1.0 Introduction

Tanzania has adopted the universal access to HIV and related services by 2010, but the universal access report of 2009 indicate that this target may not be reached. Through the SADC, the 50 by 15 target has also been passed aiming at preventing half of new infections occurring now by 2015. If these targets are achieved will save the country from the commitment to provide life long treatment which is expensive.

2.0. The situation

Tanzania estimates that 1.4 million women becoming pregnant each year, with 8.2% prevalence among pregnant mothers[1], there are 114,800 pregnant mothers who are HIV infected. With the estimation of up to 35% transmission of HIV, then the are likely to be about 40,000 babies infected annually. In year 2008, Tanzania estimated a total number of 217,704 new infections, 43,300 (20%) being due to mother to child transmission. Using the 2008 estimation, there are 596 people infected by HIV every day, out of these 118 are innocent children infected by their mothers, yet this is preventable.

In Tanzania 6 in 10 HIV positive women access PMTCT services through 12.2% facilities which offer PMTCT. Coverage of ART for children is challenged by many issues including problems with Early Infant Diagnosis, availability of Fixed Dose combination, nutrition and limited access to services due to stigma and decision by parents/guardian. If not treatment done, 21,500 (50%) of 43,300 infant infected will die before their second birthday and 34,450 (75%) of 43,300 will die before their fifth birth day. The remaining 10,450 babies will need life long treatment and the cost of maintaining life health expectancy will be high to family and nation.

3.0 The project:

HDT in collaboration with African Network for the Care of Children Affected by AIDS (ANNECA), Tanzania AIDS Forum (TAF), Tanzania Pediatric Association (TPA) and Association of Journalists Against AIDS in Tanzania (AJAAT) will be working with other key partners to implement an advocacy to end pediatric AIDS in Tanzania. The project is implemented in 6 African countries; those are Tanzania, Kenya, Uganda, Zambia, Mozambique and Nigeria. This advocacy program is abbreviated as (CEPA) and the project is expected to take place between 2009 and 2012. CEPA will therefore advocate for a number of issues including 80% coverage of PMTCT, early infant diagnosis and treatment. Other areas of advocacy will include full funding to PMTCT services, family centered care and nutrition service provision. **Global AIDS Alliance (GAA)** has pioneered and came up with the idea and gave about 36,000 US$ to initiate planning of National Advocacy Action Plans (NAAP) in the six countries. GAA has pledged to provide 100,000 as part of funding to Tanzania for the project to start early January 2010. The project total budget for 2010 is US$ 485,273.00. More information about CEPA is available at www.endpediatricaids.net

[1] ANC surveillance report of year 2005

4.0. The bottlenecks (Cause and effect).

Details of the bottlenecks can be found at HDT website in a report to be finalized soon, at www.hdt.or.tz. The bottlenecks include:

4.1 Inadequate Human recourse for health

Despite the fact that became a priority policy and Programme for the government, the effort to attract and retain in open market have fallen short to compete in free market economy. Both quantity and quality to provide optimum services are challenged.

4.2 Access to Fixed Dose combination and Early Infant Diagnosis services.

HIV exposed children are supposed to start taking septrine at their sixth week after delivery, but this is often not available. The paediatric medication are in separate formulation which is cumbersome than if there were fixed combination to increase convenience for the carers. With regard to the Early Infant Diagnosis, this is hindered by the fact that PCR machine are only available in referral hospitals and logistic for collection, transporting and returning results are not well focussed.

4.3 Inadequate working tools that address paediatric medical needs.

For children to be initiated on ARV, series of laboratory test are required. This includes; CD4 percentage, kidney and liver function test. Widely distributed CD4 machines in the country are mainly designed to test the absolute CD4 count and not percentage[2]. This fact means that a mere test of CD4 is not enough to signal the start of ART, and coupled with limited knowledge on paediatric treatment skills, there are limitation to access services. Maintenance of available CD4 machines has been problematic in many parts of the country, leading to many not functioning for significant amount of time.

4.4 Lack of family and patient centred services

RHC and CTC services are run in separate units which adds burden on time and cost to care givers and leads to loss of follow-up. The CTC and PMTCT both serve the same child but they are silent on linkages, in addition to limited availability of services that are also accessible to men.

4.5 Stigma and discrimination and HIV disclosure

National policy on child HIV allow counsellors together with the primary care giver to disclose to the child his/her HIV status as from the age of 7 years[3]. The policy / guidelines offers no statements on skills required by different providers to handle such paediatric complex situations.

4.6 Infant and mother feeding policy.

Interpretation of guideline by many HCW on feeding options gives preference to exclusive breast feeding for first six months in HIV infected women. The guideline considers replacement feeding for HIV infected women if it *is acceptable, feasible, affordable, accessible, and safe (AFASS).* Small proportional (6.9%) of HIV

Picture from: Community access to HIV services by Dr. Bujari, April 2008

[2] ENGENDERHEALTH-Tanzania. DR Motta Witness PMTCT clinical advisor

[3] National Guideline for management of HIV and AIDS, 3rd Ed 2008 Pg 225

infected mothers opt for replacement infant feeding[4], however majority are not optimally practicing it as per national guideline. The guidelines don't acknowledge the poor condition that most of families have, thus to provide alternative feeding to all needy infants. This has lead to children testing negative at 4 months but seroconvert at later age indicating transmission during breastfeeding. This practice leads to malnutrition and affect treatment outcomes as it offers no hope for children who are already malnourished and yet has to face increased food demand as a result of ARV intake.

4.7 Funding allocation for PMTCT and PAIDS care.

There is more funding needed to provide optimal access to PMTCT ART, paediatric medication, Early infant treatment, infant feeding to ensure that HIV positive mothers and exposed children access service on time. Ensuring that each district plans what and how to provide PMTCT services will be critical instead of leaving it to implementers. The actual resource needed for PMTCT program are not known. For financial year 2009, PEPFAR program allocated 7% of its entire budget for PMTCT[5].

5.0. Action required

There is agreement that prevention is going to be the priority area if the world have to survive this human tragedy. As such we have to do all it takes to prevent new infection. In sub-Saharan Africa, Tanzania is one of the country with high burden that has to reprogram to ensure the universal access to PMTCT to 80%. The Campaign to End Paediatric AIDS operating currently in six countries is one of the initiatives. This program which will be implemented in Tanzania by NGOs, media and professional associations focuses to achieve 80% coverage by 2012. To achieve this, it focuses on the following objectives namely:

Ensure that services are provided in **family -Centered Care and Nutrition** is provided as alternative feeding. In light of food shortage and hunger world wide, food for prescription needs to be given to optimize the treatment outcome.

On second place, there is a need to ensure that **early infant diagnosis and treatment** is provided and turn around time is shortened to 2-4 weeks. In addition to this, appropriate medication for infants will need to be available through a fixed dose combination.

The above will be achieved if **full funding to PMTCT** is made available to responsible units for both creation of demand and supply side.

5.1. Immediate actions required.

On urgent note, coordinating, financing and implementing partners needs to come together to discuss this and give it a high profile it deserves. It should be discussed in DPG AIDS, DPG health, TNCM, Regional care and treatment partners etc. In this discussion, reprogramming to ensure full funding is available is going to be of prime importance in addition to setting performance benchmark and doing things unusual.

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[4] Health Sector HIV and AIDS Strategic Plan 2008-2012
[5] Human Development Trust publication: Je bajeti ya UKIMWI inakidhi mahitaji? 2009

Secondly, the quick review of policy and practice that can allow robust delivery of services to HIV positive mothers and exposed infants. Such options may rationalize and formalize the use of expert patients and follow up as it links with Home Based Care to minimize defaulters. Resources for infant feeding, speed up sample collection, testing and return of results to parents than mother only merit consideration.

5.2. Long-term actions

Under this section, systematic review of human resource and financing of the same to remove bureaucratic hiring process, increase retention through motivation and structured human resource management. Policy option to change of service from the current setting to family centered counseling where men will feel part of care system. Issues of staff capacity especially at primary health care level and maintenance of the CD4 machines may be another area needing consideration.

6.0 CEPA IMPLEMENTING PARTNERS

CEPA implementing partners are TAF, PAT and AJAAT under the leadership of HDT.