality and sexual relations must be increased in families, schools and the general public without shyness and with respect for the needs of different age-groups and cultural traditions. The HIV epidemic is largely driven by irresponsible sexual behaviour especially among men on the one hand, and by female subordination and lack of economic independence, on the other. Hence men can use their economic, social and cultural advantages to impose their desires on their spouses, girl-friends and contacts; and women are driven by economic need to engage in transactional sex.

The “democratisation of sexual relations” is as important as the fight against other aspects of gender imbalances and abuse.

- **Capacity building and community participation.** The key to successfully curbing the spread of HIV and dealing with its impact is the capacity of local actors and communities to respond appropriately to the challenges and the existence of democratic processes that engage the community members, including the poor in the overall response efforts. All programmes and interventions must strive to enhance local capacities and make communities and individuals competent to deal with the threats posed by the virus.
- **Alignment with the overall government development response.** The HIV epidemic is not a short-lived disaster which can be dealt with in a separate and exclusive way. The epidemic has already been in existence for more than twenty years in the country. The NMSF and the different intervention plans which will be developed under its umbrella need to be strategically aligned to the overall government development efforts including poverty reduction. The successful implementation of NMSF, therefore, should strongly depend on building the capacity of appropriate and structures at central, regional, district, ward and village levels to deliver on their respective mandates.

4.1.3 Guiding Principles

The National Response to HIV is guided by the following general principles. These principles have to be taken into account and included in all plans, programmes and projects:

1. The protection of health is a basic Human Right of the people of Tanzania.
2. Preventing and Combating HIV and AIDS need the involvement and participation of the entire society.
3. Preventing and Combating HIV and AIDS are a priority and an integral part of the development policy of the country and is supported by continuously strong political and government commitment at all levels.
4. Success and synergies can only be achieved through multi-sectoral and multidisciplinary approaches necessitating effective coordination and partnerships of all actors under government leadership.
5. The Human Rights of persons living with HIV are respected and their active participation in programming and implementation is pursued.
6. Interventions are based on scientifically and ethically sound approaches (“best practices”) respecting the dignity, values and cultural diversity of the people while promoting gender equality/equity and seeking to change backward cultural forms which promote female subordination and irresponsible male behaviour. Due attention will be given to cost-effective interventions.
7. Programmes and interventions are “people-centred” assisting and empowering communities, families and individuals to develop their own responses to the challenges and threats of HIV and AIDS and to learn from the experiences of others.

4.2 Vision, Goals, Indicators and Targets

The Vision of the NMSF 2008 - 2012

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

Goals and Indicators of the NMSF 2008 - 2012

The progress towards this vision or 'overall goal' of the NMSF will be reached through the progress made achieving four general goals in the four thematic areas of the NMSF. The degree of progress will be measured through the indicators for each goal.

1. Enabling Environment:

Goal: Create a political, social, economic and cultural environment for the national response to HIV based on a human rights and gender sensitive approach with transparency and accountability at all levels, broad public participation and empowerment of PLHIV, women and youth.

Indicator*:* National Composite Policy[32] Index score

2. Prevention:

Goal: Reduce the HIV transmission in the country.

Indicator: Percentage of women and men aged 15 to 49 who are HIV positive, by 5-year age bands
Percentage of infants born to HIV infected mothers who are HIV positive

3. Care and Treatment:

Goal: Reduce morbidity and mortality due to HIV and AIDS.

Indicator: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

4. Impact Mitigation:

Goal: Improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children.

Indicator: Current school attendance among orphans and among non-orphans aged 10–14

---

[32] The National Composite Policy Index is a questionnaire consisting of 20 questions that UNAIDS developed. The questions cover tall enabling environment issues in terms of the HIV response. National AIDS Commissions are supposed to complete the questionnaire once every 2 years, when the UNGASS report is submitted.

In addition, the NMSF formulates four further goals related to the monitoring, management, resource needs and the process of moving from strategic to operational planning and implementation.

5. Monitoring and Evaluation:

Goal: Use relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision-making.

Indicator: Percentage of implementers of HIV and AIDS interventions who report that they have participated in HIV dissemination workshops in the last 12 months

6. Organisations and Institutional Arrangements for the Implementation of the National Response at Central, Regional and LGA Levels:

Goal: Provide well – coordinated, effective, transparent, accountable and sustainable leadership and management structures based on the "Three Ones Principle" at central, regional and LGA levels to deliver the National Response as well as involving stakeholders from the public, private and civil society sectors.

Indicator: Percentage of HIV coordination structures at national, regional and district level that provide services according to their mandate of satisfactory standard

7. Financial, Human and Technical Resource Framework of the National Response:

Goal: Provide the necessary and appropriate financial, human and technical resources for the implementation of the National Response to the HIV epidemic through combined, coordinated and sustained efforts by the Government of Tanzania, the private and civil society sectors and the Development Partners.

Indicator: Domestic and international AIDS spending by categories, financing sources and levels of government

8. From Strategic Framework to Operations and Implementation:

Goal: Translate the NMSF into well-defined operational plans at national and LGA levels under the leadership of the PMO (TACAIDS) and PMO-RALG involving all stakeholders through a participatory approach and implement the plans effectively and efficiently.

Indicator: Percentage of districts that have tracked the implementation of one joint and consolidated district-level HIV response plan in the last 12 months

4.3 Thematic Areas: Goals, Strategic Issues, Strategic Objectives, Strategies, Indicators and Targets

4.3.1 Thematic Area: Enabling Environment related to the entire National Response

Goal: Create a political, social, economic and cultural environment for the national response to HIV based on a human rights and gender sensitive approach with transparency and accountability at all levels, broad public participation and empowerment of PLHIV, women and youth.

Indicator: National Composite Policy Index

1. Advocacy and Political Commitment

Strategic Issues

- Advocacy seeks to support commitment and recognition of an issue by policy and political decision makers as well as the general public. Advocacy also provides support and solutions to social issues. Despite continued mobilisation of decision makers (politicians, government and traditional leaders) and opinion leaders (business, faith and community based leadership) in Tanzania, political and leadership commitment and accountability remains substantially low on issues related to HIV.

Mobilisation of political and leadership commitment and ensuring transparency and accountability will be critical to the success of the NMSF. Sustained advocacy, therefore, can reduce the social, behavioural and cultural barriers in the fight against HIV and in particular, empower girls, women and vulnerable groups. It can also strengthen political and leadership support for HIV interventions which are vital in the promotion of public awareness as well as an understanding of the needs and concerns of PLHIV and vulnerable and marginalized groups.

CSOs, gender organisations and CBOs can play a major role in the fight against HIV by raising advocacy issues including those around human rights and gender inequalities.

Strategic Objectives

Maintain and strengthen political commitment, transparency, accountability and popular support for HIV interventions using a human rights and gender sensitive approach as well as deepen public awareness, acceptance and understanding of the

needs and concerns of PLHIV and other vulnerable and marginalized groups through sustained advocacy at all levels.

Recognize the special needs of specific groups such as women, youth, people with disability and those living in rural areas.

Conduct a situation analysis of HIV and AIDS advocacy to identify achievements to date and outstanding challenges and gaps with a view to implementing effective and sustainable advocacy mechanisms and strategies that will counter stigma, discrimination and denial.

Strategies

1. To advocate for legislation aimed at enhancing an effective HIV response at all levels of society as well as ensuring accountability for its implementation.
2. To mobilize sustained political and leadership commitment, transparency and accountability at all levels in the response to HIV.
3. To ensure that all advocacy activities use a human rights and gender sensitive approach.
4. To work with the Ministry of Culture and Information, the media and relevant stakeholders in the development and dissemination of appropriate and accurate information on HIV and AIDS to the general public.

Indicators

- Number of sets of HIV legislation enacted
- Percentage of members of parliament who have publicly undertaken an HIV test or declared that they have gone for an HIV test

2. Fighting Stigma, Denial and Discrimination

Strategic Issues

The major mode of HIV transmission in Tanzania is through sexual intercourse. Stigma is structured by gender and class, and increases basic misunderstanding about the causes and transmission of HIV. In Tanzania, like in many African countries, sexual matters are largely taboo subjects that are not normally discussed in public. People who contract the infection are assumed to have got it through "promiscuous" sexual behaviour which is frowned upon by the community. Subsequently they often are stigmatized and discriminated by the wider community. Although substantial efforts have gone into educating the general public about HIV, stigma and discrimination against individuals and families infected and affected by HIV remain rampant in most communities.

- The stigma associated with HIV as well as discrimination against and denial by PLHIV remains one of the strongest barriers against successful interventions.

They prevent open and informed discussion about issues related to sexuality and transmission of HIV. They marginalize and exclude people from communities and families, creating unnecessary suffering by those infected. Stigma, denial and discrimination also appear to be major drawbacks to access HIV services, including life saving antiretroviral treatment.

- Although nearly every household in Tanzania has been affected by HIV, the rights of PLHIV continue to be violated through stigma and discrimination. National laws and regulations are insufficiently addressing the human rights of PLHIV and their families. At the same time, PLHIV have a responsibility to adopt positive prevention practices to ensure that they are not re-infected and do not pass the virus on to their partners. Interventions that enhance the dignity of PLHIV and enable them to lead a healthy and productive life must be encouraged.
- Stigma and gender discrimination associated with HIV reinforces prejudices, discrimination and inequalities related to access to services and increases poverty.

Strategic Objectives

Safeguard human rights of PLHIV and their families through non-discriminatory attitudes in their communities and through improved access to user-friendly and gender sensitive HIV services.

Promote high level leadership (political, traditional and community based) to engage in anti-discriminatory and stigma reducing activities.

Strategies

1. To promote a rights based and gender sensitive approach in HIV campaigns and programming by high level leaders, key stakeholders and partners to address stigma, denial and discrimination at all levels and sectors of society.
2. To create an enhanced sociopolitical and cultural environment wherein sex and sexuality issues can be openly discussed.
3. To promote greater involvement of PLHIV, their families and their networks in HIV responses at all levels through self-organisation and advocacy.
4. To ensure quality of and access to preventive information, care and treatment as well as impact mitigation services for PLHIV.
5. To review and enact laws and regulations (inheritance rights, gender based violence, property laws, marriage laws, workplace regulations, employment laws, child welfare etc.) aimed at enhancing a gender sensitive approach to and human rights for people infected and affected by the epidemic.

Indicators

- Percentage of people expressing accepting attitudes towards people with HIV
- Percentage of functional PLHIV support groups
- Percentage of PLHIV reporting no stigma or discrimination

3. Regional, District and Community Response

Strategic Issues

Effective responses to the epidemic with adequate resource allocations from central and local government are based on the capacities of people living in communities to assess their vulnerability, plan their responses and implement interventions. Community mobilisation, empowerment of and support to communities to respond effectively are key elements of the national response and also need to take account of the gender imbalances and other structural differences within families and communities. It is in the communities and at local levels that the fight against HIV will have maximum impact. Civil Society Organizations (CSOs) (e.g. NGOs, CBOs and FBOs) can make important contributions towards the mobilisation of communities. In addition, National, Regional and Local Human Resource Development Plans should be considered as key elements for sustainable HIV interventions.

- The GOT has embarked on a major reform of regional and local government through the "Decentralisation by Devolution" policy. PMORALG is the responsible ministry and has the legal, institutional and organisational framework to implement the HIV response. At the regional level, the RASs are important coordinating, supervisory and advisory structures to the LGAs. RFAs have provided valuable assistance in enhancing the local response.
- LGAs in the form of district, municipal and town governments are the most appropriate level for planning, coordinating and supporting the HIV response at the community level. It is in the wards, villages and urban neighbourhoods that interventions are needed for the population. The district, ward and village multi-sectoral AIDS committees that are now in place must ensure inclusive representation and be supported and sustained to lead the planning, resource mobilisation and coordination of the local response. The principle of the 'Three Ones' will also apply at the local level.

While encouraging experiences exist in a limited number of regions, districts and communities, scaling up these experiences to all districts faces severe constraints with regards to human resources and capacity for district planning and community mobilisation. There is thus a continuous need for Technical Assistance and facilitation for the foreseeable future within a region and its districts. To compliment the role of facilitating agencies new forms of partnerships with CSOs, the private sector and government, therefore, have to be created, supported and maintained to make it happen.

There has generally been a tendency of low proportion of HIV funding reaching the district. Within the district, very low proportion of HIV funding is reaching the ward and village levels

Strategic Objectives

Capacitate communities to develop local responses to the challenges of HIV based on local knowledge of the epidemic, on creativity and local competence through a wide range of partnerships involving the civil society and public sectors.

Make effective use of the existing government structures and committees at LGA level in developing HIV responses and provide them with adequate resource.

Enable regional organisations and institutions to provide technical assistance and coordinating facilities for the local responses using the continued inputs of the regional facilitating structures.

Strategies

1. To promote, facilitate and expand models of community mobilisation for HIV in all districts.
2. To build on the strength, creativity and determination of communities to find their own solutions to reduce their vulnerability to HIV.
3. To strengthen and accelerate the local responses by:
    a. Promoting, improving and including all sectors in comprehensive planning.
    b. Promoting and improving the coordination of the various actors under the ‘anchor’ of the local councils, with regular participation and representation of CSOs selected by their own constituencies in relevant bodies such as CMACS, WMACS and VMACs.
    c. Promoting the use of the TOMSHA monitoring system.
    d. Improving mechanisms for disbursing funds and supporting the civil society organisations’ response (NGOs, CBOs and FBOs) through the councils.
4. To strengthen the involvement of CSOs as well as political and community leaders in advocacy and community mobilisation in initiating and implementing community interventions.
5. To mobilise political and leadership commitment and accountability at district, town and municipal leadership levels for HIV responses.
6. Identify and address capacity building needs of various actors in districts, towns, municipalities and communities with particular emphasis on the needs of the WMACs and VMACs.

Indicators

- Percentage of districts that have tracked the implementation of one joint and consolidated district-level HIV response plan in the last 12 months
- Percentage of HIV coordination structures at national, regional and district level that provide services according to their mandate of satisfactory standard

- Percentage of annual LGA budget used to fund the LGA's HIV coordination activities
- Percentage of total HIV funding which is used to implement the district HIV plans of action

4. Mainstreaming HIV and AIDS

Strategic Issues

- Mainstreaming HIV deals with two aspects: concerns about the well-being of the employees and their families in that sector through an HIV workplace programme and addressing the effects and impacts of the epidemic on its external interventions in the 'target' population. While government structures (MDAs, regions and LGAs) are expected to take the lead in the mainstreaming initiatives, the sector they represent comprises many more actors and stakeholders including private sector institutions, businesses, civil society institutions and organisations of development partners. These are all called upon to make HIV concerns their "business". [33]
- While mainstreaming efforts have started in many public and private structures, they often lack comprehensiveness and sustainability due to a lack of commitment from their leadership and insufficient technical, human and financial resources available to them.

Strategic Objective

HIV concerns are mainstreamed in key sectors of Tanzanian society in line with NMSF priorities.

Strategies

1. To strengthen the human and technical capacities (focal points, committees) in government, the private sectors, NGO and CBO sectors to plan and implement HIV mainstreaming interventions.
2. To increase transparency and accountability by the MDA, regional and LGA leadership for delivering effective HIV mainstreaming.
3. To provide technical support to the sectors on how to internally and externally mainstream HIV in their core business covering the thematic areas of NMSF.
4. To monitor and evaluate mainstreaming plans to enhance performance and provide relevant information for effective programme management.

Indicator

[33] The workplace aspect of the mainstreaming issues will be dealt with under the Thematic Area: Prevention

- Percentage of MDAs that employed a fulltime HIV focal person in the last 12 months

5. HIV and AIDS, Development and Poverty Reduction Policies

Strategic Issues

- The HIV epidemic has been declared a national disaster in Tanzania and in many other African countries. Achievements of years and decades of development are threatened to be reversed. Poverty in all its economic, social and human facets is being worsened by the epidemic. On the other hand, the effects of poverty, such as unequal income distribution, economic inequalities between men and women and inadequate or non existent social security systems drive the epidemic and worsen its impact. It is evident that poverty can only be successfully tackled if the epidemic is controlled and that epidemic control can only be achieved if poverty and gender inequality can be reduced substantially. The MKUKUTA strategy addresses the impact of HIV and AIDS on poverty and details the responses to the epidemic. Safety nets for infected and affected persons and families within available resources and capacities must be developed and sustained to mitigate the impact of the epidemic.
- The gaps between MKUKUTA and the previous NMSF have been identified. MKUKUTA provides the basis for integrated planning especially at district, village and community level with budget support through the government systems. TOMSHA adds value to the monitoring systems within the MKUKUTA strategy.

Strategic Objective

Ensure full integration of the challenges related to the HIV epidemic into the country's major long-term development plans and policies taking into account the particular effects on PLHIV, their affected families and communities as well as gender and poverty related issues.

Strategies

1. To assess the major country documents (HIV Policy, MKUKUTA, Joint Assistance Strategy ,Vision 2025 etc.) to ensure that they take on board emerging challenges and the impact associated with HIV and adapt appropriate measures that will contribute successfully to the control of the epidemic.
2. To build the capacity of national planners in non-health sectors to analyse and track the long-term, multidimensional impact of the epidemic and its implications for national development using a gender sensitive approach and to develop relevant intervention strategies.

Indicator

- Percentage of development-related policies and strategies that have been assessed to determine the extent of HIV mainstreaming within them

4.3.2 Thematic Area: Prevention

Goal: Reduce the HIV transmission in the country

Indicators:

- Percentage of young women and men aged 15 to 24 who are HIV infected
- Percentage of infants born to HIV positive mothers who are HIV infected

Introduction

Reduction of new HIV infections is the first priority of the NMSF. It will be possible in the next five years if achievements and lessons learnt from past prevention efforts are carefully considered and if new evidence about factors that facilitate HIV transmission are taken into account.

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 their knowledge and skills to protect themselves against HIV infection and through making relevant health services more accessible and youth friendly. At family and community level, dialogue about sexuality, gender inequality and cultural practices will be facilitated in order to initiate critical reflection and action to reduce local factors that increase vulnerability to HIV. Availability of relevant health services, such as STI management, HIV testing and counselling, prevention of mother to child transmission, post-exposure prophylaxis and safe blood and procedures will be further expanded while safeguarding the quality and ensuring gender sensitivity. Condoms, both male and female, will be made available at community level through innovative and alternative channels and outlets. The feasibility, expected benefits and possible negative effects of new interventions, such as promotion of medically safe male circumcision and prevention and/or treatment of herpes simples-2 virus (HSV-2) infections will be carefully considered before embarking on implementation.

1. Promotion of abstinence, delayed sexual debut, partner reduction and consistent condom use among young people in and out of school

Strategic Issues

- In Tanzania, like in most countries, much hope concentrates on the so-called "window of hope": children and young people who are not infected and who should be supported to remain "HIV-free" in their future. Young people aged 10 to 24 constitute a third of the population.
- Children of school age can best be reached through the school based life skills and HIV education programme, which has been initiated by the Ministry of Education and Vocational Training. Capacity needs to be build among teachers as well as

among tutors in teacher's colleges and in vocational training colleges. The councils, through the CMACs, will ensure that the programme is implemented in all primary and secondary schools.

- Institutions of higher education are yet to incorporate life skills and HIV education in their programmes. The Ministry of Science, Technology ad Higher Education will provide guidance and coordination in order to gradually cover all relevant institutions.
- Parents, guardians and other "significant adults" have significant influence on young people's life. Unfortunately, the majority of them lack the knowledge, skills and courage to talk with their children about sexuality.
- Children out of schools can be reached through the Ministry of Community Development, Gender and Children, the Ministry of Labour, Employment and Youth Development, Councils and CSOs. These agencies need capacity building for working with young people in different situations to identify their needs and to plan, implement and evaluate effective HIV interventions.
- Young people are increasingly involved in HIV interventions organized by NGOs and CSOs, especially in urban areas. Youth centers, youth friendly health services and edutainment appear to be the favorite, although many of these interventions have not been subjected to thorough impact evaluation.
- There is need for appointment of youth officers in all LGAs to plan and coordinate life skills and HIV activities for out of school youth and to link them with livelihood programmes.
- Most programmes for youth work better when young people are involved in planning and running them. Education and communication programmes must go beyond merely offering information to fostering risk-avoidance skills such as delay of sexual debut, abstinence, negotiation with sex partners and consistent condom use.
- HIV education should start early, preferably before young people become sexually active. Messages have to be adapted to the age group, with emphasis on abstinence and delayed debut for those who are not sexually active yet and on negotiating skills, partner reduction and consistent condom use for those who are already sexually active. Young people in a steady relationship need to know that mutual faithfulness is only protective if both partners have been tested and are HIV negative. Youth friendly reproductive health services need to be expanded to all districts.

Strategic Objective

Empower young people with knowledge and skills to dialogue about sexuality, to adopt attitudes and practices that protect them against HIV-infection and to access reproductive health services

Strategies

1. To build capacity among parents and guardians to communicate with their children about sexuality and reproductive health issues and to support school

based reproductive health and HIV education (i.e. through School Counseling and AIDS Education Committees).

2. To challenge prevailing gender norms and socialization processes that encourage male assertiveness and aggression and female subservience at family, school and community level.
3. To strengthen advocacy with gatekeepers to understand and support life skills based reproductive and sexual health education and interventions for youth.
4. To strengthen and expand comprehensive life skills and HIV education and interventions for primary and secondary schools, teacher training colleges and tertiary education institutions, both through inclusion of these issues in the curriculum and through school and institution based peer education and counseling services.
5. To train sufficient numbers of teachers and tutors to cover all schools, colleges and institutions of higher learning
6. To encourage pupils and students to develop their own projects and interventions (school- clubs, theatre groups, competitions etc.).
7. To promote and expand peer-education and counsellor training for in and out of school youth.
8. To increase provision and utilization of youth friendly and gender sensitive reproductive and sexual health information and services and link to livelihood and income generation issues.
9. To promote and expand programmes against drugs and substance abuse, especially excessive alcohol consumption.

Indicators and Targets

- Indicator: Percentage of schools that provided life-skills based HIV education in the last academic year (UNGASS 11)

- Indicator: Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

- Indicator: Percentage of young women and men who have had sexual intercourse with more than one partner in the last 12 months

- Indicator: Percentage of young men and women (15-24) who have had sexual intercourse before the age of 15 (Universal Access)

- *Universal Access Target: Percentage of young men and women (15-24) who have had sexual intercourse before the age of 15 reduced from 9.5% and 10.6% in 2003/4 to 7% in 2012*

- Indicator: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

2. Reduction of risk of HIV infection among the most vulnerable populations

<u>Strategic Issues</u>

- Women may be aware of risk reduction measures but often lack realistic capacity to put them in practice. Practicing safe sex involves a process of sexual negotiation which requires open communication about sexual issues between women and men, girls and boys. The socio-cultural reality where men control sexual decision making, often resulting in coercive sex and sexual violence, necessitates interventions to strengthen women's sexual negotiation skills be conducted concurrently with men, or for girls and boys.
- Very little is known about men's attitudes to sex and sexuality – including anal sex with women or sex with fellow men - within the overall conceptual framework of masculinity. Hence education and promotion of sexual responsibility among men is central to the sexual and reproductive health of both women and men
- Widows and divorcees are particularly vulnerable; HIV prevalence among formerly married women is significantly higher than among currently married women (20% versus 7%)[34]. While the high prevalence may be due to having been married to infected men, it may also be related to their impoverished circumstances leading to engagement in sex for survival.
- Vulnerability is often caused by local socio-economic or cultural factors that need to be identified and addressed at family and community level. Anecdotal evidence exists that young girls from poverty stricken household who are sent to towns to work as house maids, come back home pregnant or infected with HIV; and of school girls in secondary schools without hostels, who rent accommodation in private homes and engage in sex for survival. Cultural traditions like early initiation and marriage of girls, as well as widow 'cleansing' are still practiced in some regions. Girls are often pulled out of school to look after sick relatives, denying them the opportunity to gain skills to become economically independent and driving them towards transactional sex or early marriage -often with much older husbands- and thus exposing them to the risk of HIV infection.
- Cases of sexual abuse of children, both boys and girls, are increasingly coming to light. Orphans who are staying with distant relatives often suffer discrimination as well as sexual abuse and molestation. Some orphans end up on the streets where they are particularly vulnerable to abuse and often end up as commercial sex workers. Sexual coercion of pupils by teachers is also reported from time to time.
- Persons with disabilities are often left out of the HIV response owing to their lack of visibility in society. The special needs of persons with disabilities demands

[34] Tanzania Commission for AIDS (TACAIDS), National Bureau of Statistics (NBS) and ORC Macro. 2005. *Tanzania HIV/AIDS Indicator Survey 2003-04.* Calverton, Maryland, USA

conscious efforts to provide them with equitable, accessible and appropriate information and services.

- Refugees and displaced persons are covered under programmes of the UNHCR and GLIA. Improved coordination will be needed with such agencies to ensure coverage while avoiding duplication of efforts.
- Intravenous drug users are highly vulnerable because of their habit of sharing equipment, needles and syringes. A recent study carried out in Dar es Salaam indicates that the HIV prevalence among intravenous drug users is very high (42%)[35]. IDUs also tend to engage in commercial sex to finance their drug dependency and therefore are a potential source of infection for non-IDU patrons as well. The interventions implemented so far have largely been educational, empowerment and income generation but harm reduction measures and rehabilitation have so far not been initiated.

Strategic Objective

Reduce risk of infection among those most vulnerable due to gender inequality, sexual abuse, socio-cultural factors and involvement in illegal practices (women in relationship without control to practice safe sex, women engaging in commercial and transactional sex, sexually abused children, widows and divorcees, men who have sex with men (MSM), prisoners, refugees and displaced persons, people with disabilities and intravenous drug users)

Strategies

1. To promote open discussion and awareness about gender inequality, gender based violence and sexual abuse that increase vulnerability of women, girls and boys to HIV within families and at community level and promote respect for human rights of women and children.
2. To empower girls and women to negotiate safer sex through enhancing knowledge about sexuality, reproductive health and HIV and imparting life skills that increase their effective control to protect themselves.
3. To strengthen programmes with and by men to promote life skills and male responsible behaviour in sexual and family relations (reduce male dominance, irresponsible parenthood, domestic and gender based violence).
4. To advocate with influential men to promote gender equity and social transformation at community level.
5, To facilitate the identification of local socio-cultural determinants of vulnerability at community level and support communities to address these factors.
6. To advocate for repealing of laws and practices that violate women's social protection.

[35] Kilonzo et al, (2006) *Injection Drug Use in Dar es Salaam*. Muhimbili University College of Health Sciences and University of Texas

7. To revise legislation that condones early marriage for girls (before age 18) and does not recognize rape within marriage.
8. To promote increased access to HIV preventive information and services (IEC, condom access, peer education, friendly testing and counseling and STIs services) for the vulnerable populations.
9. To build partnerships between government and CSOs and other agencies working with vulnerable populations to advocate for their empowerment and protection and stimulate documentation and exchange of experiences.
10. To acknowledge the vulnerability of sex workers and men who have sex with men and advocate for their access to HIV preventive information and services and for decriminalization of their activities.
11. To provide PEP, emergency contraception, presumptive treatment of STI, counseling, legal support and protection for rape victims, including for sexually abused children and for women in abusive and forced marriages.
12. To make condoms available to prisoners and address sexual abuse of male and female prisoners.
13. To develop and implement a comprehensive strategy to reduce HIV transmission among IDUs, including education, condom provision, harm reduction measures (disinfection and exchange of needles and syringes) and rehabilitation services for persons who inject drugs.

Indicators and Target

- Indicator: Percentage of women who feel that a wife is justified in proposing condom use if she knows that her husband has a sexually transmitted infection

- Target: Percentage of women have increased from 75% in 2005 (TDHS) to 85% in 2012

- Indicator: Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected (UNGASS)

3. Expansion of workplace interventions, with special attention for mobile and migrant workers

Strategic Issues

- Workplace programmes on HIV can reach substantial numbers of people in the public and private sectors. Most ministries, departments and agencies in the public sector have started some workplace activities, but they lack comprehensiveness and sustainability mainly due to lack of commitment at high levels. PO PSM has developed a draft guide for workplace interventions in the public sector, which includes support for PLHIVs. At the decentralized level,

regional and local government authorities should equally expand their workplace interventions, including for extension workers at community level.

- Businesses and enterprises (including parts of the informal sector operators) have joined the national response by starting their own workplace programmes. The AIDS Business Council of Tanzania (ABCT) is mandated to coordinate and support the private business response. Many programmes are still concentrated in larger private enterprises in the main cities and there is need to cover the medium and smaller enterprises dispersed over the country. Many leaders of private enterprises and the operators in the informal sector still need to be convinced of the necessity and desirability of such programmes and need support to initiate them.
- Employers of mobile and migrant workers need to devote special attention to reduce risk taking and promote safe sex among those workers. Wherever possible, separation of families for long periods of time should be avoided, through providing housing and social services for families of workers and arranging for joint transfers of married workers wherever possible.

Strategic Objective

Increase the proportion of public and private sector enterprises and informal sector operators developing and implementing comprehensive workplace interventions with special attention for mobile and migrant workers.

Strategies

1. To implement guidelines on workplace interventions in the public sector focused on the protection, care and support of employees and their families.
2. To integrate HIV education in new staff orientation and staff seminars in the public sector and standardize HIV education and peer education training across sectors to ensure quality.
3. To expand workplace interventions in the private sector including the SME and document and share experiences through ABCT.
4. To ensure a legal environment (Protection of worker’s rights, adherence to ILO code of conduct on HIV/AIDS) that is conducive for promoting and facilitating effective workplace interventions.
5. To strengthen labour and employment policies and regulation to incorporate HIV and to discourage and address misconduct, including sexual harassment and sexual exploitation in the workplace.
6. To develop outreach programmes to include families and communities of the workers and employees in workplace HIV activities.
7. To develop and support special HIV prevention and control programmes designed to reach the operators in the informal sector, through collaboration with government and the private sector.
8. To make information and condoms available to all mobile and migrant workers in the public and private sectors (road works, mining, tourism, plantations, transport,

military) and in the informal sector (traders, fishermen, small scale miners, farm workers etc.,)

Indicator:

- Percentage of large workplaces (public and private) that have HIV prevention and care policies and programmes

4. Prevention, treatment and control of other sexually transmitted infections (STI)

Strategic Issues

- STI prevention and control has been proven to be one of the major prevention strategies in reducing HIV transmission. The Mwanza trial of 1994 has convincingly demonstrated the contribution of STIs and their control to the dynamics of the epidemic. Experiences from other regions (Mbeya) and countries point into the same direction.
- STI syndromic management is available in all hospitals and health centres and in the majority of dispensaries but the services are still lacking in many remote rural areas. While the reported number of patients with STI has doubled over the past 4 year, there remain concerns about the quality of the services, especially the observed lack of proper counseling, condom demonstration and referral for HIV testing[36].
- Youth friendly sexual and reproductive health services have been established only in 10 districts so far and initial assessment shows that young people's satisfaction with the services is high and that they increased their SRH knowledge as a result of the exposure to a peer service provider, who among other demonstrated proper condom use.
- The important role of genital herpes virus (HSV-2) infection in facilitating HIV transmission has increasingly been recognized. So far, prevention and/or treatment of HSV-2 is not included in the syndromic management of STI protocols.

Strategic Objective

Expand quality, gender sensitive and youth friendly STI services including counselling and condom promotion to all health facilities in the country and enhance appropriate utilization of services.

Strategies

1. To expand the coverage of quality STI services to all of the health facilities in the county and make services youth friendly and gender sensitive.

[36] NACP, Tanzania (2005) *Evaluation of Sexually Transmitted Infections Services Delivery in Tanzania Mainland,* 2005.

2. To improve and maintain the quality of STI services trough capacity building, supervision and quality circles and through including STI syndromic management in relevant pre-service trainings.
3. To assure the continuous availability of essential STI drugs at all public and private health facilities offering STI services.
4. To strengthen public/private partnerships through involvement of private health care providers (hospitals, practitioners, pharmacists) in training and quality control and through enforcing appropriate regulations.
5. To regularly update guidelines and treatment protocols in line with findings from research and surveillance of drug resistance, with special consideration for prevention and treatment of HSV-2 infection .
6. To make quality STI services available and accessible to specific most at risk populations such as commercial sex workers and their clients.
7. To empower health workers to provide appropriate counselling on risk reduction, condom use, partner notification and importance of HIV testing to individuals and couples presenting with STIs.

Indicators and Target

- Indicator: Number of STI patients per 100 000 population

- Indicator: Percentage of patients with STI at health care facilities who are appropriately diagnosed, treated and counselled

- Target: Percentage of patients with STIs who are appropriately diagnosed, treated and counselled increased from 67% in 2005 (NACP) to 75% in 2012

5. Promotion and expansion of HIV testing and counselling services

Strategic Issues

- Counselling and testing has proven to be effective in adopting risk reduction in HIV positive people and discordant couples. Further expansion of counselling and testing services, especially in rural areas, will facilitate early access to care, treatment and support for those who are infected as well as advice on how to protect their partners from infection and themselves from re-infection. Joint couple counselling and testing will also be promoted as a way to facilitate dialogue about sexuality within couples and allow identification of discordance and joint discussion on how to prevent the transmission to the HIV negative partner.
- The number of counselling and testing sites has increased considerable over the past 3 years, resulting in at least 4 sites per district. About 15% of adults aged 15 to 49 had ever been tested for HIV by 2003/4. In order to accelerate the increase in the number of people tested, provider initiated testing and counselling, with an option of refusing, will be gradually introduced for all clients attending health facilities.

- Also mobile and community/family counselling and testing have been implemented in some pilot projects, with positive initial results. In order to expand these new approaches, the human resources for testing and counselling will need to be increased substantially. Training of non-health workers, such as community development officers, social welfare officers and people living with HIV, will need to be explored.

Strategic Objective

Increase the number of people in Tanzania who know their HIV status and who adopt appropriate measures to protect themselves and/or their partners from infection and re-infection.

Strategies**:**

1. To expand socially acceptable, youth friendly and gender sensitive HIV testing and counselling services to additional health facilities and stand alone sites.
2. To introduce and gradually expand provider initiated testing and counselling, with option to refuse, to all sites.
3. To explore the community based selection and training of non-health workers - including people living with HIV- for mobilization, counselling and testing at community and family level, as appropriate, and adapt the guidelines accordingly.
4. To link HIV testing and counselling services to existing reproductive and child health services, HIV care and treatment centres, TB services and care and support services in the respective communities, including post-test clubs.
5. To ensure adherence to requirements of confidentiality and medical ethics in HIV testing and counseling.
6. To promote and strengthen testing and counselling services for (discordant) couples, children and young people and reduce the age requiring parental consent for testing and counseling.

Indicators and Targets

- Indicator: Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and know the results (Universal Access and UNGASS)

- Target: Percentage of women and men aged 15 to 49 who received an HIV test in the last 12 months and know the results increased from 7% in 2006 (TDHS) to 12% in 2012

- Indicator: Number of testing and counselling sites per district population

6. Prevention of mother to child transmission of HIV

Strategic Issues

- While the expansion of the PMTCT programme has initially been slow, it has accelerated in the past 3 years covering 710 health facilities by the end of 2006. HIV testing and counselling are integrated within antenatal care and HIV testing is done using rapid HIV tests with same day results.
- The uptake in health facilities with PMTCT services is very high, with 87% of pregnant women accepting HIV testing in 2006[37]. However, only 53% of the women found to be HIV positive received ARV prophylaxis, due to frequent stock-outs of Nevirapine, the policy of dispensing Nevirapine only from 28 weeks of gestation, an inadequate follow up system for HIV-infected women and shortage of trained PMTCT providers at facility level.
- Extrapolated to the entire country, about 12 percent of the estimated total number of HIV positive pregnant women received a course of ARV prophylaxis to reduce transmission to the child in 2006[38]. Rural women are four times less likely to be offered HIV testing and counselling in antenatal care than urban women.
- In order to accelerate further expansion of PMTCT services, the responsibility for selection of new sites, training and initiation of services will be gradually decentralized to the Council Health Management Teams (CHMTs).
- Male participation is low and needs to be encouraged through making reproductive and child health clinics more "parent friendly".
- The referral of HIV positive mothers to care and treatment centres is not yet routinely done. Also the follow-up of babies of infected mothers needs to be strengthened, including the access to paediatric AIDS care. More efficacious antiretroviral regimen are now available and need to be introduced in line with emerging scientific evidence.

Strategic Objective

Reduce the transmission of HIV from mothers to their children, during pregnancy, birth and/or breast-feeding and ensure entry into care and treatment for mother and baby

Strategies

1. To regularly update policy and guidelines to encompass new developments and research findings.
2. To promote access to family planning integrated in reproductive and child health to prevent unwanted pregnancies in HIV positive women.
3. To expand PMTCT services through integration of testing and counselling with opt-out option in antenatal care services..

[37] Ministry of Health and Social Welfare, Tanzania, PMTCT Summary report, 2006
[38] Ministry of Health and Social Welfare, Tanzania, Tanzania Joint Mission on PMTCT and Paediatric AIDS, Draft Summary Report, October 2006

4. To strengthen capacities among health workers to provide quality and ethically sound testing and counselling services and to support HIV positive women to make appropriate decisions about delivery and infant feeding.
5. To advocate and sensitize the public at all levels on PMTCT and address stigma related to PMTCT.
6. To mobilize male partners to participate actively in PMTCT and create an environment conducive to joint responsibility of parents.
7. To link the HIV positive mother and her baby to care and treatment and support services.

Indicator and Target

- Indicator: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother to child transmission

- Target: Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother to child transmission increased from 12% in 2006 to 50% in 2012.

7. Promotion and distribution of condoms

Strategic Issues

- Male Condoms are one of the most effective and easy to use barriers preventing the transmission of HIV and other sexually transmitted infections. Female condoms have been introduced in some urban areas, especially targeting female sex workers.
- The number of condoms sold and distributed in the country has increased dramatically in the last 5 years from about 50 million in 2001 to 150 Million in 2006. Although male condoms are promoted through social marketing and free distribution in the country, their general acceptance and regular use is still very limited. Access to free condoms, especially in rural areas, needs to be improved through channels and outlets beyond the health facilities. Female condoms are still a widely unknown product. Use of both male and female condoms is hampered by women's limited decision making power in sexual issues.
- Furthermore, messages on condoms and their effectiveness in the prevention of HIV infection have been highly unbalanced leaving majority of prospective users in total confusion. Condom use is the only available method to reduce risk of sexual transmission if the sero-status of one or both partners is either not known or is positive. Advocacy with gatekeepers, especially religious leaders, is needed to be more tolerant towards condom use, especially in discordant couples.

Strategic Objective

Increase the proportion of the sexually active population, especially in the rural areas, who use condoms consistently and correctly and promote and expand the availability of female condoms as a female controlled and dual protection method.

Strategies

1. To include condom issues (procurement, quality control, distribution, right to condom access of every sexually active person) in the revised National HIV and AIDS Policy and Guidelines.
2. To increase knowledge and skills on correct and consistent condom use (male and female) in the general public and throughout the country and address misconceptions and misinformation.
3. To expand the availability and accessibility of quality condoms to all areas of the country through social marketing and through strengthening and diversifying the distribution mechanisms and outlets for free public sector condoms.
4. To address gender and other socio-cultural barriers to using condoms.
5. To advocate with religious leaders who are opposed to condoms, to accept condom use, particularly in discordant couples.
6. To make female condoms more accessible and affordable through the public sector and through social marketing.

Indicators and targets:

- Indicator: Percentage of women and men aged 15 to 49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse.
- Target: Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse has increased from 38.0%F and 49.7%M in 2003/4 to 45%F and 55% M by 2012.

- Indicator: Number of male and female condoms distributed to end users in the last 12 months (Universal Access)
- Target: Number of male and female condoms distributed to end users in the past 12 months increased from 158 million (M)/ 776,000 (F) in 2006 to 250 million (M)/1.5 million (F) in 2012

- Indicator: Percentage of prisons that make condoms available free of charge to prisoners

8. Prevention of HIV transmission through blood transfusion, exposure to contaminated body fluids and contaminated instruments

Strategic Issues

- The gradual expansion of the national blood transfusion services to all the zones has been planned. In the mean time, there is a need to ensure that supplies for HIV screening of donors are continuously available in all the hospitals where blood screening of donors is carried out.
- While the policy on post-exposure prophylaxis (PEP) exists, the supply and distribution of PEP kits is not yet organized. Guidelines on waste management and safe disposal of sharps have been developed and disseminated, but implementation is not yet satisfactory. The supply and distribution of personal protective gear for health workers also needs to be strengthened. Home based care givers, especially relatives, will receive training on how to protect themselves against accidental infection and protective gear will be provided to them.
- Data from the population based HIV survey in Tanzania show that circumcised male virgins were almost 3 times more likely to be HIV positive than uncircumcised male virgins. Contaminated circumcision equipment is a likely explanation for these findings. This highlights the need to continue efforts to ensure that traditional practices are reduced or carried out in hygienic conditions.

Strategic Objective

Reduce the risk of HIV transmission through blood, contaminated instruments and non-observance of universal precautions in health care settings as well as through the use of contaminated instruments in traditional practices such as scarification, male circumcision and female genital cutting.

Strategies

1. To expand the National Blood Transfusion System to cover all regions and districts.
2. To provide quality screening for HIV anti-bodies, hepatitis and syphilis for people donating blood.
3. To expand the availability of Post-exposure prophylaxis kit to all health facilities and ensure implementation of guidelines.
4. To improve the supply and distribution of laboratory supplies for HIV blood screening.
5. To intensify advocacy and train health workers on issues related to HIV transmission risks through procedures, contaminated equipment and medical waste and reinforce the proper application of sterilization, waste management and personal protection guidelines.
6. To support home based care providers, including relatives, with protective gear and knowledge to protect themselves against accidental transmission of infection through care giving

7. To provide appropriate information at community level on the risks of HIV through traditional practices and involve practitioners in reducing the risks.

Indicator

- Percentage of blood units screened for HIV in a quality assured manner (UNGASS)

9. Introduction of new prevention interventions

Strategic Issues

- Recent evidence from two trials in Kenya and Uganda on male circumcision demonstrated that the risk of HIV infection was halved among men who became circumcised during the trial compared to those who were not circumcised39. WHO and UNAIDS are currently revising the evidence and developing technical guidance for countries, including a rapid assessment toolkit to determine male circumcision prevalence, assess acceptability and identify potential safe practitioners. In Tanzania male circumcision prevalence is about 70%, with considerable variation between regions. The high HIV-prevalence regions of Mbeya and Iringa have relatively low male circumcision rates (34.4% and 37.7% respectively), which might imply a causal relationship. Stakeholder consultations will carefully need to consider policy, cultural, human rights, ethical and operational aspects of promoting male circumcision. Possible adverse effects such as undermining of existing protective behaviour and performance of circumcision under unhygienic conditions by untrained practitioners have to be anticipated and avoided.
- According to the counselling and testing guidelines, self-testing is not recommended in Tanzania. Since self-testing kits are being sold already in private pharmacies, it might be advisable to look into the demand and the measures needed to ensure that individuals who want to test themselves are aware of the proper procedure and interpretation and are appropriately advised on where they can access counselling, care and support.

Strategic Objective

Emerging prevention intervention are introduced and scaled up based on international scientific evidence and on results of assessment of local acceptability, demand, operational and regulatory issues as well as stakeholder consultations

Strategies

1. To promote and scale-up safe male circumcision as a preventive measure in appropriately selected regions in Tanzania, after careful study of policy, cultural,

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

human rights, ethical and operational aspects and while safeguarding against adverse effects.

2. To assess acceptability and demand of self testing for HIV and regulate the sale of self-test kits to ensure they are appropriately and safely utilized.
3. To study evidence of other emerging prevention interventions and initiate implementation as appropriate (HIV vaccine, pre-exposure prophylaxis, microbicides, etc.).

- Indicator*: to be formulated as interventions are introduced*

4.3.3 Thematic Area: Care, Treatment and Support

Goal: Reduce morbidity and mortality due to HIV and AIDS

Indicator: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral treatment

Introduction

The National HIV and AIDS Policy launched by the former President of Tanzania in 2001 stated that "PLHAs have the right to comprehensive health care and other social services…. However, PLHAs were required to meet the cost of Highly Active Anti-Retroviral Therapy (HAART)". But it was only in 2003, after a considerable reduction of costs for antiretroviral treatment, that it became feasible to introduce treatment with antiretroviral drugs as a strategy in Tanzania. The prospect of additional external resources prompted the process of the formulation of the National Care and Treatment Plan (NCTP), which was endorsed by the government in 2004.

It is estimated that about 1.3 million adults in Tanzania are living with HIV, according to calculations based on the THIS 2003/4. Among these, about 260,000 are actually eligible for treatment according to the guidelines of the Ministry of Health and Social Welfare (MOHSW). Additionally, about 30,000 children aged 0 to 14 are eligible for treatment as well using the paediatric treatment guideline by the MOHSW.

The careful scaling up of ART, with due consideration for quality and equitable access for people in need, poses a huge challenge for the health system, already overstretched and not prepared for treating chronically ill patients in ever increasing numbers.

70% of people on ARV treatment survive for more than one year in Tanzania and continue to be in need of treatment. Not only does ART raise the CD4 count and well-being of clients but also clients become less infectious, an effect contributing to prevention. Many of those who are not yet eligible for treatment will eventually start treatment in the near future. Furthermore, as people become newly infected, progressively more and more people will be in need of antiretroviral treatment. This development will continue for years to come even if the number of new infections stabilizes or starts to decrease.

Those who are infected and need treatment for opportunistic infections and prophylactic therapy have to be cared for as well. Keeping them in good health will result in a postponement of the start of ART and will also prolong their lives.

TB is one of the major causes of adult morbidity and mortality in Tanzania. The number of notified TB cases has seen a five-fold increase in the past 20 years, largely due to the HIV epidemic. Efforts to address the dual epidemics of HIV and TB in synergy have been initiated but need to be expanded.

When antiretroviral therapy was introduced in October 2004, only about 2,000 patients were receiving ARV treatment. The efforts of the MOHSW and its partners have resulted in a total of 70,000 patients being on treatment by end of 2006. However, many challenges were and are still being faced.

1. The Continuum of Care, Treatment and Support

Strategic Issues

- Public sector health care services are facing a massive human resource crisis with 40% of positions vacant and many positions filled with people lacking the necessary qualifications and skills. Any additional requirement and extension of duties aggravates this situation. Antiretroviral therapy relies on the personnel already in place and assigned to other duties, thereby overburdening the already weak system. In most care and treatment centres antiretroviral therapy is offered on certain day(s) of the week only, in order to allow other services to be continued as well. Staff have been trained in large numbers. Due to the increasing demand for ART services, more trained service providers, laboratory technicians, pharmacists and counsellors are needed. This situation restricts the access to and further scaling up of ART and it interferes with the continuity of other relevant health services.
- The infrastructure of health facilities was not sufficiently prepared for the additional ART related duties, which require counseling and consultation rooms, equipment and laboratory facilities.
- This situation makes it difficult to guarantee optimal quality of services and rapid scaling up. In some care and treatment centres, patients cannot be monitored adequately because of lack of sophisticated laboratory equipment.
- Although ART provision has been introduced in health facilities located in rural areas, there is a clear bias of service provision towards the urban population. However, slum areas in the cities are disadvantaged, as well as rural areas.
- Women and men have equal access to ART services but more women than men are currently on treatment, mainly because health facilities are visited more by women than by men, due to the focus on reproductive and child health services.
- The variations in prevalence rates within the country should be taken into account when scaling up treatment in an equitable way, with more treatment centres per population allocated to urban areas and to the high prevalence regions (Mbeya and Iringa).
- Appropriate prevention and treatment of opportunistic infections can significantly increase life expectancy of people living with HIV and prolong the period without antiretroviral treatment. However, management of opportunistic infections is not well implemented, partly due to the insufficient availability of required drugs. In order to improve the situation, the drug supply system has to be revisited and should include a provision for health facilities to directly purchase these relatively inexpensive treatments for their clients.

- Traditional healers can play an important role in this aspect. Herbal medicine is known to strengthen the immune system and treat several opportunistic infections effectively. Traditional healers are well accepted by the community and are often visited before the formal health system. The cooperation between the traditional and the modern health care system needs to be improved and referral systems created in both directions. The MOHSW has to engage in a constructive dialogue and build a relationship based on mutual respect and trust.
- Accurate information on antiretroviral treatment is lacking, leading to poor adherence, sharing and misuse of ARV drugs, including prophylactic use of ARVs. Support to the community of people on treatment needs to be enhanced and the role of PLHIV in this area has to be recognized and strengthened. More targeted IEC/ BCC approaches must be developed and widely implemented. Attitudes towards sick people in general, both by health workers and the community at large, need to be more supportive and empathic.
- It is common knowledge that good nutrition delays progression to disease as well as increases the effectiveness of antiretroviral treatment, especially in the initial phase, thus enabling people to live healthy and productive lives. However, access to adequate and nutritious food remains a problem to most PLHIV especially in the rural areas. In addition, lack of nutrition education and awareness about an appropriate diet is another limitation. Nutrition education for PLHIV as well as care-givers is therefore essential. Service providers must be able to advise on nutrition according to the kind of food available in the respective areas.

Strategic Objective

Increase equitable access for PLHIV to a continuum of care, treatment and support.

Strategies**:**

1. To enhance the capacity at Regional and District levels to plan, implement, coordinate, monitor and evaluate a quality continuum of care, treatment and support services.
2. To increase the numbers of qualified service providers.
3. To strengthen procurement and supply management systems of HIV & AIDS-related commodities.
4. To expand the availability and accessibility of prophylaxis and treatment for opportunistic infections.
5. To scale up the involvement of the private sector in the provision of the continuum of care, treatment and support.
6. To build partnerships with traditional healers in provision of the continuum of care, treatment and support.
7. To enhance linkages between the continuum of care, treatment and support services with those of PMTCT, HIV counselling and testing, STI management and condom provision and promotion.
8. To promote gender-sensitive research and its application on the clinical management of AIDS clients.

9. To strengthen IEC/BCC in the area of care, treatment and support for HIV & AIDS, targeting both providers and beneficiaries.
10. To incorporate nutritional counselling, education and support in care and treatment of PLHIV and care-givers, including changes of the diet according to food locally available.
11. To ensure that PLHIV are actively involved in (adherence) counselling and support of newly enrolled patients.

Indicators:

- Percentage of women and men with advanced HIV infection receiving ARV combination therapy in the last 12 months (UNGASS)
- Number of ARV sites per 100,000 population per district and region
- Percentage of health facilities with no stock outs of Fluconazole[40] for more than a week in the last 12 months

2. The dual Epidemic of HIV and TB

Strategic Issues

- Service providers of care and treatment for PLHIV can learn and profit from the experiences gained from the implementation of management of tuberculosis. The TB programme works well and reacts immediately and effectively to problems arising such as drug resistance, poor adherence and difficult access for specific population groups.
- Although 60% of patients with TB are also HIV infected and co-treatment of both infections is very important, cooperation between the two programmes for the better of the patients is very weak. Only 4% of TB patients are tested for HIV
- Better cooperation between the two programmes can improve the health of PLHIV. However, care should be taken that this does not negatively affect the quality of TB services.

Strategic Objective

To improve the quality of care for both PLHIV and TB patients through closer collaboration between the two programmes.

Strategies

1. To create and implement stronger mechanisms for collaboration between TB, HIV and AIDS related services.
2. To identify and adapt 'best practices' from the TB/Leprosy Control Programme to enhance effectiveness of the HIV & AIDS Care, Treatment and Support Programme, especially in the area of adherence.

---

[40] *Oral or intravenous fluconazole is used in the treatment of candidiasis (one of the most common opportunistic infections) in immuno-compromised adults with AIDS*

3. To strengthen adequate screening for and prophylaxis or early treatment of TB in all PLHIV.
4. To expand provider initiated testing and counselling for HIV to all TB services.

Indicator:

- Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV

3. Home-Based Care and Support

Strategic Issues

- Chronically ill AIDS patients are mostly taken care of by family members and particularly by women and children, who usually lack adequate training and support. Home based care providers support them and establish the continuum of care through connecting the health facilities with the community. However, two way referral systems are inadequate to effectively support patients and their families in identifying and linking with the HBC providers and accessing health facility based care when required.
- Whilst a lot of training of health facility and community based care providers has been done over the past five years, coordination and cooperation between the public sector and civil society organisations is still limited. In order to extend home-based care and support services to more PLHIV and their families, capacity building and collaboration have to be strengthened. Moreover, there has been inadequate attention given to the training and support needs of primary care givers in the family.
- Through wider and stronger involvement of non-health workers and PLHIV, the access to HBC services can be improved further. However, all providers have to undergo the same standardised training and use the same reporting and monitoring system to ensure quality of care at community level. However the materials used have to be relevant and adapted for the specific target group.
- HBC services have been supported by various NGOs and development partners. In order to rapidly scale up services to all districts, the responsibility for the programme needs to decentralised to the Council Health Management Teams (CHMT) and standardized HBC drug and supply kits need to be provided at this level, bearing in mind that these patients would otherwise request the drugs from the health facilities.

Strategic Objective

Scale up availability and accessibility of quality community and home-based care services

Strategies

1. To train adequate numbers of health facility, community and family and home based care providers, women as well as men.

2. To strengthen linkages and referrals between health facility and home based care services.

3. To promote advocacy and public education activities in communities to make them respond effectively to the needs of PLHIVs and their families.

4. To promote greater involvement of PLHIVs in planning and implementing home based care and support.

5. To ensure that care givers are aware of rights and entitlements to care, treatment and support, according to the National HBC Guidelines..

Indicators

- Percentage of adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months due to HIV and AIDS, whose households received basic external support in caring for chronically ill adults

- Number of organisations providing HBC per district population

- Number of HBC person-visit in the last 12 months

- Number of HBC providers trained according to National Guidelines

4.3.4 Thematic Area: Impact Mitigation

Goal: Improve the quality of life of PLHIV and those affected by HIV and AIDS, including orphans and other vulnerable children.

Indicator: Current school attendance among orphans and among non-orphans aged 10–14 (UNGASS)

Introduction:
Many households, extended families, neighbourhoods, communities, and public and private sector institutions have been severely affected by HIV and AIDS. Among other effects, this is reflected in the rising numbers of orphans and other vulnerable children (OVC), worsening caregiver burdens, the inability of households with infected members to cope effectively with their many challenges, and increased costs associated with responding to the epidemic. It is currently estimated that there are some 2.2 million OVC in Tanzania, of which half (1.1 million) are estimated as *most vulnerable children* (MVC). The epidemic has undermined social capital, weakened social networks, and divided neighbourhoods and communities in unforeseen ways. As almost all mitigation of impacts occurs locally, mostly within extended families but also including friends, neighbours, and formal and informal community-based organisations, the weakening of this 'sense of community' is especially problematic for effective impact mitigation.

While Tanzania appears to have been able to stabilise rates of new infections, the *effects* of HIV will continue to be felt during the 2008-2012 NMSF planning horizon. It is important to remember that Tanzanians will increasingly need to cope with the *cumulative* impacts of HIV and AIDS over time, and not just the multitude of problems arising from new infections. Children who were orphaned in the 1980s and 1990s have reached adulthood, many without the benefit of intergenerational learning and effective parental control and guidance. Furthermore, studies show that many orphans and other children made vulnerable by the epidemic have grown up under difficult conditions, with poor nutrition and inadequate access to important social services and protection. The economic status of a large number of affected households has been in the decline for many years, affecting the lives and well-being of both current and future generations, while social capital, so important in effective livelihood strategies, is also substantially weakened. All these findings highlight the importance of extending life among those affected, through improved economic livelihoods, social protection, nutrition and lifestyles, and through the provision of ARVs for those in need.
As almost all coping with HIV and AIDS impacts occurs **locally**, responding to these impacts needs to be focused at this level. This means enhancing the role of local authorities, informal and formal social networks and coping mechanisms, and community-based organisations in responding to varied needs.
Consistent with Tanzania's commitment to **decentralised** development, to the extent possible impact mitigation will work through decentralised institutions, and will endeavour to enable these institutions to better respond to the many challenges they face.

Impacts vary considerably across men and women, young and old, as well as poor and non-poor. Impact mitigation actions must take cognizance of these differential impacts, as well as the varied ability of different groups to respond to these impacts. At the same time, the magnitude of the epidemic and the costs associated with an effective response underlines the need to **target** those most in need.
Local responses, supported by decentralised institutions, require much more emphasis on *horizontal* implementation mechanisms, rather than an emphasis on *vertical* service delivery. Through such an approach, Tanzania is posed to make significant progress in reaching Tanzania's most vulnerable children (MVC) with a minimum package of support, geared towards the particular needs of each child and caregiving family.
Many effective means of impact mitigation are directly linked to poverty alleviation and, therefore, the national poverty strategy **MKUKUTA**. This requires that implementation of interventions under MKUKUTA take cognizance of MVC issues, and ensures that MVC are integrated into MKUKUTA strategies.

1. Most vulnerable children

Strategic Issues

- According to the THIS (2003/4), 10.8% of all those aged 0-17 are orphans. With a population of 0-17s of 20,400,000 by 2006, this yields approximately 2.2 million orphans. It is estimated that approximately half of OVC are 'most in need', at between 1 and 1.1 million MVC as of 2007. About 6% of orphaned children aged 0-17 are living in households that reported to have received some free external support (THIS, 2003/4), covering some 110,000 children; no estimates are available for reach to other vulnerable children.
- Government, in collaboration with its development partners, has developed an extensive, and informed, 'Most Vulnerable Children Costed Action Plan' that highlights the challenges and outlines a number of strategies intended to help meet the needs of MVC and their caregiving households.
- In terms of helping to mitigate impacts associated with most vulnerable OVC, the establishment of the RFA structure has been especially important, but a catalyst for local response has been of equal importance: the establishment and active support for most vulnerable children committees, which now exist in 40 of the 122 districts. Often working with these committees, there are a number of donor-supported initiatives designed to enhancing coping for households looking after MVC. The overwhelming majority of proposals from CSOs to the RFA for financial support have been dealing with MVCs.
- The Department of Social Welfare tries to oversee the expansion of services in a coherent fashion. However, some districts have no social workers falling under the Department's technical mandate, and many that do exist are involved in implementation, rather than co-ordination and facilitation. Social Welfare is nevertheless moving ahead in terms of trying to guide the national response, and is in the process of developing a minimum package of support focused on those most in need, along with standards for service provision.

Strategic Objective

Community-based support for MVC through a multi-sectoral response is enhanced, supported by expanded service delivery.

Strategies

1. To strengthen the capacity of families, neighbourhoods and communities to protect and care for MVC through the following:
    a. Strengthening local systems to provide families caring for MVC with economic support.
    b. Strengthening local systems[41] to provide health and nutrition care for families caring for MVC.
    c. Strengthening local systems to roll-out appropriate, community-based psycho-social support for MVC.
    d. Supporting local systems to roll-out early childhood development that includes reaching MVC.
    e. Expanding access to skills training opportunities among MVC.
    f. Strengthening community-based systems to prevent abuse and exploitation, coupled with increased awareness raising around abuse, neglect, and exploitation.
    g. Responding to the differential impacts of MVC protection and care on women and men, young and old, taking care to target those most in need and recognising the significant differences in impacts of HIV and AIDS across Tanzania.
    h. Recognise, and respond to, the varied needs of boys and girls.
2. To mobilise and support community-based responses to help MVC most in need of external support through the following:
    a. Provide both immediate and long-term support to vulnerable households caring for MVC.
    b. Work closely with local government authorities and community representative institutions to mobilise and co-ordinate the community response, while at the same advocating for the care and protection of MVC, and strengthening systems to identify and respond to abuse, neglect and exploitation.
    c. Strengthen the decision-making influence of households caring for MVC, while at the same time recognising the particular challenges women face in this regard.
3. To enhance access to essential quality services for MVC most in need through the following:
    a. Through local systems, establish the education requirements of MVC, prioritise needs, and improve access, attendance, and quality of education.
    b. Improve access of MVC to essential health services through local support mechanisms.

[41] Local systems include, but are not limited to, families, local networks, community based organisations and FBOs working in the community, as well as local government

c. Scale-up treatment of HIV positive children and youth through the identification of children and young people at greatest risk of infection, or showing signs of AIDS-related illnesses, and providing support services to link them to treatment.
   d. Expand systems of community-based lay counselling to assist MVC most in need of these services.
   e. Expand community justice interventions, and enhance awareness of rights violations.
4. To ensure the protection of MVC through the following:
   a. Implementation of the Children's Act.
   b. Preparation and dissemination of an MVC Policy.
   c. Harmonisation of conflicting legal provisions related to children.
   d. Recognition of the different roles of women and men in MVC protection.
   e. Recognition of the different protection needs of boys and girls.
   f. Focus particular attention on child-headed households.
   g. Implement MVC care and support guidelines.
5. To recognise the particular vulnerabilities facing child-headed households and elderly-headed households with MVC.
6. To create a supportive environment for all children affected by HIV and AIDS through advocacy and social mobilisation, with particular attention to the following:
   a. Assisting communities to come to terms with stigma and discrimination, taking care to recognise that stigma and discrimination affect women and men differently, differences that will increase vulnerability.
   b. Promoting the participation of children, and child interest groups, in any interventions that affect their lives, recognising the different participation constraints affecting boys and girls.
7. To strengthen the capacity of key institutions at national, regional, district and community levels who are responsible for the co-ordination of the MVC response. Align institutional responses with the structures put into place by Government.
8. To monitor and evaluate the MVC response in Tanzania, with particular attention focused on how support for MVC integrates with positive coping within households, extended families, neighbourhoods, and communities.

Indicators and Targets:

- Indicator: Percentage and number of MVC aged 0–17 whose households received free basic external support in caring for the child (UNGASS (10), UA2)[42]
- Target: By 2008: 500,000 households with MVC; by 2010: 750,000 households with MVC; and by 2012: 1,000,000 households with MVC.

- Indicator: Percentage of districts where there are community-based committees responsible for mobilising services for households with MVC.

[42] Population in need:- 10.8% of 0-17s are OVC, estimated at 2.2 million in 2005. Most vulnerable children estimated at 5.3% of 0-17s = 1.1 million in 2005. Baseline (2004) : 120,000

- Target: By 2012, 100% of districts have community-based committees.

2. The Affected

Strategic Issues

- No reliable estimates of the number of affected persons by HIV and AIDS exist in Tanzania. The best estimates put the number of affected households at some 1.6-2 million. Broader neighbour-level impacts are also felt, as social networks are weakened and social capital undermined. These estimate highlights the widespread impacts of HIV and AIDS on Tanzanian society.

- Coping with the impacts of HIV and AIDS is disproportionately borne by women and girls during times of chronic illness, and by elderly caregivers (again mostly women) following premature death. The economic impacts are generally borne directly by family members, including extended family members, with periodic support (especially during funerals) from friends and neighbours. Longitudinal studies in Kagera Region in north western Tanzania have found that the decline in economic status for poorer households triggered by AIDS undermines recovery, and that entrenched poverty becomes intergenerational. In short, families are affected *over time*, with impacts of HIV and AIDS being cumulative and generational. Weakened households and worsening inequality in communities spread impacts of HIV and AIDS beyond those directly affected, and in the long-run undermine local economies.
  However, despite considerable impacts, HIV and AIDS are not generally viewed as discrete challenges to overall development in many communities, even those severely affected. In many respects this arises from the fact that communities already face severe development challenges, including chronic illness and premature death and the consequent economic problems. HIV and AIDS fit within a pattern of health problems that households must contend with. But, it also arises from the way in which community consultation around development issues proceeds, without HIV and AIDS (and its gender dimensions) being mainstreamed into the deliberations. Given that HIV and AIDS undermine household food and economic security and weaken social networks, mainstreaming of HIV and AIDS in development planning and the poverty response is especially important.

- Given the long-term impacts of HIV and AIDS on the development potential of affected households, and given that widespread impacts across directly and indirectly affected households, it is important to respond to the specific problems facing those who are affected, and the broader development challenges that face the communities they live in.

Strategic Objective

The ability of individuals, families, and communities to respond to the impacts of HIV and AIDS is strengthened.

Strategies[43]

1. To quantify and understand the nature of impacts in caregiving households affected by HIV (both MVC and infected), recognising the varied roles of women and men, and recommend means to mitigate the socio-economic impacts of HIV.
2. To engage local government authorities, civil society organisations, communities, and caregivers themselves as active partners in designing, supporting and evaluating community-based strategies to support caregivers, recognising and responding to the fact that both women and men are stakeholders with varied power to make decisions.
3. To focus attention on caregivers in particular need, including the elderly, the child caregivers in poor health and caregivers with disabilities, recognising the varied roles of women and men.
4. To link caregivers most in need with health and social services.
5. To provide lay (non-professional) and, to the extent possible, specifically-targeted psycho-social support to those most in need.
6. To strengthen community-based volunteer and peer emotional support networks, recognising and responding to the fact that both women and men are stakeholders.
7. To identify and support referral of vulnerable caregivers to relevant services (such as those who are destitute and in need of relief services; those in need of economic development and income generation support services; the chronically ill; households where MVC are in danger; etc.), using community-based mechanisms.
8. To reduce stigma and discrimination against caregiving households affected by HIV and AIDS, through effective dialogue and community-based interventions, recognising the different situations and impacts facing women and men.
9. To roll-out community justice interventions, recognising the differential impacts on women and men.
10. To strengthen solidarity systems to better protect the rights of vulnerable caregivers, recognising the different vulnerabilities of women and men.
11. To empower informal and formal community-based groups to be able to extend support activities for the most vulnerable through:
    a. Organisational skills development.
    b. Helping link those in need to agencies capable of supporting them to improve their economic situation.
    c. Build partnerships between informal and formal groups and community-based organisations and non-governmental organisations that can assist in planning, implementation, and evaluation.

[43] For each of the following, to the extent possible focus attention on local means to identify and respond to the needs of affected populations, emphasising those most in need, consistent with the principals noted above.

d. Strengthen the institutional environment within these informal and formal community-based groups to be responsive and responsible.
e. Recognise the importance of women and men as stakeholders.

Indicator:

- Percentage of adults aged 18-59 years who have been chronically ill for 3 or more months in the past 12 months whose households receives, free of user charges, basic external support including health, psychological or emotional and other social and material support (MKUKUTA)

3. People Living with HIV and AIDS (PLHIV)

Strategic Issues

- There is no specific policy framework for persons infected with HIV. The majority of those who are HIV infected (about eight out of ten) do not know that they are HIV positive. Increased access to testing, expanded provision of ARVs, and an improved response to the nutritional needs of those on ARVs, should improve this situation. Most of those who die of an AIDS-related illness will not know for sure that they died from AIDS, or would never have admitted that it might be a possibility. In these cases, households so affected may not view themselves as directly or indirectly affected by HIV and AIDS, but rather as households whose poverty is further entrenched through chronic illness and premature death. A wider development response, falling under MKUKUTA, is especially important in this regard.

- For those living with HIV (and who know or suspect that they are HIV positive) and their families, stigma and discrimination will continue to represent serious challenges to their health and well-being for years to come. These are matters best tackled through informed community-based stigma and discrimination reduction activities, but also require to strengthen of PLHIV networks. (These issues are addressed in the Thematic Area Enabling Environment Strategic Objective 2: Fighting Stigma, Denial and Discrimination.)

- As testing services are expanded and more go for testing, increased referrals will result in stronger post-test and PLHIV clubs, requiring more support from the national networks. Unfortunately, these networks remain quite weak, in large part because they are comprised of diverse members who have varied interests, but also due to other structural problems. Many of those who go for testing do so only when they have suffered from severe illnesses for some time, and when assets have been depleted, and those who know they are HIV positive and look for support outside of their families tend to come from poorer households.

- For some PLHIV, their means of livelihood are seriously affected, with the lost of a breadwinner seriously constraining livelihood strategies. These have to be

targeted for economic support and skills for improving their livelihood respectively. Such impacts are likely to affect men and women differently.

Strategic Objective

People living with HIV and AIDS (PLHIV) and other stakeholders are empowered to respond effectively to PLHIV needs and rights, taking into account the different situations and needs of women and men.

Strategies

1. To advocate for the establishment of a strong umbrella platform of PLHIV associations at the national level.
2. To assess the legal, institutional, policy and strategy environment affecting PLHIV and the national response, and make recommendations in this regard.
3. To investigate means to expand insurance coverage and the range of insurance services for those who are HIV positive in the formal sector.
4. To support enforcement of the HIV/AIDS Act to reduce discrimination against PLHIV.
5. To strengthen the voice and influence of PLHIV, as rights holders, in national decisions that affect their lives, and the lives of others, taking care to recognise that women and men have unequal influence at the outset.
6. To strengthen human rights mechanisms to more effectively respond to the needs and demands of PLHIV.
7. To engage local government authorities, civil society organisations, communities, and PLHIV themselves as active partners in designing, supporting, and evaluating community-based and other strategies to support PLHIV.
8. To use community-based mechanisms and health facility-based interventions to identify and support referral of most vulnerable PLHIV and the chronically ill.
9. To support community-based initiatives to supplement and support the food supply requirements of PLHIV in need, and mobilising additional support when nutrition support for those on ARVs is inadequate.
10. To increase membership in PLHIV groups to strengthen emotional and material support to those in need, and enhance their advocacy and stigma reduction roles.
11. To use community-based mechanisms to identify and support referral of ill PLHIV for medical care.
12. To provide lay (non-professional) and, to the extent possible, specifically-targeted professional psycho-social support to those most in need.

Indicators

- Percentage of people expressing accepting attitudes towards people with HIV.
- Existence of a national PLHIV umbrella organisation that has the support of all the major PLHIV support groups in Tanzania.
- Percentage of PLHIV support groups that are functional (functional is defined as PLHIV support groups that provide livelihood skills, psychological support to

their members, can conduct advocacy activities, understands the national HIV workplace programme, and can promote positive learning.

Chapter 5: Monitoring, Evaluation, Research and Review of the NMSF

Goal: To use relevant and comprehensive evidence provided in a timely manner in HIV-related planning and decision-making.

Indicator: Percentage of implementers of HIV and AIDS interventions who report that they have participated in HIV dissemination workshops in the last 12 months

Strategic issues

Monitoring and evaluation is a cornerstone of strategic planning. It provides the basis for assessing results against desired levels of performance. Five main strategic issues have affected the extent to which data have been available to assess past performance of the HIV response in Tanzania: the lack of an enabling environment for M&E; insufficient harmonization of data and systems; unclear flow of data accompanied by a lack of data quality assurance of data that have been received; limited use of data for decision making; and lack of a well coordinated research agenda .

1. Enabling environment for M&E functions

Strategic Issues

- M&E staff are in place at TACAIDS and MoHSW, but in other sectors (including MDAs) and at lower levels there is understaffing and low capacity. Decentralizing the HIV response has led to the need to devolve HIV M&E to sub-national levels. Availability of staff and staff capacity for HIV M&E at local government level and amongst HIV implementers is low.

Partnerships between stakeholders involved in HIV M&E (e.g. between government and civil society, between TACAIDS and MoHSW, between government and the private sector, and amongst M&E TWG members) are weak and need to be strengthened to ensure that all HIV M&E processes are harmonised and coordinated.

- Funding to implement HIV monitoring and evaluation functions is inadequate at all levels. The lack of understanding, capacity, motivation and accountability mechanisms have all led to a lack of funding to execute HIV M&E activities mandated in the various guidelines (e.g. executing responsibilities in TOMSHA guidelines). There are few HIV M&E activity plans, councils do not budget for HIV M&E and those that do concentrate solely on follow-up visits. This has resulted in district level HIV M&E staff having inadequate working facilities, equipment, and budgets to carry out their mandates.

Strategic Objective

To ensure an enabling environment for HIV monitoring and evaluation

Strategies

1. To create and maintain strong national HIV M&E partnerships amongst all actors through the strengthening of the national HIV M&E technical working group as a standing committee of TACAIDS to coordinate all HIV M&E activities in Tanzania.
2. To develop and implement a national HIV M&E communications and advocacy strategy as part of the national HIV communications and advocacy strategy.
3. To rapidly increase the number of HIV M&E professionals in civil society, private sector and public sector by harmonising and focusing the available M&E academic courses and creating a profession within the government's establishment post structure for monitoring, evaluation and information systems management.
4. To include monitoring and evaluation in relevant government processes, including budget guidelines by, as a minimum, adapting the MTEF budget guidelines so that they includes a provision that HIV M&E should be adequately funded to enable all HIV M&E functions to be comprehensively executed.
5. To ensure that a minimum of 2.5 percent of all HIV funding from development partners, civil society, the private sector and government is allocated for HIV M&E.
6. To build applied and relevant capacity in HIV M&E that will include capacity building on data analysis, data use, gender sensitive analysis of data, M&E systems building, data interpretation, and related issues as revealed by training needs assessments undertaken from time to time

Indicator:

- Percentage of annual funding for HIV interventions that is spent on HIV and AIDS monitoring and evaluation

2. Harmonization of data and M&E systems

Strategic Issues

There are four other M&E systems being developed that are interrelated with the national HIV M&E system – the MKUKUTA monitoring system, the MoHSW vertical systems for collecting routine HIV data, the Social Welfare section's Most Vulnerable Children database and the anticipated new MoHSW Health Information System. The National HIV M&E system needs to collect data from the MoHSW systems, and provide data to the MKUKUTA poverty monitoring system. Although these linkages have been defined on paper, they have not yet been operationalised.

- The MKUKUTA monitoring system currently contains HIV indicators that (a) cannot be measured and (b) targets about 'reduction in HIV prevalence' that are

unrealistic to ever achieve as HIV prevalence is not expected to reduce given the advent of ARVs (which tend to stabilise or even increase HIV prevalence in the medium term).

- Routine monitoring systems at the local government level have not yet been established, although a new system – the local government monitoring database – has been developed to capture all data at local government level. Efforts to ensure that national database systems from different sectors - e.g. Most Vulnerable Children database, Ministry of Health routine data – aggregate data at the district level, are new; even the systems that have been redesigned to allow for decentralised data collection (i.e. at the district level) are not yet harmonised with or linked to the local government monitoring database.

Strategic Objective

To harmonize existing national and sub-national M&E systems and functions, including data.

Strategies

1. To harmonise and align HIV monitoring and evaluation functions with other HIV coordination functions at the local government authority level.
2. To align the national HIV M&E system with sectoral and other national M&E systems that include HIV aspects (e.g. MKUKUTA).
3. To maintain the national HIV information system so it is harmonized and complementary to existing information systems.
4. To link HIV data with other national data sets, including the Tanzania Socio Economic Database
5. To include surveillance requirements for HIV-related declarations and commitments to which the Government of Tanzania committed itself in the national surveillance systems and other data collection processes (e.g. The Great Lakes Initiative on AIDS (GLIA) and other HIV-related conventions).

Indicator:

- 100% of MKUKUTA indicators related to HIV is in the national HIV M&E system, can be monitored, and data are received on a regular basis by the MKUKUTA monitoring team

3. Flow of data and the validation of their accuracy

Strategic Issues

- Surveys and surveillance relating to HIV is sufficient but not supported by sufficient routine data about the implementation of HIV services. In particular,

local government authorities have not monitored the delivery of HIV services in communities, except in isolated cases.

- Not all data sets are disaggregated by sex, and gender-based analysis of data are not always carried out

Supervision to ensure data quality does not take place on a regular basis. Overburdened local government authorities are responsible for follow-up with stakeholders in all sectors, including civil society and the private sector. Civil society organisations often do not heed government regulations that compel them to report to government and there is no consequence if they do not report back to the CMAC; reporting by MDAs has been on an activity-by-activity basis.

Strategic Objective

To produce accurate data on the achievement of the objectives of the national HIV response

Strategies

1. To conduct regular sentinel surveillance among women attending antenatal clinics and most-at-risk populations to track the spread and drivers of the epidemic.
2. To carry out other population-based surveys to track the dynamic drivers of the epidemic and understand the efficacy and quality of HIV services delivered.
3. To strengthen, align and implement routine data management systems in all sectors to enable local governments to track HIV service delivery as part of the regular and routine government functions, including the Health Management Information System (HMIS), Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) and the monitoring and evaluation of the health sector HIV response.
4. To strengthen financial monitoring systems for HIV as part of the HIV coordination functions and in line with government accounting procedures.
5. To ensure that gender-sensitive data and analysis are available to provide data on and enable decision making about the gender dimension of the epidemic
6. To strengthen, standardise and implement procedures to ensure data quality of all HIV-related data at the national, regional, district, community and implementation levels.
7. To develop and maintain a national HIV information system so that all HIV-related data are consolidated into a single repository where it is easily accessible.
8. To periodically assess latest information to understand the drivers of the epidemic and evidence about the efficacy of HIV services and report it to stakeholders.

Indicators:

- Percentage of health facilities that reported on HIV services that they carried out in the last 12 months
- Percentage of implementers of non-medical HIV services that have reported TOMSHA data on time to the districts

4. Use of HIV data for planning and decision making

Strategic Issues

- Survey and surveillance data are published and made available through print and electronic media (ANC surveillance, THIS). NACP also works with the World Health Organization (WHO) to use the EPP and Spectrum models when making projections on prevalence and mortality. There is a need for the surveys and surveillance reports to be prepared in a timely and easier to read manner so as to be used by stakeholders for formulating policies, planning and budgeting.

- At the district level prevalence data among blood donors, VCT clients and increasingly among ANC attendees (for PMTCT services) are collected. The capacity to interpret these data correctly at local level is often lacking.

Strategic Objective

To promote the use of available HIV and AIDS information for planning and decision making

Strategies

1. To produce regular standardised information products (reports, brochures, and others) and disseminate them in appropriate forms to all sectors at national, regional, district and community levels.
2. To produce relevant local information products based on validated data extracted from national information products where applicable, for advocacy, communication, planning and decision-making purposes.
3. To make data available through different mechanisms, including a national HIV information and resource centre.
4. To build capacity in data interpretation.

Indicator:

- Percentage of CMACs that conducted the required number of feedback workshops in the district where standard information products (as defined in the national HIV M&E system) were shared

5. HIV research

Strategic Issues

HIV biomedical and social science research is taking place but is not well coordinated and not based on a nationally-agreed HIV research agenda. Therefore, research that is undertaken may not produce what is required, whilst necessary research goes unfunded. Research is not often related to the strategic orientations of the National Response.

Funding for research is inadequate, and the results of research that has been undertaken have not always been disseminated locally.

- There is limited understanding of the nature and drivers of the HIV epidemic at the sub-national level and among various sub-populations. Information about HIV services are scanty and not always provided to all the Council Multisectoral AIDS Coordinating Committees (CMACs), to HIV implementers or to communities affected by the research. This has hampered the ability of the CMACs and TACAIDS to coordinate the HIV response at the district and national levels, respectively.

Strategic Objective

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

Strategies

1. To strengthen the research capacity of stakeholders and institutional structures involved in HIV research.
2. To strengthen the use of appropriate ethical standards and ensure adherence to ethical approval procedures.
3. To engage service delivery levels to undertake operational research in HIV.
4. To establish a national HIV research strategy and research agenda that is connected to the key aspects of the NMSF.
5. To improve processes for disseminating HIV related research products and to use them for decision making.

Indicator:

- Proportion of results of research studies with approval of the health ethics and scientific committee that have been disseminated in Tanzania

6. Mid-term Review of the NMSF

Strategic Issues

- Halfway through the NMSF, a midterm review will be undertaken. This Midterm Review will be conducted at the start of 2010 to review the progress,

achievements and challenges of the National Response. Internal and external experts will participate in this review and all relevant stakeholders will be involved. The review will be led by TACAIDS, who will nominate a Steering Committee that is representative of all sectors (government, civil society, private sector, development partners and UN), including persons living with HIV.

Data from the national HIV M&E system will be used to conduct the review, complemented by interviews and field visits, as appropriate. . It is therefore imperative that the M&E information products have been generated before the review commences. The availability of synthesised, regional and district-level data on the drivers of the epidemic at sub national levels in Tanzania should be a conditionality for the midterm review to be undertaken.

Strategic Objective

To assess to what extent Tanzania mainland has mounted a comprehensive and relevant HIV response of appropriate scale, and to identify what should be done in future to improve it.

Strategies

1. To assess the reasons for success or failure of specific aspects of the national response.
2. To assess if the NMSF is achieving its intended goals and objectives.
3. To assess if the NMSF is still valid and appropriate to the challenges of the epidemic.
4. To assess the adequacy of resources available for the response.
5. To assess the performance and adequacy of the institutional framework, especially the coordination mechanisms at national and local levels.
6. To make recommendations for mid-course corrections.

Indicator:

- The Midterm Review process was informed by (a) data on the drivers of the epidemic at the sub regional level and (b) indicator values for at least 70% of indicators in the national HIV M&E system.

7. Final Evaluation of NMSF and Drafting of next NMSF

Strategic Issues

- At the end of the NMSF period, a final evaluation will be conducted in mid-2012. Internal and external experts will participate in this review and all relevant

stakeholders will be involved. The review will be led by TACAIDS, who will nominate a Steering Committee that is representative of all sectors (government, civil society, private sector, development partners and UN), including persons living with HIV.

- The evaluation will be based on sound evaluation practice, will be done in a way that ensures that data are analysed prior to commencing with the evaluation, and will utilise data from the national HIV M&E system, including available HIV research data.

Strategic Objective

To review the progress, achievements and challenges of the National Response, and to draft a new NMSF.

Strategies

1. To assess overall achievement of NMSF objectives.
2. To assess the major challenges to achieving NMSF objectives.
3. To develop the new NMSF.

Indicator:

- The new NMSF is prioritised, based on drivers of the epidemic

Chapter 6: Organisations and Institutional Arrangements for the Implementation of the National Response at Central, Regional and LGA Levels

Goal: Provide well – coordinated, effective, transparent, accountable and sustainable leadership and management structures based on the "Three Ones Principle" at central, regional and LGA levels to deliver the National Response as well as involving stakeholders from the public, private and civil society sectors.

Indicator: Percentage of HIV coordination structures at national, regional and district level that provide services according to their mandate of satisfactory standard

- **Coordination and Management Principles**

The institutional and management framework provides guidance on how the National Response will be organized and coordinated. Translating the general orientation of the NMSF into concrete and detailed plans, programmes, projects and interventions and to ensure their effective implementation using gender sensitive policies and a rights-based approach requires leadership at all levels and strong and well-coordinated multi-sectoral partnerships with the wide array of actors at national[44], regional and local levels.

The coordination and management of the National Response is confronted with the following major challenges:

To create a conducive environment and willingness among all partners to work together on a common goal;

To support gender capacity initiatives for key policy actors and implementers (TACAIDS and others) at different levels to ensure sustainable institutional gender expertise;

To provide the organizational and institutional settings and mechanisms for effective coordination and management, and

To cooperate, share experiences and sustain trust among all partners.

A number of mechanisms and institutional arrangements have already been put in place through the last NMSF which facilitated the coordination and management of the National Response at the central[45], regional and LGA levels.

- **Overall Oversight and Accountability**

The national multi-sectoral response to HIV is managed by different structures at different levels. At a political level, political parties, parliament, cabinet and the Prime Minister's Office are the main oversight structures with the key coordinating structure being TACAIDS.

[44] National in this instance refers to the whole country.
[45] Central refers to level of government.

Political parties have had HIV as a priority issue within their party manifestos and party activities. It is important that they keep HIV on the agenda and provide leadership within their structures and constituencies as well as support the GOT in its multi-sectoral response.

Parliament has various committees that provide for accountability and oversight over the National Response. Health, Education and Welfare Committees get reports of the line-MDAs and review the activities of TACAIDS but no parliamentary debates have occurred on HIV. The Tanzania Parliamentary AIDS Committee (TAPAC) has a paid multiparty membership of 210 members of parliament and conducts advocacy work at various levels and sectors. A multiparty committee on HIV should be constituted in parliament. It can provide political leadership, advice and support to the multi-sector response as well as mobilize resources for and review the HIV activities of the PMO. Many members of parliament also serve as councillors in LGAs and should play a similar role in the regions and districts. TAPAC should be supported as an important advocacy group in the National Response.

Cabinet is the highest decision making body in the executive arm of government. The formation of an Inter-ministerial Committee (IMC) chaired by the Prime Minister (PM) will add impetus to the HIV response as well hold accountable the various MDAs with respect to their internal and external mainstreaming activities. The Deputy Minister of Disaster Management and HIV and AIDS in the PMO can play a key role in supporting the PM in this effort. While its creation has been appreciated, it may need greater clarity about its structure, roles and responsibilities. The cabinet will discuss twice a year the progress achieved by the MDAs in implementing their HIV plans based on reports provided by TACAIDS. The PS in the PMO has an important role in supporting cabinet's oversight function through technical and administrative inputs.

TACAIDS

The Tanzania Commission for HIV and AIDS (TACAIDS) was set up by an Act of Parliament (Act No. 22 of 2001) in 2002 and serves as the coordinator of the National Response on HIV. It is now moving into a consolidation phase and has a new executive manager. TACAIDS has done a remarkable job over the short period of its existence and has provided a substantial base for this NMSF. TACAIDS reports to the PS in the PMO.

TACAIDS needs to remain within its core mandates of coordination, planning, mobilising resources, and advocacy[46]. It can provide support to the regions and LGAs via PMORALG, provide support at a central level to political parties, parliament, the IMC, MDAs and non-state actors (DPG, CBOs, NGOs, FBOs and the private sector) that have a national presence. It must continue to play a critical role in TOMSHA given that the monitoring and evaluation function is still in its formative stages and will need implementation over the 2008 – 2012 period.

[46] England R, Shirima L & Moshi F. Assessment of the Institutional Capabilities of TACAIDS. HLSP. November 2004.

Technical support at regional level can be provided via the Facilitating Agencies in the regions and technical advisors can be used at the LGA (district) level with TACAIDS involved with the commissioning process.
Coordinating and commissioning empirical and operational research to better understand the epidemic, inform the national and local response and enhance the quality of prevention, care, treatment and impact mitigation activities will also be part of the revised mandate for TACAIDS.

The Tanzania National Coordinating Mechanism (TNCM) is another important multi-sectoral forum for sharing information and coordination of resources within Tanzania from various sources for HIV, TB and Malaria, and any other health related emergency requiring multi-sectoral action and monitoring their implementation. TACAIDS serves as the secretariat for the TNCM. TACAIDS also provides support to the Great Lakes Initiative on AIDS (GLIA) which is a multi-country coordinating body in the great lakes region. These roles may have to be reviewed to either provide more resources to TACAIDS as part of its secretariat function or reduce its role to that of being part of the governance of the TNCM and GLIA.

With the evolving National Response, the management and institutional framework as well as TACAIDS' central role needs an urgent review in the light of the consolidation phase of the National Response and the decentralization policy of the GOT. There may be a need to simplify the management and organisational arrangements as well as make changes to TACAIDS' functions and modus operandi with concomitant changes in its governance and management structure. In addition, the GOT needs to strengthen the human, technical and infrastructural capacity of TACAIDS and safeguard the means and instruments that TACAIDS will have at its disposal in line with its revised mandates, roles and responsibilities.

PMORALG

The Prime Minister's Office for Regional Administration and Local Government (PMORALG) is the key implementing arm of government within the framework of the 'Decentralisation by Devolution' policy of the Government of Tanzania (GOT). PMORALG coordinates the activities of the regions and LGAs as well as provides the supervision and support for their programmes. TACAIDS and PMORALG are based within the Prime Minister's Office (PMO) but report to different heads. The Ministry of Public Service Management equally plays an important role as it is responsible for issues of the well-being of the civil servants and incorporating HIV issues in the respective job-descriptions of focal points in the public sector and other related staff.

The Office of the Auditor General

Given the large financial and technical resources being made available for the National Response, the role of the Auditor General is of extreme importance in conducting regular performance and regulatory audits. Misuse of funds and non performance should become criminally liable offences within the framework of strengthened Public Finance Management and Procurement regulations.

Roles and Functions of the MDAs at the Central Level

To strengthen the multisectoral approach of the NMSF, all Ministries, Departments and Agencies (MDAs) must consolidate and expand their HIV activities. This includes:

All MDAs have to develop, implement and monitor an HIV workplace programme for their staff and the families (internal mainstreaming). As part of this programme, a situation and impact analysis must be developed.

While most MDAs have focussed on internal mainstreaming, very little attention had been given to external mainstreaming, i.e. to address HIV through their core mandate. Selected key MDAs especially the:

1. Ministry of Health and Social Welfare
2. Ministry of Education and Vocational Training
3. Ministry of Agriculture, Food Security and Cooperatives
4. Ministry of Water
5. Ministry of Community Development, Gender and Children
6. Ministry of Labour, Employment and Youth Development
7. Ministry of Defence and National Service
8. Ministry of Justice
9. Prime Minister's Office Regional Administration and Local Government

will develop, implement and monitor strategies and interventions to deal with the consequences and impact of HIV on the population they are serving ("target population') (external mainstreaming).. TACAIDS is mandated to assist the MDAs in the development of their plans, support them with gender based capacity inputs as well as monitor their progress on a bi-annual basis. MDA sector plans need to reflect the NMSF priorities that respond to the epidemic.

All MDAs should strengthen the role and function of the focal persons of HIV activities. When the focal points are senior programme officers, they take their work seriously and the MDAs have active HIV programmes. Depending on the size of the workforce and the complexity of the MDA, the focal person/s may need to spend a considerable part of his or her time on HIV activities. Reporting should be to the personnel administration for the workplace programmes and the policy and planning division for external mainstreaming activities. The focal persons should become key resource persons in gender advocacy and HIV. They also need permanency, should have a career path and support the HIV committees and technical teams in the MDAs.

All MDAs should review and strengthen the role and function of the HIV Committees and technical teams. It is the responsibility of these committees and technical teams to develop policies and plans, strategies and programmes, ensure the availability of human, technical and financial resources and provide support for the implementation of HIV activities within and outside the MDA.

The MDAs are supported in their activities by TACAIDS or can commission or contract out their needs and activities to outside organisations where TACAIDS cannot provide support.

The MOHSW and the NACP

A special role is assigned to the Ministry of Health and Social Welfare (MOHSW) and its National AIDS Control Programme (NACP) as substantial parts of the National Response especially in the important areas of prevention, care and treatment fall under its responsibility. The MOHSW also has substantial funds flowing through its MTEF that cover the HIV and AIDS health interventions. The NACP is responsible for the external mainstreaming of the Health response in the MOHSW. As part of the MOHSW HIV and AIDS 2003 – 2006 strategy, the HIV response has been integrated into the health system. Previously, it had been a vertical programme within the MOHSW. The NACP has been redefined as a programme within the MOHSW and is based within the office of the Director of Preventive Medicine. As a specialised agency within the health sector HIV and AIDS Strategy[47], it focused on three thematic areas viz., care, treatment and support, prevention and cross-cutting issues. Its objectives were to develop and implement comprehensive care strategies in public and community based settings, provide the highest attainable standard of management of HIV and AIDS and improve the capacity and working conditions of health personnel.

It provides services through the public and private health sectors (both profit and not-for-profit) and supports the health sector activities at all levels of the health system through setting standards and provision of technical assistance, guidance and supervision of compliance by the health sector in implementing HIV interventions. While there has been substantial progress in the health response (safe blood supplies, scaling up of prevention, care and treatment activities and support for home based care), there are human resource, logistic and supply chain problems that have prevented the provision and extension of services in some districts[48].

The NACP also conducts the routine HIV epidemiological surveillance as well as commissions and conducts biomedical research related to HIV and AIDS. The epidemiology section is being transformed into a fully fledged monitoring and evaluation unit and should work closely with TOMSHA. The NACP supports the training of health workers in HIV so that they are capable of keeping abreast with the rapidly changing professional environment and recent advances in HIV interventions as well as the use of updated treatment guidelines.

The NACP is involved with setting up the comprehensive workplace programme for all health and support workers and their families within the MOHSW. This is a necessary intervention given the impact of the epidemic on health workers as part of the general

[47] MOHSW Health Strategy for HIV / AIDS. 2003. (The Health Strategy 2003 – 2006 is being revised currently by the MOHSW and is not part of the NMSF review process).

[48] Kireria AM and Ngowi D. Assessment of the Human and Financial Resources for the revised HIV/AIDS NMSF. TACAIDS. March 2007.

population, their need for mental health support as well as their infection risk through contact with body fluids and secretions in the health service setting. The expertise within the MOHSW workplace programmes can also be used by other MDAs.

The relationship between TACAIDS and the NACP needs strengthening and with the demarcation of activities and mandates will lead to each complementing the other. In addition, the NACP works closely with PMORALG to support the health services that are under the jurisdiction of the regions and the LGAs. Coordination of the implementation at regional and local levels is a shared responsibility between the NACP, Regional Health Management Teams and Council Health Management Teams. At the region and district level, the Health Sector Regional AIDS Control Coordinators (RACCs) and District AIDS Control Coordinators (DACCs) are critical in assisting the Regional Medical Officer and District Medical Officer, respectively, to play the coordination role. The regional facilitating structures should also work closely with the NACP to support the regions and districts.

Institutions of Higher Learning

Institutions of Higher Learning (universities and research institutes) can play an important role in the National Response by providing technical assistance to MDAs and other stakeholders and undertake much needed research in line with the National research agenda for HIV.[49]

Roles and Functions at the Regional Level

RASs

Given the size and complexity of Tanzania, the Regional Administrative Secretariats (RSAs) together with the Regional Consultative Committees and the Regional Commissioners are important in supporting the implementation of the NMSF at regional and LGA level. The RASs can provide a coordinating, advisory and clearing house function, share good practice across the districts and synthesize the district plans into a regional HIV annual plan. They have a major role to play within TOMSHA and should be strengthened to ensure accountability for implementation of the National Response within the districts.

The RASs also need to provide internal workplace programmes for their employees and their families and conduct baseline impact studies. The Regional AIDS Control Coordinator (RACC) should also function as the focal person for the internal mainstreaming.

PMORALG must make sure that all the guidelines and policies regarding HIV developed by the MDAs are sufficiently incorporated into the activities and planning procedures of the RAS as well as the LGA structures.

Regional Facilitating Structures

Given the capacity constraints and the lack of experiences within the RASs, there is a continuous need for Technical Assistance and facilitation for the foreseeable future

[49] See Chapter 5 on the M&E Framework Point 5 HIV Research

within a region and its districts. Based on the experiences of Regional Facilitating Agencies, adjustments in the Terms of Reference of such structures may be needed which will include revised mechanisms for governance, accountability and funding. The capacity building process of the RAS should be strengthened in the assignment of the RFAs or similar structures.

Roles and Functions at the LGA Level

The region, district and village / mitaa level responses are not yet as developed as the central response. However it is in the urban and rural communities were the people live and the success of HIV interventions will be decided. Enormous efforts in developing a nation-wide structure of committees and focal points for the HIV response at local level have been undertaken in the country during the period of the last NMSF. These structures are the backbone of the National Response and will need continuous support in (re-) training, supervision and facilitation.

These local structures: Village Multisectoral AIDS Committees (VMACs), Ward Multisectoral AIDS Committees (WMACs), Council Multisectoral AIDS Committees (CMACs), Council HIV and AIDS Coordinators (CHACs), District AIDS Coordinators (DACs) and the council and district commissioners and district consultative committees are important mechanisms to plan and deliver the HIV programmes. In addition to the public sector programmes, they also coordinate the various NGOs, CBOs, FBOs and private sector initiatives in their area of jurisdiction.

Consistent with the Government policy on decentralization by devolution, the NMSF places increased responsibilities and expectations for the strengthening of the National Response through better planning, implementation, monitoring and evaluation of the National Response at the LGA level.

Specifically, LGAs through the CMACs, WMACs and the VMACs are expected to coordinate bottom-up HIV planning while ensuring that the needs of different groups and stakeholders are taken on board by making best use of the existing planning tools for development (COPTA, O&OD). Planning must be done in a participatory manner involving public (state) and non-state actors and groups. Continuous technical assistance, training and supervision through the RASs and the RFAs need to be maintained throughout the period of the NMSF.

The Council HIV and AIDS Coordinator (CHAC) as well as the District AIDS Coordinator (DAC) of the health sector are key persons in assisting the CMACs in developing the local response to HIV and their function and role must be strengthened. The CHACs are in place to support the CMAC activities, facilitate multi-sectoral collaboration and mobilise communities but need strengthening through the use of technical advisors similar to the RFAs role at the regional level[50]. While the CHAC's and the DAC's position and activities seemed well defined, the planning at the LGA levels was mostly confined to activities of the health sector with some additional elements on orphan care and needs to be widened to cover all sectors depending on the needs of the

[50] In some districts encouraging experiences supported by UN Volunteers and/ or NGOs exist already

LGA, the nature and dynamics of the epidemic and the evidence about the drivers of the epidemic in the respective regions.

Similar to the MDAs and RASs, the LGAs need to provide workplace programmes for their employees and families.

Roles of Non-State Actors

Development Partners Group AIDS (DPGA):

A key role-player and stakeholder in the National Response is the Development Partners Group AIDS (DPGA) who has made substantial human, material and financial contributions to the HIV programme. This group must build on the progress already achieved in 'harmonisation and alignment' of inputs and activities for HIV in the last period as shown in the Resource Mapping report[51].

The revised Memorandum of Understanding (MOU)[52] of the DPGA provides the commitment to support the GOT in implementing the NMSF based on the principle of the "Three Ones" at central, regional and LGA levels. Special attention will be given by the DPG to support the implementation of the new M&E framework of the NMSF.

The Joint UN Team on HIV and AIDS, thanks to its technical capacity and experiences should continue to provide and commission relevant Technical Assistance.

Civil Society Organisations (CSO):

(Non-governmental Organisations (NGOs), Faith-based Organisations (FBOs), Community-based Organisations (CBOs))

The general public organised in the CSOs will continue to play a double role in the National Response. On the one side it complements the public sector in delivering services to the communities and families and on the other side it plays the role of a "watchdog" by the society as part of an ongoing process of democratisation and participation by citizens in public affairs. A vibrant and self-conscious civil society can enrich the political culture of Tanzania which is still very much centred on the idea of the state as the sole deliverer of services and solutions. With the active involvement of wider parts of the society in shaping and implementing the National Response, the CSOs will therefore have to assume increased responsibility for the achievements of the goals and results alongside their active involvement.

There are several thousand CSOs involved in the National Response in Tanzania. The richness of the multiple inputs as well as the commitment from the various stakeholders and role players bodes well for Tanzania. Many are volunteer associations and are based in villages and hamlets. The National Response cannot be implemented by state actors alone. The full participation of the society of Tanzania through the different organisations of its citizens is a vital and a recognised part of the National Response. Already in the past, civil society has made an impressive contribution and its role is expected to increase in the period ahead. There is an absolute necessity to increase the partnership between the

[51] TACAIDS, HIV & AIDS Resource Mapping, (CD ROM) finalized June 2006

[52] For full text of the MOU see Annex 3.

public and the private actors and to increase the mutual understanding and trust to develop synergies and sustainability of interventions and activities.

However, the rapid development and increase in numbers of CSOs involved in HIV activities has created at times problems of control of quality and supervision. Continuous capacity building and close supervision as done by the RFAs in the last years need to be continued. The CSOs involved in service delivery have to respect and adhere to national guidelines and standards of quality.

The CSOs need to integrate their activities better in the local planning and coordination structures, while the government structures, especially at LGA level need to develop more participatory approaches and avoid isolating or marginalising the CSOs in their area of jurisdiction. Local CSOs should be registered with the CMACs and provide regular reports on their HIV activities while national CSOs should be registered with and report to TACAIDS in line with current NGO laws.

The sheer number and the dispersion of the CSO across the country make it difficult at times to fully integrate them into national coordination and planning mechanisms. The CSOs have started to form an umbrella organisation, the Tanzania AIDS Forum, which has already played an important role in preparing for this new NMSF. As its membership is increasing and its procedures are consolidating it is hoped that the voice and role of the CSOs can be strengthened at the national level through this new self organisation body.

Some FBOs have values regarding the HIV and AIDS that may be disabling. They have fairly strong views on commercial sex activities, condom promotion and other prevention activities. More advocacy work will be needed with such FBOs to provide greater understanding of the dynamics of the epidemic as well as the promoting of interventions that are evidence based, culturally accepted and scientifically valid and with which they may not always agree with. While all CSOs including the FBOs will have to operate within the framework of the NMSF, not all organisations may wish to support all recommended strategies based on their own convictions and mandate. However, while they may select their own preferences, they should refrain from contradicting other elements of the NMSF.

Persons living with HIV:
The full participation of persons living with HIV (PLHIV) in the National Response is not yet achieved. The organisation of the PLHIV is not firmly rooted across Tanzania and needs further work. In addition, there is slow progress with the formation of a consolidated network of NGOs that are supporting the PLHIV. Special attention must be given to existing / emerging networks of PLHIVs. Efforts will continue to be made at national, regional, district and community levels to associate these networks and groups at all levels of planning, implementation and monitoring the response.

The Business Sector:
The small, medium and large private business sector is spending considerable resources on treatment and care activities as well as losing personnel through premature deaths or

early retirement[48]. There are about 800 companies in Tanzania which form the business sector. The “AIDS Business Coalition Tanzania (ABCT)” formed in 2004, has mainly trans-nationals and large corporations as members (52 by end of 2006) with few small and medium enterprises participating. ABCT is mandated by its members to coordinate the private sector workplace HIV programmes and facilitate the sharing of good practice between members. ABCT also attempts to serve as a human resource centre, providing HIV related information and technical experts for companies and organisations in need of training for their workforce. ABCT also participates in the TNCM which supports the “Global Fund to fight AIDS, TB and Malaria” activities in Tanzania. ABCT works in close collaboration with other business organizations such as TUCTA (Trade Union Confederation Tanzania), ATE (Association of Tanzanian Employers), CTI (Confederation of Tanzanian Industries) and TCCIA (Tanzanian Chamber of Commerce and Industry). Businesses like all other ‘players’ should integrate their programmes in the respective council plans and activities and ABCT should support this process.

The informal business sector is covered under the Tanzania Informal Economy Networks on AIDS Initiative (TIENAI). It is an important but difficult sector to work in given the reality of the informal sector with little job security, small employee base and poor networks. The possibility exists for ABCT to explore the provision of infrastructural support to this sector with additional support from the Ministry of Labour, Employment and Youth Development.

This is a start and the business sector should be encouraged to scale up their activities, stimulate the involvement of the trade unions and be part of the monitoring and evaluation system under TOMSHA.

Chapter 7: Financial, Human and Technical Resource Framework of the National Response

Goal: Provide the necessary and appropriate financial, human and technical resources for the implementation of the National Response to the HIV epidemic through combined, coordinated and sustained efforts by the Government of Tanzania, the private and civil society sectors and the Development Partners.

Indicator: Domestic and international AIDS spending by categories, financing sources and levels of government

Introduction

The resource framework for the NMSF 2008 – 2012 covers three strategic areas: *financial*, *human* and *technical* resources. The success of the NMSF will depend on the mobilisation of sufficient financial resources, applying the necessary human (both skill and quantity) and technical resources, and implementing the response with visionary leadership and management. The infrastructural needs, including extended and new facilities, are also important in providing enhanced quality for many of the interventions that will take place over the next five years.

The NMSF 2008 – 2012 cannot be costed as it is not an operational plan. Costing will and must occur in moving from strategic to operational planning and in the development of national sector plans and the integrated HIV and AIDS district plans (see chapter 8). Costing will have to take into account many different aspects. In addition to the direct costs of delivering services and interventions for prevention, care and treatment, and impact mitigation it also includes costs related to the monitoring and evaluation framework as well as the research to be undertaken. Further, there are many direct costs related to the inputs (social workers, nurses, doctors, counsellors, drivers, laboratory technicians, condoms, ARVs, etc) that need to be costed. And there are other, indirect costs that need to be included as well, but which are difficult to cost (community, workplace and family inputs, multi-use facilities and vehicles, etc).

At this juncture in Tanzania, the most significant cost item is the ARV intervention, including its supportive human and laboratory infrastructure. It must be noted that, as more PLHIV access the programme on a cumulative basis, these costs will continuously rise, and its share of the overall cost of the National Response will further increase (see below). It is therefore of utmost importance that prevention efforts are increased and scaled up to reduce the number of new infections, so that care and treatment costs remain within reasonable limits or decline over time. Resource allocation also includes support to PLHIV not requiring ARVs through adequate secondary prevention interventions such as treatment for opportunistic infections, wellness programmes and behaviour change activities, so that the need for ARVs will be delayed, and infections reduced. Impact mitigation activities can also be costly if institutional care for orphans continues to grow,

with the cost burden shifting from families to institutions. This underlines the fact that it is utmost importance to keep families intact, supported by community-based mechanisms, as a key element of the National Response.
The cost implications of the NMSF are high and may crowd out other aspects of the GOT health and social services budget. Thus it is important to use the resources that will be mobilised under the NMSF to strengthen the health and social services sector wherever possible. With functioning and effective primary and secondary interventions, it is possible, over time, to reduce the morbidity and mortality associated with the epidemic. Some examples include:

- Extending prevention programmes like PMTCT will reduce the number of paediatric HIV patients.
- Decreasing stigma, denial and discrimination will allow more PLHIV to access services at an earlier stage, reducing infections in others and securing services that will help prevent the onset of AIDS-related illnesses. Treatment literacy will also prevent the emergence of resistant strains that will increase the costs.

Improved monitoring and evaluation of the NMSF is essential to show value for money for the large amount of resources being allocated to the National Response. Baseline studies and periodic assessments will be of importance to assess the impact of the interventions and re-direct resources where necessary.

Financial Resources

From a financial sustainability point of view, a key area of concern is the dependence on donor funding for 80% of the National Response. Of equal concern is the dependence on three donors (United States Government (USG), the Global Fund to fight AIDS, TB and Malaria (GFATM) and World Bank for 80% of this financing[53].

Government remains committed to fighting HIV and AIDS and has increased domestic resources aimed at responding to the epidemic[54]. The government has created a strategic objective on HIV and AIDS within the Medium Term Expenditure Framework (MTEF) and therefore can track HIV spending.

The gap in HIV financing has, to date, been met by the Development Partners (DPs)[55]. The Memorandum of Understanding (MoU)[56] serves as a basis for further discussions with the DPs. Their continuous support for implementation of the NMSF is essential. The DPs have so far committed funding up to 2008, and there is uncertainty about what will come thereafter. This underlines the importance of continued resource mobilisation as an important element of the National Response. Sustainability of the National Response, especially for the treatment and care of PLHIV, has important moral, ethical and public health implications.

[53] NMSF Human and Financial Assessment Report. AM Kireria & D Ngowi. TACAIDS. March 2007.
[54] For references to figures, see Chapter 3 p41
[55] For funding provided by the DPs see equally Chapter 3 p41
[56] Developed as part of the 2003 – 2007 NMSF and modified for the 2008 – 2012 NMSF.

The HIV resource mapping[57] exercise showed inequalities in the distribution of expenditure, favouring urban areas, despite the fact that, most people live in rural areas. Currently, there are no guidelines on equitable access to treatment and care and no explicit targets for at risk and vulnerable individuals and groups. The GOT does provide financial support for its employees to access treatment and care, as do larger formal firms in the private sector, but beyond this there is little support. The additional costs of transport to a site are borne by the individuals and increase the vulnerability of poor persons in accessing HIV services. Access to free ARVs are provided in the private health sector and may disproportionately allow for rich persons to access care even if they have to pay for the consultation and laboratory tests.

A study related to HIV funding[58] found that almost two-thirds of all funding (64%) went for care and treatment, while only 14% went for prevention, 8% each for cross-cutting issues and multi-purpose interventions, 4% for policy and administration, and only 2% for impact mitigation. There is a need for an inclusive and transparent review and discussion among all partners and stakeholders about the criteria for the allocation of funds. This discussion will, by its very nature, raise important political, social, economic and ethical questions. Under the prevailing constraints of financial resources from inside and outside the country, it is highly unlikely that all aspects of the new NMSF will be funded in their entirety.

In such a resource constrained environment, a balance has to be reached which may compromise the needs of the 7% of the population who are HIV positive, with the long-term needs of the country to meet the challenge of ensuring that the 93% of the uninfected population remains uninfected. Practically speaking, this means scaling up prevention and impact mitigation activities, and the more efficient utilisation of allocated resources.

The future interventions that are needed include:

- Ensuring sustainability of HIV funding through further mobilization of domestic resources (public, private and community based) and better targeting of both domestic and external resources.
- Ensuring equitable allocation of HIV resources with rural areas receiving a better share of financial resources (informed by population distribution and levels of infection and risk).
- Ensuring that HIV funding promotes equitable access to care and treatment with explicit targets for demographic groups as well as adequate coverage of rural areas.
- Targeting HIV expenditure with a view to protecting and promoting the well-being of the 7% of the population which is HIV positive, while at the same time preventing infection in the 93% of the population that is HIV negative.
- Promoting innovative financing methods especially for the care and treatment initiatives, including revolving drug funds, health insurance funds and social responsibility activities by local businesses.

---

[57] Resource Mapping for HIV and AIDS. Candelaria D. TACAIDS. 2007.

[58] Deloitte and Touché, 2006

There are various mechanisms that guide the flow of funds in Tanzania from the donor to the recipients. These include General Budget Support (GBS), basket funding, and direct funding to recipient organisations. Under the Joint Assistance Strategy for Tanzania (JAST), the GBS is seen as the most appropriate mechanism with funds flowing through the GOT financial system. In the interim, the GOT will continue to use a mix of basket and special fund arrangement as its main approaches for ring-fencing HIV funds, with continued attention to reducing the transaction costs associated with a project approach.

Future Funding Scenarios[53]
Resource projections under the "Best Case" scenario show that Government's own resource allocations to HIV are expected to increase by 30% from TSh 35 billion in 2005/06 to TSh 46.6 billion in 2007/08 and by a further 75% to TSh 82 billion by 2012. The main reason for the increase is to support the scaling up of ARVs nationwide, particularly in terms of supporting the emergency-hiring plan of health human resources, as well as additional funding required by MDAs to fund HIV-related strategic plans.

Under the "Middle Case" scenario, Government's own resources are expected to increase following historical actual releases to HIV in 2005/06. This trend shows that funding will increase by about 6% from TSh 35 billion in 2005/06 to TSh 37.4 billion in 2007/08 and to a further 50% to TSh 56 billion by 2012. According to sources within the Ministry of Finance, this "Middle Case" scenario is the most likely scenario for the next five years. Higher allocations to HIV are likely if domestic revenue increases beyond current projections.

Development Partners' financial resources
Under the aforementioned "Best Case" scenario, the Development Partners are expected to maintain their level of financial support of the last years, or to slightly scale it up. However, the increase will not automatically go to HIV interventions, partly because some donors have decided to channel funds through GBS and the GOT cannot guarantee that additional funds through GBS will be released for the HIV response. A few donors continue to disburse HIV funding off-budget due partly to restrictions imposed by their government financial regulations. It is hoped that the "Best Case" scenario will prevail and that the GOT will access additional financial resources from Development Partners as an increase from TSh 255.8 billion in 2005/06 to about TSh 448 billion by 2012. Under the "Middle Case" scenario, the Development Partners are likely to increase their funding gradually from TSh 255.8 billion in 2005/06 to TSh 365.4 billion by 2012.

Even under the "Worse Case" scenario, the Development Partners will not reduce funding to below TSh 255.8 billion in the next five years. The three "big" HIV financial supporters, which account for close to 80% of the donor funds, are committed to the current funding support level (as a baseline) and hope that it will not decline in the next three years.

The conclusion, however, is that the NMSF should not expect large scaling up of financial resources from GOT's own resources. The operationalisation of the NMSF

strategy should be very pragmatic and design interventions within a framework of highly constrained GOT own resources and limited commitments from the Development Partners.

Human Resources

Human resources are critical for scaling up the response to HIV. Considerable progress has been made under the 2003-2007 NMSF in relation to addressing the problem of human resources related to the provision of prevention, care and treatment and, to a limited extent, for impact mitigation activities. Over the past five years the public sector, which constitutes the bulk of human resources for HIV interventions, has witnessed a persistent sharp decline in the numbers of health staff and other workers, despite increased demand for care and support for PLHIV. Specifically, the health workers have declined by 20% from 67,000 in 1994-95 to 54,245 in 2002, and a further decline of 48,800 is projected by 2015[53].

The geographic imbalances and shortages of skilled health and non-health staff, inadequate utilisation of trained staff and in some cases an over-emphasis on the medicalisation of the HIV service cadre, are major constraints affecting almost all areas of the national response. With regard to prevention, there are few professionals with skills in behaviour change communication[59]. Under the planned "aggressive" National Care and Treatment Programme, an additional 10 000 health care workers will be required. This represents about 25% of the available workforce in the health sector

While Tanzania is experiencing shortages of skilled staff in almost all key areas of the HIV response, the country is also facing unprecedented growth in unemployment of young graduates with the potential for developing the skills required to fill in the gaps in staff shortages[60]. Unemployment is worse among the youth, including those with high levels of education[61]. Many graduates are sitting at home due to a lack of jobs, yet the policy and legal framework in the health sector limits efforts for deploying this human capital to supplement the National Response resource gaps.

To assist in overcoming some of these problems, there are commendable efforts underway to strengthen Human Resources capacity, specifically for scaling up care and treatment. Key partners in this regard include The Clinton Foundation, the Benjamin Mkapa HIV and AIDS Fellows Programme, as well as the Ministry of Health emergency plan for recruitment of health workers.

Another important way in which to respond to these human resource shortages is to increase the involvement of non-medical personnel in the delivery of appropriate HIV services, leaving health workers to concentrate on those aspects that are specifically relevant to their skills. Consideration needs to be given to closer collaboration with traditional healers and supporting mid-level and community based workers to assist with

---

59 URT, PMOs, 2006, NMSF, Medium Term Review,p.13

60 Unemployment stands at 2.3 million (1.3 million women and 1.0 million men) equivalent to 12.9 per cent of labour force

61 United Republic of Tanzania, Vice Presidents' Office, 2005, National Strategy for Growth and Reduction of Poverty (NSGRP), p.9

the various interventions. While this may realise some efficiency gains, these efforts may be thwarted by a problematic policy and legal framework which needs to be revised (see Chapter 1).

In considering the protection of experienced, skilled and semi-skilled human resources, resources in short supply in Tanzania, it is especially important to strengthen public and private sector HIV workplace programmes. While coverage in the public sector is good, there are gaps in service provision, notably the exclusion of family members and only a small percentage of those in the private sector are covered.

Given the diverse strategies included in this NMSF, skilled and experienced human resources are required for effective implementation at all levels. For example: the enabling environment strategies require people with public policy and communication skills, while visionary leadership and management are needed to assist with strategic and operational planning and implementation and the TOMSHA will need persons with data management, monitoring and evaluation skills. Thus a key part of the operational plans for the NMSF will be to detail the human resource needs for each activity, conduct a gap analysis and ensure that continuous capacity building must occur using local tertiary institutions.

Technical Resources

There are many inputs in comprehensive HIV programmes varying from distributing commodities like condoms, ARVs and laboratory equipment to process activities such as conducting meetings and developing policy to ensure desired outcomes. Management inefficiencies, as well as supply chain, procurement and logistics problems also have adverse effects on the national response. While considerable emphasis is placed on front line workers (counsellors, laboratory technicians, nurses, doctors, social workers etc) to deliver the services, there is an increased need to deal with the issues of 'back office' or support staff and their activities. In addition, other departments such as Public Works that manage facilities and develop new buildings, the telecoms, water and electricity authorities that provide utilities need equally to be consulted and integrated in the response. Given the dearth of data, forecasting becomes an impossible task leading to delays in drug supplies, reagents and other materials. In many instances, many of these activities can be outsourced to the private sector and thus skills in contracts management will be needed. The operational plans need to take these back office activities into account and provide adequate human, infrastructural and financial resources to support them.

Chapter 8: From Strategic Framework to Operations and Implementation

Goal: To translate the NMSF into well-defined operational plans at central and LGA levels involving all stakeholders and actors in a participatory way and implement the plans effectively and efficiently.

Indicator: Percentage of districts that have tracked the implementation of one joint and consolidated district-level HIV response plan in the last 12 months

1. Launch and Dissemination of the new NMSF

The NMSF 2008 – 2012 will be launched by TACAIDS and the PMO at central level in a public meeting where all relevant stakeholders from the public and the private sector as well as the community of development partners will be invited. The Office of the Prime Minister will underline the importance the Government of Tanzania attaches to the continuous fight against HIV and AIDS as one of the national development priorities for the coming five years.

TACAIDS will prepare a media brief summarizing the most important aspects of the new framework and organise a special briefing session for the media in the country to solicit the support of the media (TV, Radio, Print) in advocating for the new strategy and informing the general public about the goals and targets to be achieved.

TACAIDS will convey a special one-day workshop for the Focal Points of the RSA as well as the Regional Facilitating Agencies to enable them to organise at regional level stakeholder meetings where the relevance of the new NMSF for the regional and LGA actors as well as the general public (media) can be presented and advocated.

To facilitate these tasks, TACAIDS will produce a comprehensive version of the new framework in Swahili.

A one page poster capturing the most important elements of the new framework: goals and targets will be designed, printed and distributed widely in the country.

2. Next Steps: Support to Development of Plans at National and LGA Levels

A major challenge in advancing the national response is translating the Strategic Framework into much more detailed and concrete operational plans with clear responsibilities, timelines and results to be achieved by all partners involved at central and LGA levels. This important step was lacking during the period of the last NMSF 2003 – 2007.

Based on the decentralisation approach of planning and coordination prevailing in the country with the LGA Reform Programme[62], this process will be divided into two major steps:

a. Facilitation and Development of National Sectoral Plans on HIV and AIDS
b. Facilitation and Development of Integrated District Plans on HIV and AIDS

Ad a. Under the guidance and supervision of TACAIDS and with the support of the Development Partners for technical facilitation, central ministries, departments and agencies (MDAs) will develop their national sector plans incorporating the three major elements:

a. Situation and Impact Analysis of HIV and AIDS
b. Workplace Programme on HIV for their staff including families
c. External mainstreaming Plan with emphasis on supporting the LGA level based on the Guidelines provided by TACAIDS.

The Departments of Policy and Planning in the MDAs will be charged for the development of the Situation and Impact Analysis and the External Mainstreaming Plans. The Department of Human Resources in the MDAs will be charged to develop and implement the Workplace Programme on HIV.

While all MDAs of the country are requested to have developed their workplace programmes by the end of 2007 and incorporated them into their MTFE for the Fiscal Year 2008/9 the following key ministries will have to develop all three components:

Situation and Impact Analysis
Workplace Programme
External Mainstreaming Plan

1. Ministry of Health and Social Welfare
2. Ministry of Education and Vocational Training
3. Ministry of Agriculture, Food Security and Cooperatives
4. Ministry of Community Development, Gender and Children
5. Ministry of Labour, Employment and Youth Development
6. Ministry of Defence and National Service
7. President's Office Regional Administration and Local Government

Ad b. Facilitation and Development of Integrated District Plans on HIV and AIDS

[62] Countries with a more centrally organized planning structure may opt for an integrated national operational plan encompassing all stakeholders and actors. This approach seems not to be feasible in Tanzania where responsibility for planning has been largely shifted to the LGA levels.

Most if not all districts in the country have already started to integrate some HIV related activities into the integrated district development plans. Although no systematic analysis exist on the exercise of fiscal year 2006/7, there is anecdotal evidence that a large majority of the district plans contain mostly if not exclusively activities related to the health sector response at times complemented by activities for support of OVCs.

The multisectoral approach of the NMSF is still not very well understood by many district and lower level planners (village and municipality level); and most CSOs and CBOs concentrate on so-called impact mitigation activities for orphans and vulnerable children only.

Increased efforts in training and technical facilitation will be necessary to enable the development of integrated district plans using the available methodologies for identification and planning of needs (O&OD), knowing and understanding the specific elements which contribute to the spread of HIV in the area (local customs and traditions, "high-transmission areas", vulnerable situation like mining sites, road construction, guest houses or other informal business situation where large numbers of men congregate for some time outside their families) and designing approaches (messages, peer-group approach, theatre groups, special events etc.) to address these local challenges. Only when the communities are "AIDS – competent"[63] meaning understanding the local dimensions of the threat and disaster and responding to them in a way which reduces the vulnerability of its members to the spread of HIV than local planning of HIV and AIDS could be regarded as a major step forward in the national AIDS response.

The decentralisation process in Tanzania has only started recently and the wide-spread mentality of local actors to wait for instructions from the "centre" still prevails, the process to build the capacities at local level for appropriate responses will necessarily take time and can not be achieved through one or two short training sessions[64].

The special regional facilitating structures to provide technical assistance in planning, monitoring and evaluation and capacity building for HIV for the village and municipality levels need to be strengthened, increased and sustained until enough capacities and experiences are available to enable the local actors to become champions of their own destiny.

---

[63] AIDS Competence—The ability of all elements of society (individuals, families, communities, business, government and non-governmental institutions of all sectors at all levels) to recognize the reality of HIV and AIDS, to analyze how it affects life at home and at work, and to take action to prevent its spread, maintain and improve the quality of life of PLWH, families affected by AIDS and the community at large.

[64] The difficulties of the LGA level in appropriate planning and coordination is not confined to the HIV and AIDS area. The capacities and experiences of the LGA councils to develop appropriate plans based on the needs of the population lacked widely realism, priorities and participation (see REPOA, Local Government Reform in Tanzania 2002 – 2005, Summary of Research Findings on Governance, Finance and Service Delivery, Brief No 6, October 2006)

Annex 1

The Process of Developing the NMSF 2008 - 2012

Background

The development of the new NMSF (2008 – 2012) involved quite a long drawn consultative process with the stakeholders dating back to 24 February 2006 when the Mid-term Evaluation Report for 2003 – 2007 NMSF was presented to TACAIDS, NMSF Task Force and Development Partners. Cognizant of the key recommendations from the review, a Steering Committee (see Annex 1a) was officially established with a number of mandates one among which was the coordination of the development of the 2008 - 2012 NMSF. In an effort to gather all the necessary inputs for the preparation of the new NMSF, a Joint Technical Review Meeting drawing participants from the different Technical Working Groups in the five NMSF thematic areas was held from 8 -10 March 2006. The recommendations from this meeting were presented in the Steering Committee meeting held on 15 and 16 March 2006. Both the Joint Technical Review and Steering Committee meetings were attended by representatives from the public and private sectors as well as Development Partners. The Steering Committee deliberated on a number of issues including a Concept Paper and Roadmap for the development of the new NMSF. The meeting resolved that the Health Sector Strategy on HIV/AIDS (HSS HA) should be linked to the new NSMF. It was also agreed that a panel of consultants should be established consisting of 12 consultants divided in 6 pairs of two where one of each pair should be international while the other a national to cover the following NMSF thematic areas: Care & Treatment, Prevention, Crosscutting, and Impact Mitigation and Human Resource and Financial Assessment. One of the pairs will share the lead role of coordinating the consultative process and final production of the NMSF document. A full list of the consultants is presented Annex 1b.

In September 2006, formal communication was made with the Prime Minister's Office and all Permanent Secretaries of all ministries informing them about the review process of the 2003 – 2012 NMSF calling upon each ministry to develop their sector specific response strategies. The remaining period in 2006 and part of January 2007 was used in the development of TORs for consultants and potential candidates identified, short-listed, interviewed and contracts were prepared for successful consultants.

The NMSF Review Process

Consultations with National Stakeholders

The consultants started the actual Review Process with an Orientation Meeting with the Steering Committee and TACAIDS on 5 February 2007. During this meeting the consultants were presented with objectives and expectations of the review as well as the

available logistics for carrying out the consultative activities. The Review Team then spent about one week reviewing the various documents that were made available to it by TACAIDS in preparation for the situation analysis.

The overall review process used two major approaches: general national and regional consultative meetings with specific stakeholders or their representatives; and individual interviews with key officials at the national, regional and district levels. While the consultative meetings were attended by all the members of the review team, the individual meetings were set up by TACAIDS at the request of the consultants based on the information needs of their respective thematic areas. These individual interviews were normally held in between the consultative meetings and in most cases were driven by the information gaps arising from such meetings. In jumpstarting the situation analysis process the Review Team held 3-days consultative meeting with MDAs from 12 – 14 February 2007 with the objective of establishing the status of NMSF implementation as well as identifying the key challenges experiences in the operationalization of the strategy. This was followed with one day meetings with each of the following: Civil Society Organizations, Faith Based Organization, and members of the Informal, and Private Sectors. The team analyzed and summarized the information gathered through these meetings and made a formal presentation to the Steering Committee on 2 March 2007.

While analyzing the findings of the consultative meetings, the Team also met with the Tanzania National Coordinating Mechanism (TNCM) and the Development Partners' Group on AIDS (DPGA) on 22 and 26 February 2007 respectively. During these meetings, the Lead Consultant made a brief presentation highlighting the progress made in the consultative process and challenges. The Review Team also held a one day meeting with the Stakeholder Reference Group on 5 March 2007 whose members were established by the NMSF Steering Committee. This group was composed of key representatives from MDAs, CSO, public and private sectors. During this meeting, highlights of the situation analysis with MDAs, CSO, the public and private sectors were presented and discussed.

Consultations with Regional Stakeholders

An extensive and broad consultation with stakeholders at all levels was one among the terms of reference given to the Review Team. As such, following consultations at the national level, the Review Team immediately started preparations for regional consultations. A full list of public and private sectors, institutions, and CSOs involved in the whole consultative process is presented in Annex 1c. Cognizant of the limited time allocated for the regional consultations the Review Team proposed such consultations to be carried out only from a sample of 4 regions out of the 21 regions in Tanzania mainland. However, the Steering Committee strongly felt that such data be collected from all the regions to give each region an opportunity to provide inputs to the development of the new NMSF. It was for this reason that the committee saw the need to augment the composition of the team with the 21 National Facilitators chosen by the District Response Directorate at TACAIDS. These were contracted to carry out consultations in all the

regions including the four that were already selected by the Review Team. The Review Team only visited the 4 regions that were originally sampled for this activity accompanied by the respective Regional Facilitators. To ensure quality of the information to be collected during the regional visits, the Review Team held a 2 days meeting on the 6th and 7th February 2007 with the Regional Facilitators where the tools and the nature of information to be collected and the approach to be used were shared and discussed. The teams left for a one week the regional consultations on 10th February 2007.

Upon return from the regional visits the Review Team and the national facilitators held a two days workshop on 19th and 20th February 2007 where the findings from the regions were presented. To enhance the development of the new NMSF the participants spent half of the first day of the workshop working in small groups summarizing the findings in terms of their relevance in the implementation of the NMSF at central, regional and district levels. These summaries were later presented in the plenary and discussed. The Review Team had two days to analyse the information gathered from the meeting after in preparation for a briefing meeting for the Steering Committee which was held on 26 March 2007. The district findings were also presented in the 2nd Technical Working Groups (TWGs) where the members deliberated and reached a consensus on the relevant and priority issues that needed to be brought on board in the new NMSF. At this 2 days meeting, the M&E TWG members were divided into the four key thematic areas to facilitate the development of relevant M&E indicators based on the objectives developed by the FWGs in the respective thematic areas.

Development of Draft Strategy Document

With almost all the necessary information at hand each pair of consultants was tasked with the responsibility of preparing a chapter for their respective thematic areas. The International and National Lead Consultants were also assigned to prepare chapters for the New NMSF while coordinating and editing the overall strategic document. They were assisted by another international consultant from the prevention area. The three then formed the Core Group of Consultants. The first draft of the new NMSF was worked on during the first two weeks in April 2007 and presented to the Steering Committee on 23 April 2007 and the Development Partners Group on AIDS (DPGA) on 25 April 2007.

Based on the feedback from the Steering Committee and DPGA meetings the Review Team revised the draft document before it was presented to the members of the Public Sector (MDAs) on 2 May 2007, and the stakeholders of the private and informal sectors, as well as CSOs and FBOs on 3 May 2007. The meetings, particularly the one for the CSOs, the private and informal sectors had quite extensive deliberations on each of the thematic areas where critical and relevant issues were raised and elaborated by the Review Team. Acknowledging the importance of the feedback from these stakeholders, the Review Team invited individuals and organizations that were represented there to send in writing any other comments that they might have in relation to the document so that the respective consultants could address these in their final revisions. The stakeholders were given about a week to submit such comments before a deadline of 9 May 2007. Indeed a substantial number of written comments were received by the Core

Group of Consultants and passed over to the respective teams of consultants for review and action. Due to delays in receiving comments from key stakeholders, the finalization of the strategic document was delayed by one week and submitted to the Steering Committee on 22 May 2007.

Lessons Learnt[65]

1. **Overall:**
   a. Strength:
      i. The process of the review has been much better structured than one used in the development of the 2003 – 2007 NMSF
      ii. More intensive consultative process and better participation by stakeholders including CSOs
   b. Weaknesses:
      i. Limited participation by key staff from TACAIDS and NACP
      ii. With the exception of PMO-RALG, there was inadequate participation of focal persons and key decision makers from MoF, and MDAs.
      iii. Technical services could have been engaged earlier in the key thematic areas to provide background information for the review team to cut down on the number of consultative meetings

2. **Consultant Team:**
   a. Strength
      i. Excellent technical competence and country experience covering key areas of NMSF
      ii. Good team structure and working environment between national and international consultants
   b. Weaknesses:
      i. Identification and recruitment of National Consultants (NC) and international consultants (IC) was suboptimal. Despite six months lead time:
         - 3 out of six NC were notified only one week before the start of the process
         - one should not have been in the team since he is a member of RFA (potentially conflicting interests)
         - with the exception of one NC who was available full-time during the whole period, the rest of the NC were engaged in other assignments in the course of this task
         - IC on Care & Treatment left after one week and was only replaced in the last week of the assignment

[65] *The lessons presented here are based on the discussions by the Consultant Team at the end of the review process (end of March) as well as specific observations made by the two lead consultants during the review process. As such, they may not necessarily reflect the overall consensus of the Consultant Team.*

- two IC arrived one week late and were absent for more than one week during the assignment
- Absence of "gender specialist" in the Review Team

3. Logistics

a. Strength

Consultant team was offered a separate office for internal discussion and work

b. Weaknesses

i. Physical working environment at Ubungo Plaza office is too far away from the town and was operational 10 days after the work had started

ii. The meeting room was not sufficient for larger meetings and lacked key technical aids like overhead projectors

4. Steering Committee:

a. Strength

i. Good and timely initiation of the process (started in September 2006!)

ii. Planned for wide participation of stakeholders at national and regional / district level

iii. Proved quite flexible to request from Consultant Team to adjust the review process schedule

b. Weakness

i. Despite long preparation process there were suboptimal preparation and oversight (see recruitment of consultants)

ii. Insufficient participation of members of SC in some of the meetings

iii. Obliged Consultant Team to visit all regions under inadequate preparations for the visits (this was an expensive undertaking both in terms of human and financial resources in relation to the output)

iv. Too many consultative meetings planned with too many participants some of whom were illinformed since they were simply representing some focal persons from their organization. Participatory approach overrode effectiveness and efficiency of meetings.

v. No 'mechanism' was in place to ensure appropriate participation of top leadership from MDAs (i.e. directors and policy and planning officials) in meetings instead few Focal Points persons whose attendance was also poor.

5. Development Partners Group AIDS:

a. Strength

i. Sharing of responsibility for the process including recruitment of consultants

ii. Active participation during the two months process

b. Weakness
    i. Insufficient support (see recruitment of consultants)

6. TACAIDS:

a. Strength

Supported the process at highest level through assignment of a full-time program officer

b. Weakness
    i. Insufficient participation of key technical staff in major meetings
    ii. Missed learning opportunity by technical staff
    iii. Lack of experienced and highly placed desk officer to accompany the consultant team in the review process
    iv. Absence or non visibility of M&E Technical Officers throughout the process (took only part in meetings with M&E consultants)

7. MDAs

a. Strength

Good participation of PMO - RALG

b. Weaknesses

    i. Insufficient participation of MoHSW (NACP)
    ii. Absence of key persons (Departments of Planning and Policy, and Human Resources) in meetings
    iii. Only few Focal Points attended the consultative meetings

8. Visits to the Regions:

a. Strength
    i. All regions covered
    ii. Good participation in regional workshops from various stakeholders
    iii. Valuable insights by the consultant team in regional and district realities

b. Weaknesses
    i. Fewer regions could have been selected for more intensive contacts
    ii. Selection of National Facilitators not transparent
    iii. Lack of adequate preparation for the regional visits
    iv. Misleading information sent to regions (5 day workshop announced!) without prior consultation with consultant team
    v. Delayed transfer of funds to the regions highly inconvenienced the planned regional consultation process

9. CSOs

The preparatory meeting of the CSO community through the HIV/AIDS Working Group of Policy Forum (November 2006) to review the NMSF and provide written comments was an excellent move and should serve as a model for other sectors and organisation in preparing themselves for such an exercise.

Annex 1a

Members of the Steering Committee for the NMSF Review			
No:	***Name***	***Org/Department***	***E-Mail***
1.	Dr. Joseph Temba	TACAIDS	temba@tacaids.go.tz
2.	Dolorosa Candelaria	TACAIDS	dolorosa@tacaids.go.tz
3.	Dr. Adeline Moshi	TACAIDS	amoshi@tacaids.go.tz
4.	Dr. Brigitte Jordan	GTZ/DPG	brigitte.jordan-harder@gtz.de
5.	Dr. Bergis Schmidt-Ehry	GTZ/DPG	bergis.schmidt-ehry@gtz.de
6.	Ken Heise	MSH	kheise@msh.org
7.	Tracy Carson	PEPFAR	CarsonTL@state.gov
8.	Dr. Faustin Njau	MOHSW	mwita52@yahoo.com
9.	Dr. Emanuel Malangalila	WB	emalangalila@wb.org
10.	Dr. Chilanga Asmani	UNFPA	chilanga.asmani@undp.org
11.	Rachel Smyth	TACAIDS	rsmyth@fastmail.co.uk
12.	Bernadette Olowo-Freers	UNAIDS	Bernadette.olowo_freers@undp.org
13.	Dr. Faustin Njau	MoHSW	faustinnjau@africaonline.co.tz
14.	Bengi Issa	TACAIDS	bissa@tacaids.go.tz
15.	Dr. Donan Mmbando	TACAIDS	don@tacaids.go.tz
16.	Richard Ngirrwa	TACAIDS	ngirwa@tacaids.go.tz
17.	Dr. Peter Bujari	Human Dev. Trust	dr_bujari@hdt.or.tz
18.	Dr. Roland Swai	NACP	Swairo@nacptz.org
19.	Dr. Elly Ndyetabura	UNDP	dr.elly.ndyetabura@undp.org

Annex 1b

List of Local and International Consultants			
No:	***Name***	***Role/Responsibilities***	***E-Mail***
1.	Dr. Ulrich Vogel	International Lead Consultant	ulrichfvogel@gmx.net
2.	Dr. Justin K. Nguma	National Lead Consultant	jnguma@healthscope.or.tz
3.	Prof. Eustace P.Y. Muhondwa	Prevention	emuhondwa@muchs.ac.tz
4.	Hilde Basstanie	Prevention	hilde.basstanie@gmail.com
4.	Dr. Phares G.M. Mujinja	Impact Mitigation	pmujinja@muchs.ac.tz
5.	David Cownie	Impact Mitigation	siapac@mweb.com.na
6.	Dr. Suma Kaare	Enabling Environment	tunsuma@yahoo.com
7.	Dr. Barry Kistnasamy	Enabling Environment	barryk@ebucksmail.com
7.	Prof. Gabriel Mwaluko	Care and Treatment	gmwaluko@yahoo.co.uk
8.	Dr. B. Jordan Harder	Care and Treatment	brigittejordan-harder@gtz.de
9.	Julie Tumbo	Monitoring and Evaluation	tumbojulie@yahoo.com
10.	Merleze Gorgens	Monitoring and Evaluation	mgorgens@worldbank.org
11.	Daniel Ngowi	Resource Assessment	ellyngowi@yahoo.com
12.	Kireria A.M	Resource Assessment	akireria@gmail.com

Annex 1c

List of Stakeholders Consulted During the Review of the 2003 – 2007 NMSF

No:	Public Sector	Private Sector/UN/Bilateral Organizations	Civil Society Organizations (CSOs)
1.	PMO - RALG	World Bank	TANESA
2.	Regional Secretariat, Coast Region	UNDP	Action Aid international Tanzania
3.	Regional Secretariat, Arusha	S.I. Resource Investment Ltd.	
4.	Regional Secretariat, Mbeya	UNAIDS	Care Internaltional
4.	Regional Secretariat, Rukwa	USAID	RFA – Lindi/Mtwara
5.	Regional Secretariat, Kagera	MUCHS	RFA – Shinyanga/Mara
6.	Regional Secretariat, Ruvuma	GTZ	RFA – Kilimanjaro/Tanga
7.	Regional Secretariat, Iringa	CUAMM	RFA – Iringa/Ruvuma
8.	Regional Secretariat, Shinyanga	TTCL	RFA – Dar es Salaam
9.	Regional Secretariat, Singida	MEDEX	RFA – Rukwa/Mbeya
10.	Regional Secretariat, Mara	TAZARA	RFA – Arusha/Manyara
11.	Regional Secretariat, Dodoma	Price Water Coopers (PWC)	RFA – Morogoro/Cost
12.	Regional Secretariat, Morogoro	National Insurance Corporation (NIC)	RFA – Tabora/Kigoma
13.	Regional Secretariat, Lindi	National Construction Council	BAKWATA
14.	Regional Secretariat, Mtwara	National Microfinance Bank Ltd.	CCT
15.	Regional Secretariat, Lindi	National Health Insurance Fund (NHIF)	CSSC
16.	Regional Secretariat, Kilimajaro	Independent Television (ITV)	Orphanage Centre – Msimbazi D'Salaam

17.	Regional Secretariat, Tanga	University of Dar es Salaam	Makao ya Watoto Yatima
18.	Regional Secretariat, Dar es Salaam	TANESCO	WOFATA
19.	Public Service Commission	UNFPA	AED/TMARC
20.	Department of Social Welfare. MOHSW	UNICEF	AMREF
21.	RMO - Kilimajaro		Social Development Network NETWO+
22.	Ministry of Agriculture and Food Security		
23.	MOHSW		Network of Young People Living with HIV (NYP+)
24.	The President's Office – state House		The Anglican Church
25.	TAMISEMI - Dodoma		Evangelical Lutheran Church of Tanzania
26.	Ministry of Education and Vocational Training (MOEVT)		UMASITA
27.	Institute of Social Welfare (ISW)		About Health Foundation
28.	Ministry of Defense and National Service		Baraza la Musikiti Tanzania (BAMUTA)
29.	MOHSW - NTLP		Tanzania Episcopal Conference
30.	Ministry of Finance - TRA		Baraza Kuu la Jumuiya za Kiislamu Tanzania
31.	Ministry of Lands and Urban Settlements		Radio Kheri
32.	Ministry of Water		TYJA, Tanga
33.	Commission for Human Rights and Good Governance		Measure Evaluation Constella Features
34.	Ministry of Foreign Afdfairs and International Cooperation (MOFIC)		MUCHS
35.	Prisons Department		KILONEPHA
36.	Ministry of Public Safety and Security		MEDGC

37.	Prevention of Corruption Bureau PCB)	TANEPHA
38.	Ministry of Labour, Employment and Youth Development	HIDEPHA+
39.	Ministry of Public Safety and Security - Immigration Department	TNW+
40.	Drug Control Commission	MPEE
		Family Health International (FHI)
		TGNP
		Care International
		Oxfam
		Pathfinder International
		Forum - SYD
		Help Age International Tanzania
		Dogodogo Centre
		Social Action Trust Fund
		Kiota Women Health Development (KIWOHEDE)
		PACT Tanzania
		Friends of Don Bosco
		Keko Furnature
		VIBINDO

GYOWAAT

TANAPA

CHAWANA

JMBL

UMASIDA

UJAWADA

UKAWADA
Umoja wa Wauza Samaki
Ferry VUSHA/WASWI

TEMNWO
Mburahati Metal Works &
Carpentry Cooperative
Society

Mama Lishe -
Michikichini

Afro Art and Fashion

New Life Operation Home

TAMAUFI

TNW+

Youth Action Volunteers

Annex 2

References

1. Advocacy Guide: Meaningful Involvement of Civil Society in the UNGASS Review Meetings, March 2005.
2. Act No. 22 of 2001 that set up the Tanzania AIDS Commission.
3. Beegle, K. et al. Adult Mortality and Consumption Growth in the Age of HIV/AIDS, 2006.
4. Community Mobilization and AIDS, A UNAIDS Technical Update 1997.
5. Candelaria, D., Resource Mapping for HIV and AIDS, TACAIDS. 2007.
6. Deloitte and Touché Report, 2006.
7. Employer's Handbook on HIV/AIDS. A Guide for Action, International Organization for Employers, May 2002.
8. England, R., Shirima, L. & Moshi, F., Assessment of the Institutional Capabilities of TACAIDS. HLSP. November 2004.
9. Global Task Team on Improving AIDS Coordination Among Multi-lateral Institutions and International Donors, Final Report, June, 2005.
10. Joint Assistance Strategy for Tanzania (JAST), November 2006.
11. Kilonzo. et al., "Injection Drug Use in Dar es Salaam". Muhimbili University College of Health Sciences and University of Texas, 2006.
12. Kessy, F. Social and Economic Impacts of HIV and AIDS in Tanzania, Inventory of Studies, 2007.
13. Kalinaga, S.F., Kayombo, S., and Muro, S.G. Pact Makete – Songea Capacity Building: Training Needs Assessment Report, May 2006.
14. Kireria A.M and Ngowi D. Assessment of the Human and Financial Resources for the revised HIV/AIDS NMSF. March 2007.
15. Ministry of Justice and Constitutional Affairs, Proposal to Enact the HIV/AIDS Prevention and Control Act 2006, Attorney General's Chambers; March, 2006.
16. MOHSW – NACP: "Surveillance of HIV and Syphilis Infections Among Antenatal Clinic Attendees 2005/06, Report Number 3", 2007.
17. MOHSW – NACP: Evaluation of Sexually Transmitted Infections Services Delivery in Tanzania Mainland, 2005.
18. MOHSW: Recommendations from the Joint Technical Mission to Support Scale up of PMTCT+ and Paediatric HIV Care and Treatment in Tanzania, October 2006.
19. MOHSW: Health Sector PER update FY 2004
20. MOHSW: PMTCT Summary report, 2006
21. MOHSW: Tanzania Joint Mission on PMTCT and Paediatric AIDS, Draft Summary Report, October 2006
22. MOHSW: Health Sector Strategy for HIV/AIDS, 2003 – 2006.
23. Ministry of Planning, Planning Commission: Tanzania Development Vision 2025.
24. Ministry of Community Development, Gender and Chidren; National Strategy for Gender Development, September 2005.
25. Prime Minister's Office, National Policy on HIV/AIDS. United Republic of Tanzania, September 2001.

26. Putting HIV/AIDS on the Business Agenda, UNAIDS Point of View, November 1998.UNAIDS and Non-governmental Organization, UNAIDS Best Practices, June, 1999.
27. Resource Needs for an Expanded Response to AIDS in Low and Mid-income Countries, august 2005.
28. Roger, E., Shirima, L. and Moshi, F. Assessment of the Institutional Capabilities of TACAIDS, November 2004.
29. REPOA. Brief 1 Poverty and Human Development Report 2005.
30. Shellukindo, W.H. et al., "Towards Advocacy for HIV/AIDS Response Within Government, Political; and Civil Leadership in Tanzania" A Consultancy Report submitted to NACP, April 2000.
31. Sakila, B.A., Kafuko, B., Makenga, H.A., William, J., 2nd Joint Technical Review of the National HIV/AIDS Multi-sectoral Strategic Framework (2003-2007).
32. Scaling up towards Universal Access to Prevention, Treatment, Care and Support in Tanzania: Setting National targets for 2008 and 2010, (2006).
33. Starling, M., Brugha, R., and Walt, G. Tracking the Global Fund in Tanzania. Global Fund Tracking Study: Country Report, 2005.
34. TACAIDS: Tanzania HIV/AIDS Indicator Survey 2003/04.
35. Tanzania Commission for AIDS: A New Look at the HIV and AIDS Epidemic in Tanzania. December 2005.
36. TACAIDS: HIV & AIDS Resource Mapping, (CD ROM) finalized June 2006.
37. The business Response to HIV/AIDS. Impacts and Lessons Learned, 2000.
38. TACAIDS: 1st national Multi-sectoral HIV/AIDS Response Technical Review. February 2004.
39. TACAIDS: National Multi-sectoral Strategic framework on HIV/AIDS 2003 – 2007, January 2003.
40. TACAIDS: 2nd Joint Technical Review of the National HIV/AIDS Multi-sectoral Strategic Framework (2003-2007), March 2006.
41. TACAIDS: Main Review of the National HIV/AIDS Multi-sectoral Response 2003-2007, March 2006
42. TACAIDS: National HIV/AIDS Report, January 2002 – June 2005. November 2005.
43. TACAIDS: Tanzania Public Expenditure and Multi-sectoral Review: HIV/AIDS, December 2006
44. The Prime Minister's Office: National Policy on HIV and Aids, November 2001.
45. The Prime Minister's Office: National Multi-sectoral Strategic Framework on HIV/AIDS (2003 – 2007). February 2003
46. TACAIDS: National HIV and AIDS Communication and Advocacy Strategy, 2006.
47. MOHSW: Tanzania Service Provision Assessment Survey, 2006.
48. UNDP: Integration of HIV/AIDS in the National Strategy for Growth and Reduction of Poverty (NSGRP/MKUKUTA) and Zanzibar Poverty Reduction Plan (ZPRP), 2006.
49. United Republic of Tanzania: Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS); January 2003 – December, 2005.
50. UNAIDS: Identifying Linkages and Gaps between the National Strategy for Growth and Reduction of Poverty (MKUKUTA) and the National Multi- sectoral

Framework (NMSF) Implementation through TACAIDS. March 2006.
51. UNAIDS: Report on the Global AIDS Epidemic, 2005.
52. UNAIDS: Report on the Global AIDS Epidemic, 2006.
53. UNAIDS: Report on the Global AIDS Epidemic, 2006, p. 509.
54. United Republic of Tanzania, Prime Minister's Office. National Policy on HIV/AIDS. September 2001.
55. UNAIDS: Report on the Global AIDS Epidemic, 2005.
56. UNAIDS: Report on the Global AIDS Epidemic, 2006.
57. UNAIDS: Towards Universal Access to Prevention, Treatment and Care: Experiences and Challenges from Mbeya Region in Tanzania – A Case Study. December 2006.
58. URT, PMOs, 2006, NMSF, Medium Term Review.
59. United Republic of Tanzania, Vice Presidents' Office, 2005, National Strategy for Growth and Reduction of Poverty (NSGRP).
60. United Republic of Tanzania: HIV/AIDS Care and Treatment Plan 2003-2008 Business Plan 4.0, September, 2003.
61. Wyss, K. Human Resources for Health Development for Scaling up ARVs in Tanzania. WHO/Swiss Tropical Institute, 2004.
62. WHO, UNFPA, WB, UNAIDS: Statement on Kenyan and Ugandan trial findings on circumcision and HIV. Press Statement 13 December 2006.
63. World Food Program: Rapid Vulnerability Assessment of Households Affected by HIV/AIDS in Makete District, Iringa Region, March 2005.

Annex 3

Memorandum of Understanding between the Government of Tanzania and the Development Partners

MEMORANDUM OF UNDERSTANDING
BETWEEN
THE GOVERNMENT OF THE UNITED REPUBLIC OF TANZANIA
AND DEVELOPMENT PARTNERS
ON THE IMPLEMENTATION OF THE 2nd NATIONAL MULTISECTORAL STRATEGIC FRAMEWORK ON HIV AND AIDS 2008 – 2012 (Tanzania Mainland)

1. The Government of the United Republic of Tanzania (hereinafter referred to as the “Government”) and its Development Partners (the “DPs”) recognise substantial progress achieved by all those concerned with the development of Tanzania in addressing the challenges of the HIV epidemic in the past five years. The Government and DPs seek to consolidate this progress during the period of the 2nd National Multisectoral Strategic Framework on HIV and AIDS 2008 – 2012 (NMSF 2008-2012) by improving the effectiveness of development aid and by strengthening national ownership. This Memorandum of Understanding (MoU) is not a legally binding instrument and is not an international treaty. However, it declares the principles of implementing the NMSF 2008 – 2012 that are shared by the Government and its DPs for reducing the further spread of HIV and achieving the goals set by the NMSF. In this context reference is made to the international commitments of the Government of Tanzania in the UNGASS Declaration of Action, the Millennium Development Goals, the Health Ministers’ resolution for the acceleration of HIV prevention in Africa made in Maputo 2005 and the Road to Universal Access to HIV/AIDS prevention, care and treatment services by 2010. .As the NMSF is for Tanzania Mainland, this MoU applies to Tanzania Mainland only.

2. The Government and its DPs recognise that despite good progress, the HIV epidemic still presents a critical challenge threatening national development, as well as the well-being of communities, families and individuals in Tanzania.
3. In the fight against HIV and AIDS, the Government and its DPs will pursue the same principles as stated in the Memorandum of Understanding of the Joint Assistance Strategy (the "MoU JAST") for Tanzania, which are to: "strengthen mutual and domestic accountability and national ownership of the development process; align DP assistance with Government priorities, systems, structures and procedures; promote management for results; sustain progress in Government reforms; and harmonise Government and DP processes to reduce aid transaction costs" (MoU JAST, p. 2). The Government and its DPs will avoid creating parallel project implementation units and management structures – instead, integrating them into the structures and systems of the implementing Government agency.
4. The Government and its DPs will endeavor to place all decisions on aid and aid allocations related to the challenges of HIV and AIDS in the framework of the new NMSF and its overarching approach of promoting the "Three Ones" (one coordinating body, one plan and one monitoring and evaluation system).
5. The "Three Ones" apply equally at the central, district, ward and community level.
    - At the **central level**, the Tanzania Commission on AIDS ("TACAIDS") is the **one coordinating structure** of the National Response to HIV and AIDS, the NMSF 2008 – 2012 is the **one plan** under which all strategies, interventions and activities by all stakeholders and actors will fall, and the Monitoring and Evaluation ("M&E") chapter of the NMSF 2008-2012 provides the **one system of monitoring and evaluation**.
    - At the **district level and municipality level**, the Council Multisectoral AIDS Committee (the "CMAC") is the **one coordinating structure**, the Integrated Council Plan on HIV and AIDS is the **one plan** and the M&E system of the council plan provide the **one monitoring and evaluation system.**

- At the **village level**, the Village Multisectoral AIDS Committee (the "VMAC") and at the ward level, the Ward Multisectoral Committee (the "WMAC") are the **one coordinating structure**, accordingly the Village or Ward integrated HIV and AIDS Plans are the **one plan** and the M&E indicators and procedures as stipulated in the NMSF 2008-2012 for the most decentralised level provide the **one monitoring and evaluation framework.**

6. The Government and its DPs will cooperate to translate the NMSF into annual operational plans at the National Level by making use of the planning processes (Medium Term Expenditure Framework (the "MTEF") of the Ministries, Departments and Agencies (the "MDAs") as well as the integrated development plans emanating from the Local Government Authority (the "LGA") levels to foster implementation of the NMSF. While some of the external agencies and partners, due to their legal and administrative requirements, will have to continue elaborating specific (project/programme) plans, DPs will seek to ensure that these plans are in line with the government procedures and the "Three Ones" at the respective levels. The DPs and Government will work together to track the flow of HIV and AIDS expenses not only from the Government but also from DPs, private and NGO sources.

7. The Government and its DPs recognise the importance and valuable contributions of Civil Society Organisations (Non-Governmental Organisations/Community-based Organisations/Faith-based Organisations, collectively the "CSOs"), as well as the private business sector and the informal sector for strengthening the responses to HIV and AIDS at all levels. Support for these organisations and sectors is crucial in mobilising communities and reaching as many people as possible, and in defining regional and local solutions to the challenges of the epidemic based on the distinct cultural traditions and specific social and economic factors influencing the spread of HIV. In order to assist the CSOs and other sectors to operate according to the "Three Ones", DPs which support them will encourage them to integrate their activities in the NMSF frameworks at central, district, ward or village levels. To this purpose, the DPs should provide

transparent information on funding of CSOs to TACAIDS and the respective councils (see also Point 11 b).

8. The Government and its DPs will endeavor to support and implement wherever possible the principle of "Greater Involvement of People living with HIV" and other vulnerable groups in all aspects of planning, implementation and monitoring of the response to the epidemic in their respective areas of responsibility.

9. The Government and its DPs will promote the partnership and joint collaboration between the National AIDS Control Programme, the National Malaria Control Program and the National TB/Leprosy program in order to strengthen the national health system.

10. The Government and its DPs will carry out bi-annual joint programme reviews. The purpose of the bi-annual review is to assess the degree of achievement of the planned targets and the efficiency of the NMSF interventions or strategies. These reviews complement a joint mid-term review of the NMSF scheduled for 2010 which will be in line with Universal Access targets and a joint end of programme evaluation scheduled for 2012 as foreseen in the NMSF. All parties will agree on timing, terms of reference and composition of these review/evaluation missions. The Government will through TACAIDS establish an annual progress report based on the financial and programmatic indicators and targets set out in the NMSF and related operational plans and as specified in the M&E framework of the NMSF. The report by TACAIDS will be used for a comprehensive report to the Parliament and for feed-back reports to MDAs and LGAs. The report by TACAIDS will also seek to provide DPs with the information needed for their own reporting requirements and will, to the extent feasible, progressively replace the need for additional specific DP reports. Moreover, the annual Public Expenditure Review on HIV and AIDS will be maintained and supported by the Government, with assistance as appropriate from the DPs.

11. In order to increase the understanding of the HIV and AIDS epidemics and ascertain the progress achieved, it is of primary importance to implement and strengthen the M&E system of the National Response at all levels. The DPs will seek to reduce as much as possible (consistent with their own requirements) the

need for separate data collection and indicator development and will endeavour to cooperate fully with the national system. Therefore they will strive:

a) to use, wherever possible, one set of HIV indicators;

b) to require (to the extent feasible) organisations that they are funding which implement HIV services to report to the Ministry of Health using MOHSW systems (for clinical HIV interventions), and to report on TOMSHA[66] for all community-based HIV services;

c) to contribute to national HIV-related data sources;

d) to systematically use data generated by the NMSF framework for decision-making to improve the quality of services delivered.

12. Recognising the importance of containing HIV/AIDS for the overall development of Tanzania, the Government and its DPs will seek to achieve appropriate aggregate levels and increased predictability of financial support to combating HIV and AIDS in Tanzania and enhance efficiency of funding. While care and treatment will continue to receive a substantial amount of support, the priority of the NMSF is on prevention and reduction of HIV transmission. These aims should receive the highest attention by the Government as well as the DPs.

13. This MoU is signed by the Government and its DPs (DAC and UN) in the field of HIV/AIDS. The MoU is open to any other partners (International NGOs, International Health Initiatives, etc.) relevant to the fight against AIDS .

14. It is hoped that those partners who cannot sign this Declaration, will confirm the key principles of this Declaration in order to enhance the effectiveness and efficiency of the National Response to HIV and AIDS in Tanzania.

[66] Tanzania's Output Monitoring System for non-medical HIV and AIDS interventions