



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

NATIONAL AIDS CONTROL PROGRAMME



**Third Health Sector
HIV and AIDS Strategic Plan
(HSHSP- III) 2013 – 2017**



THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL WELFARE
NATIONAL AIDS CONTROL PROGRAMME



Third Health Sector
HIV and AIDS Strategic Plan
(HSHSP- III) 2013 – 2017

April, 2014

Third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013 – 2017

Published in 2014

© Ministry of Health and Social Welfare
National AIDS Control Programme

P.O. Box 11857

Dar es Salaam

Tel:-+255 22 2131213; Fax:- +255 22 2138282

E-mail: info@nacp.go.tz

Website: www.nacp.go.tz

ISBN: 978 9987 650 78 1

Any part of this Strategic Plan III can be used provided that the source which is the Ministry of Health and Social Welfare, National AIDS Control Programme is acknowledged.

Acknowledgements

The third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013-2017 was developed in a highly participatory manner. While the Ministry of Health and Social Welfare, through the National AIDS Control Program (NACP) took a leading role, various stakeholders – individuals and organisations also played an important and active role. It is difficult to mention specific organisations and people, hence I would like to start by thanking all individuals and organisations (public and private, national and international) who spared their time, provided technical advice, financed the process or helped in any way - directly or indirectly- to make this mammoth task possible.

However, I would like to mention a few individuals and organisations on behalf of all those who contributed.

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

Secondly, I would like to thank the organisations that provided financial and technical support to the process. Management Sciences for Health (MSH), Pathfinder International and University of California San Francisco (UCSF) provided the technical experts that facilitated the development of the strategy. These three organisations are all funded by the U.S. Government through the Centres for Disease Control and Prevention (CDC). The World Health Organisation (WHO) provided financial support for the two writing workshops. Through these organisations, I would like to thank the individual consultants for the good work done. I would like to thank the individual consultants for the good work done in coming up with the first draft, and all individuals, organisations, agencies and NGOs (international and local) who participated in the review of the draft Strategy document for their invaluable inputs on the said draft.

Thirdly, I would like to thank the Tanzania Commission for AIDS (TACAIDS) for the leadership and guidance.

Last but not least, I would like to recognise the National Council for People living with AIDS (NACOPHA) for its active participation in all writing workshops. Their presence helped to ensure that the strategy is correctly addressing the essential needs of the target population.



Dr. Neema Rusibamayila

Ag. Director for Preventive Services

Foreword

The third Health Sector HIV and AIDS Strategic Plan (HSHSP III) 2013-2017 comes at a time when the deadline for achieving the Millennium Development Goals is approaching and the focus on universal health coverage is gaining momentum. The development of the HSHSP III was informed by the third National Multi-sectoral Strategic Framework NMSF (NMSF III) 2013-2017 which guides the national response to HIV and AIDS. The focus of the NMSF III is to achieve zero new infections, zero deaths from HIV/AIDS and zero stigma in Tanzania by 2017. The HSHSP III therefore outlines how the health sector will contribute to the achievement of these national and global goals. This document was also informed by findings of the mid-term review (MTR) of the third Health Sector Strategic Plan (HSSP III) 2009-2015 which will come to an end in the middle of HSHSP III implementation.

A results-based approach was applied for both the NMSF III and HSHSP III and in order to maximize the use of scarce resources, HSHSP III focuses on interventions that have proven to be cost-effective as recommended in the World Health Organization's "Investment Framework". In addition, the HSHSP indicators have been carefully chosen to measure implementation at all levels. The use of a results-based approach in the HSHSP III is a very important development as this is where the national and global focus is being directed as we move towards the post-MDG era. In this regard, the HIV and AIDS interventions developed to address the outcomes of this strategy will be in harmony with the national and global health development agenda. It is important that all stakeholders take note of the roles and responsibilities of the various players at the national, regional and district levels outlined in the strategy, and effectively play their role while the Ministry of Health and Social Welfare provides the required leadership and guidance.

We look back with pride at the progress made so far. Tanzania has faced a generalized HIV/AIDS for the greater part of the past 30 years, with prevalence peaking around 12% in the general population 10 years ago before dropping gradually to the currently estimated 5%. (THMIS 2011- 12). The drop in HIV prevalence over the years is attributed to the robust national response mounted by the Government in collaboration with stakeholders from the very beginning of the epidemic; initially with the health sector playing a predominant role until the country adopted a multi-sectoral approach in 2000 with the formation of the Tanzania Commission for AIDS (TACAIDS).

It is our sincere hope that by abiding to this strategy, the contribution of the health sector towards the national response to HIV/AIDS will be more effective and that our common aspiration of zero new infections, zero deaths and zero stigma by 2017 will be achieved.

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



Dr. Donan W. Mmbando
Chief Medical Officer

Table of Contents

Acknowledgements.....	iii
Foreword	iv
List of Acronyms and Abbreviations.....	viii
Executive Summary	xi
Section One: Introduction	1
1.1 Geographic, demographic and socio-economic situation	1
1.2 Status of the HIV and AIDS epidemic and the Health Sector Response	1
1.2.1 Disease Burden and its Distribution	1
1.2.2 The Health sector response.....	2
1.2.3 Health system structure and coordination in relation to HIV and AIDS.....	3
1.3 National policies, legal frameworks and strategies that guide the HIV and AIDS response	4
1.4 The Strategic Planning Process	4
Section Two: Past Achievements in the Response.....	3
2.1 Evolution of the Health Sector Response	5
2.2 Achievements in Key Thematic Areas of HSHSP II	5
2.2.1 Prevention.....	6
2.2.2 Care, treatment and support	6
2.2.3 Cross cutting Achievements	6
2.2.4 Health systems strengthening	7
Section Three: HSHSP III Strategy Description	8
3.1 Introduction	8
3.2 National Vision and Health Sector Mission and Goals	8
3.2.1 Vision	8
3.2.2 Mission.....	8
3.2.3 Goals.....	8
3.3 Key principles	9
3.3.1 Equity.....	9
3.3.2 Universal Access	9
3.3.3 Gender and rights-based approach	9
3.3.4 Decentralisation.....	9
3.3.5 Integration	9
3.3.6 Public Private Partnership (PPP)	10
3.3.7 Meaningful Involvement of people living with HIV	10
3.3.8 Accountability.....	10
3.3.9 Sustainability.....	10
3.4 Over-arching Impact Results.....	10

Section Four: Health Sector HIV and AIDS Strategic Result Areas 12**Overview 12**

4.1	Elimination of New HIV Infections	12
4.1.1	HIV Testing and Counseling (HTC)	12
4.1.2	Condom Programming	14
4.1.3	Social and Behaviour Change Communication (SBCC)	15
4.1.4	Sexually Transmitted Infections and Malignancies	17
4.1.5	Targeted Youth Services	18
4.1.6	Voluntary Medical Male Circumcision (VMMC).....	20
4.1.7	Preventing Biomedical Transmission of HIV and other blood borne pathogens.....	21
4.2	Reduction of HIV related mortality	24
4.2.1	Elimination of Mother To Child Transmission and Keeping Mothers Alive.....	24
4.2.2	Early Infant Diagnosis of HIV	26
4.2.3	Paediatric HIV/AIDS Care and Treatment.....	27
4.2.4	Decentralised and integrated HIV and AIDS Care and Treatment Services for adolescents and adults	29
4.2.5	Co-infections and co-morbidities in PLHIVs	30
4.3	Elimination of Stigma and Discrimination.....	31
4.3.1	Reduction of Stigma and Discrimination against PLHIV in health care settings.....	33
4.3.2	Health Sector Workplace Interventions	34
4.3.3	HIV/AIDS Services for Key Populations	34

Section Five: Build Strong and Sustainable systems to support the health sector HIV/AIDS**Response 37**

5.1	Interaction of the HIV and AIDS Response and Health Systems Building Blocks.....	37
5.2	Service delivery.....	37
5.2.1	Quality Improvement of HIV/AIDS services.....	37
5.2.2	Community Based HIV/AIDS Services	39
5.3	Medicine and Technology	40
5.3.1	Procurement, Supply Chain Management and Pharmacovigilance (national level)	40
5.3.2	Supply Chain Management, Facility Commodity Management, Rational Use of Medicine and Pharmacovigilance (regional and District level).....	41
5.3.3	Laboratory Systems and Services	42
5.3.4	Laboratory Equipment Maintenance	44
5.4	Strategic Information for Monitoring and Evaluation of the Health Sector HIV Response.....	45
5.4.2	Routine monitoring of HIV/AIDS	46
5.4.3	HIV/AIDS Surveys, Surveillance, Evaluation and Research	48
5.4.4	Data Demand and Information Use.....	49

Section Six: Smart, Evidence based and Innovative Investments..... 50

6.1	Positive Health Dignity and Prevention	52
6.2	HIV/AIDS services for Key Populations.....	52
6.3	Targeted HIV and AIDS Services for Young People.....	53
6.4	Treatment as Prevention	54
6.5	New Technologies	54
6.6	Gender Based Violence	55

Section Seven: Leveraging Partnership.....	56
7.1 Key Stakeholders.....	56
7.2 Roles and responsibilities	56
7.2.1 Ministry of Health and Social Welfare.....	56
7.2.2 National AIDS Control Program (NACP).....	57
7.2.3 Research and academic Institutions	57
7.2.4 Medical Store Department (MSD)	57
7.2.5 Tanzania Food and Drug Authority (TFDA).....	58
7.2.6 Tanzania Food and Nutrition Centre (TFNC)	58
7.2.7 Private Health laboratories Board (PHLB).....	58
7.2.8 National Health Laboratory Quality Assurance and Training Centre (NHLQATC).....	58
7.2.9 Prime Minister's Office Regional Administration and Local Government (PMO-RALG)	58
7.2.10 Tanzania Commission for AIDS (TACAIDS).....	58
7.2.11 Regional Health Management Teams (RHMT).....	58
7.2.12 Council Health Management Teams (CHMT)	59
7.2.13 Health facilities (Hospitals, Health Centres and Dispensaries)	59
7.2.14 Community	59
7.2.15 Development Partners.....	60
7.2.16 Implementing Partners	60
7.3 Linkages for HSHSP III	60
7.4 Public Private Partnership	61
Section Eight: Implementation of the Strategy.....	64
8.1 National level Governance Structures	64
8.1.1 The Prime Minister's Office.....	64
8.1.2 Ministry of Health and Social Welfare.....	65
8.2 Governance Bodies at the Regional level	65
8.3 Local Government level.....	66
8.4 Organisation structure of the National AIDS Control Programme and Linkages at regional and Local Government level.....	66
8.5 Coordination structures and processes	66
8.6 Financing of the Strategy	67
8.7 Operational Plans	68
Section Nine: Monitoring and Evaluation Plan	69
9.1 Indicators and Targets	69
9.2 Reporting.....	70
9.3 Mid-Term review	71
9.4 End-Term Review/evaluation	71
9.5 Costed M&E Plan	71
Annex	72
References	83

List of Acronyms and Abbreviations

AD	Auto Disable
ADR	Adverse Drug Reaction
AE	Adverse Event
AFB	Acid Fast Bacteria
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Clinic
ART	Anti-retroviral therapy
ARVs	Anti-retroviral drugs
ATF	AIDS Trust Fund
BCC	Behaviour Change Communication
BMAF	Benjamin Mkapa AIDS Foundation
BMC	Bugando Medical Centre
CAP/CTM	CobasAmpliprep/CobasTaqman
CBHS	Community Based HIV and AIDS Services
CBOs	Community Based Organisations
CCBRT	Comprehensive Community Based Rehabilitation in Tanzania
CCHP	Comprehensive Council Health Plan
CHAC	Council HIV/AIDS Coordinator
CHBCS	Community Home Based Care Services
CHMT	Council Health Management Team
CITC	Client Initiated Testing and Counselling
CMAC	Council Multi-sectoral AIDS Committee
CPL	Central Pathology Laboratory
CPT	Cotrimoxazole Preventive Therapy
CTC	Care and Treatment Clinic
CTX	Co-Trimoxazole
D by D	Devolution by Decentralization
DACC	District AIDS Control Coordinator (DACC)
DBS	Dried Blood Samples
DPG-AIDS	Development Partners Group for AIDS
DPG-Health	Development Partners Group for Health
DPGs	Development Partners Groups
DRCHCo	District Reproductive and Child Health Services Coordinator
DTLC	District Tuberculosis and Leprosy Coordinator
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-To-Child HIV transmission
EQA	External Quality Assessment
FYDP	Five year Development Plan

GBV	Gender Based Violence
HAPCA	HIV and AIDS Prevention and Control Act
HBC	Home Based Care
HBCT	Home Based Counseling and Testing
HCT	HIV Counseling and Testing
HCW	Health Care Workers
HDSS	Health and Demographic Surveillance systems
HFS	Health Financing Strategy
HMIS	Health Management Information Systems
HMT	Health Management Team
HRH	Human Resources for Health
HRM	Human Resource Management
HSHSP	Health Sector HIV and AIDS Strategy Plan
IEC	Information, Education and Communication
IHI	Ifakara Health Institute
IPC	Infection Prevention and Control
IPT	Isoniazid Preventive Therapy
JTWG	Joint Thematic Working Group
KCMC	Kilimanjaro Christian Medical Centre
KP	Key Population
LGAs	Local Government Authorities
LMIS	Logistics Management Information System
LTFU	Lost To Follow Up
LEEP	Loop electrosurgical excision procedure
MC	Male Circumcision
MNH	Muhimbili National Hospital
MRCC	Medical Research Coordinating Committee
MRH	Mbeya Referral Hospital
MSD	Medical Stores Department
MTP	Medium Term Plan
MUHAS	Muhimbili University of Health and Allied Sciences
MVCs	Most Vulnerable Children
NBTS	National Blood Transfusion Services
NCTP	National HIV/AIDS Care and Treatment Plan
NEHSHIP	National Essential Health Sector HIV and AIDS Intervention Package
NGO	Non Governmental Organisation
NHLQATC	National HIV Laboratory Quality Assurance and Training Centre
NIMR	National Institute for Medical Research
NMSF	National Multisectoral Strategic Framework
NPMP	National Pharmaceutical Master Plan
NTCP	National Care and Treatment Plan

OIs	Opportunistic Infections
PEPFAR	President's Emergency Plan for AIDS Relief
PHDP	Positive Health Dignity and Prevention
PHLP	Private Health laboratories Board
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
PMORALG	Prime Minister's Office Regional Administration and Local Government
POC	Point Of Care
PO-PSM	President's office-Public services management
PPM	Plan Preventive Maintenance
PPP	Public Private Partnership
PT	Proficiency Testing
PWD	People With Disability
PWID	People Who Inject Drugs
QI	Quality Improvement
RACC	Regional AIDS Control Coordinator
RCH	Reproductive and Child Health
RHMT	Regional Health Management Teams
RMO	Regional Medical Officer
SBCC	Social and Behaviour Change Communication
SDPs	Service Delivery Points
SI	Strategic Information
SLMTA	Strengthening of Laboratory Management Toward Accreditation
SMART	Specific, Measureable, Achievable, Realistic and Time-bound
SMT	Senior Management Team
SOP	Standard Operating Procedures
SPD	Sentinel Panel of Districts
SRH	Sexual Reproductive Health
STP	Short Term Plan
SWAp	Sector Wide Approach
SWO	Social Welfare Officer
TACAIDS	Tanzania Commission for AIDS
TAT	Turn-Around Time
TC-SWAp	Technical Committee for SWAp
TFDA	Tanzania Food and Drug Authority
TFNC	Tanzania Food and Nutrition
THIS	Tanzania HIV Indicator Survey
THMIS	HIV/AIDS and Malaria Indicator Survey
TNCM	Tanzania National Coordinating Mechanism
TOT	Trainer of Trainer
TTIs	Transfusion Transmissible Infections
TWG	Technical Working Group
UNAIDS	United Nations for AIDS
VCT	Voluntary Counseling and Testing
VIA	Visual Inspection with Acetic acid
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WPI	Work Place Intervention

Executive Summary

The third HSHSP was preceded by review of the second HSHSP. As it was for its second strategy, the development of HSHSP III was informed by the respective National Multi-sectoral Strategic Framework NMSF 2013-2017 (NMSF III) that guides the national response to HIV and AIDS. This document was also informed by findings of the mid-term review (MTR) of the third Health Sector Strategic Plan 2009-2015 (HSSP III).

Following lessons learnt at local and international level, a results based approach was applied for both the NMSF III and HSHSP III. As a result, in order to maximize the use of scarce resources, HSHSP III focuses on interventions that have proven to be cost-effective as recommended in the World Health Organization's "Investment Framework". The use of a results-based approach in the HSHSP III is a very important development as this is where the national and global focus is being directed as we move towards the post-MDG era.

During the past 30 years, Tanzania has faced a generalized HIV/AIDS epidemic. The country response has included putting in place a series of strategic plans and interventions in prevention, care, treatment and support. Some of the credible achievement so far, includes scaling up services for providing Antiretroviral medicines (ARVs) and gradually decrease of HIV prevalence to the currently estimated 5%. (THMIS 2011-12). The drop in HIV prevalence over the years is attributed to the robust national response mounted by the Government in collaboration with stakeholders from the very beginning of the epidemic.

The focus of NMSF III is to achieve zero new infections, zero deaths from HIV/AIDS and zero stigma in Tanzania by 2017, HSHSP III therefore outlines how the health sector will contribute to the achievement of these national and global goals. The Strategic plan is a key instrument in guiding the implementation of prevention, care and treatment, and mitigation programs and it focuses on priority strategies that build towards achieving the strategic outcomes. It also outlines key indicators and targets to be achieved by year 2017. Also, the HSHSP indicators have been carefully chosen to measure implementation at all levels. The priority strategies defined in the strategy were crafted to fill the gap identified and have a causal relationship with the strategic outcomes. The Strategic plan includes a narrative which details some of the information listed above to link the strategic plan to the HSHSP III.

The narrative contains the following sections:

1. Section One: Introduction
2. Section Two: Past Achievements in the Response
3. Section Three: HSHSP III Strategy Description
4. Section Four: Health Sector HIV and AIDS Strategic Result Areas
5. Section Five: Build Strong and Sustainable systems to support the health sector HIV/AIDS Response
6. Section Six: Smart, Evidence based and Innovative Investments
7. Section Seven: Leveraging Partnership
8. Section Eight: Implementation of the Strategy
9. Section Nine: Monitoring and Evaluation Plan
- Annex 1: Description of Priority Indicators for HSHSP III 2013-2017

The HIV and AIDS interventions developed to address the outcomes of this strategy will therefore be in harmony with the national and global health development agenda. It is important that all stakeholders take note of roles and responsibilities of the various players at the national, regional and district levels outlined in the strategy and play their role. The Ministry of Health and Social Welfare will provide the required leadership and guidance.

It is important to note that, the successful implementation of this strategic plan eventually depends on the availability of technical and financial resources to coordinate its implementation. The strategy need to be operationalised by developing operational plans at national, regional and district levels. In this regard, there is a need to strengthen the management and advisory structures in all levels. The structure should ensure smooth information flow, transparency, and accountability.

Section One: Introduction

1.1 Geographic, demographic and socio-economic situation

The United Republic of Tanzania (comprising of Tanzania mainland and the semi-autonomous Islands of Zanzibar) is the largest country in East Africa covering 947,300 sq km. This strategy focuses on Tanzania Mainland only as Zanzibar is guided by the Zanzibar Health Sector HIV and AIDS Strategic Plan 2012-2016. As of November 2012, Tanzania Mainland had 25 administrative regions, 133 districts and 151 councils. Each council is divided into divisions, which in turn are composed of 3-4 wards (5-7 villages). The district authority (or council) is the most important administrative and implementation unit for public services. The Ministry of Health and Social Welfare (MOHSW) in collaboration with the Prime Minister's Office Regional Administration and Local Government (PMORALG) through the Health Sector and Local Government reforms are currently strengthening regional and district health services to render local government authorities the focus for health development.

According to the latest Population and Housing Census, the United Republic of Tanzania has a population of 44,928,923 of which 21,869,990 are male and 23,058,933 are female (National Bureau of Statistics, 2012). Tanzania mainland alone has a population of 43,625,354 comprised of 21,239,313 males and 22,386,041 females with an average annual growth rate of 2.7%. The crude birth rate is 41.6 per 1,000 populations and life expectancy at birth is 54 years for men and 57 years for women respectively. Twenty five percent (25%) of the population resides in urban areas whereas the majority (75%) of population are rural dwellers.

The socio-economic characteristics are well described in the third National Multisectoral Framework (NMSF III). The country's Gross Domestic Product (GDP) has continued to rise reaching 6.4% in 2012 and is projected to continue increasing. Since the Tanzanian economy is dependent on the labour intensive sector of service provision in agriculture, industry, mining and construction, having a healthy and skilled human capital base is critical. It is anticipated that given the favourable economic outlook, the Tanzanian government will continue to invest in health and other social sectors hence making available the required resources to combat the three main killer diseases in the country, namely; AIDS, Tuberculosis (TB), and Malaria. Also, with the post Millennium Development Goals (MDG) focus on 'Health-in-all-Policies' and inter-sectoral action for addressing social determinants for health, investments in other sectors are likely to benefit from the health sector and national HIV and AIDS response.

The ongoing reforms in the health sector and local government reforms of Devolution by Decentralization (D by D) have increased the relevance and role of communities and their local government councils in implementing and achieving progress in the social sectors as well as HIV and AIDS response. There is a gradual but consistent increase in the quality of comprehensive council health plans and achievements in implementation.

1.2 Status of the HIV and AIDS epidemic and the Health Sector Response

1.2.1 Disease Burden and Distribution

According to the Tanzania HIV/AIDS and Malaria Indicator Survey (THMIS) 2012, HIV prevalence among all adults aged 15-49 in Tanzania mainland has declined progressively from 7% in 2003/04 to 5.3% in 2011/12. The decrease has been more significant in men (from 6.3% to 3.9%) but not in women. There is a high regional variation of HIV prevalence ranging from 14.8% in Njombe, 9.1% in Iringa, 9.0% in Mbeya and 7.0 % in Ruvuma to 2.9% in Lindi, 2.9% in Dodoma, 2.4% in Tanga and 1.5% in Manyara.

The survey also established that the HIV burden is higher in individuals who are employed (6%) than among those who are not (3%) and higher in urban areas (7%) than rural areas (4%). The variation with regard to education was not consistent in women as it was in men. In men 15-49 years of age, HIV prevalence peaked in those who had completed primary school (7%) and was lowest among those with at least some secondary education (2%). However, HIV prevalence correlated positively with wealth and was lower in the lowest wealth quintile (3% in men and 5% in women) than in the highest wealth quintile (5% in male and 8% in female). In general, HIV prevalence is lower among people with secondary level education and above (3.4%), the less wealthy (3.9%), the unemployed (3.3%) and in rural populations (4.3%).

1.2.2 The Health sector response

The Ministry of Health and Social Welfare has led the national health sector response to HIV and AIDS since the epidemic broke out three decades ago. This began with a purely sectoral response in the Short Term Plan (STP) 1985-1986 and the first Medium Term Plan (MTP I) 1987-1991. Multisectoral participation was introduced in MTP II 1992-1996 and was enhanced in MTP III 1998-2002. In terms of coordination structures, the Task Force on AIDS established in 1985 was responsible for the STP that led to the establishment of the National AIDS Control Programme (NACP) in 1987 to oversee MTP I, MTP II and MTP III. A major milestone from that process was the formation of the Tanzania AIDS Commission (TACAIDS) in 2001 and the passing of the National AIDS Policy. TACAIDS took over the role of coordination, overseeing and guiding the multi-sectoral response while NACP remained with the responsibility of leading the health sector responses of the National Multi-sectoral Strategic Framework (NMSF).

While the first National HIV and AIDS Multi-Sectoral Framework (NMSF I) 2003 - 2007, and the current NMSF II 2007-2012 were developed to guide the multi-sectoral response, the health sector on the other hand, developed the Health Sector HIV and AIDS Strategy Plan I (HSHSP I) 2003-2006, followed by HSHSP II of 2008-2012. It should be noted that during both instances, the development of the health sector strategy started well in advance of the NMSF process giving little opportunity for the latter to properly guide the health sector response.

Another important milestone in the health sector response was in 2003 when the Government of Tanzania and its partners developed the National Care and Treatment Plan (NCTP) 2003-2008 to complement the Health Sector HIV/AIDS Strategic Plan (HSHSP I) 2003-2006. The NCTP became operational in 2004. The HSHSP II incorporated all interventions in the NCTP and so there was no need for a separate plan for care and treatment services. The thrust of the HSHSP II was to strengthen the already established interventions and scale up the respective services as part of the national multi-sectoral response to HIV and AIDS. Through the implementation of HSHSP II, the government aimed at achieving universal access for core health sector based HIV and AIDS interventions to all Tanzanians in need. It was also aimed at bringing core services provided in a friendlier environment to beneficiaries closer to the communities.

The theme of the HSHSP II was *“universal access to preventive, care, treatment and support services”*. This is in tandem with the bold approach of the NMSF II to HIV prevention including the scaling-up of HIV Counseling and Testing (HCT), Prevention of Mother to Child Transmission (PMTCT), the introduction of voluntary medical male circumcision (VMMC) for HIV prevention and the rapid expansion of Care and Treatment services..

In the context of elimination of mother-to-child HIV transmission (eMTCT), the MOHSW has developed a costed eMTCT national plan (2012 – 2015) to reduce new HIV infections in children from 26% to less

than 5%. Decentralised eMTCT plans have been developed in several high prevalence districts, with district-specific eMTCT targets and periodic monitoring of key indicators and a mechanism to identify bottlenecks and corrective actions. These plans should be reviewed and updated as needed in the context of the roll-out of Option B+.

The HSHSP III is tailored to respond and contribute to NMSF III 2013 -2017 developed by TACAIDS, to ensure the matching of needs and investment in HIV national response for the period 2013 –2017. HSHSP III therefore targets investments in interventions that will lead to the elimination of new HIV infections, the reduction of HIV related deaths and the elimination of stigma and discrimination against people living with HIV and AIDS (PLHIV). In this way, the health sector will be contributing to Tanzania's efforts in attaining the global goals summed-up in the three zeros as; "ZERO new HIV Infections, ZERO AIDS related Deaths and ZERO Stigma and Discrimination."

The HSHSP III is also closely aligned to the third health sector strategic plan (HSSP III) 2008-2015 whose headline is "partnership for delivering millennium development goals (MDGs)". The strategic objectives of the HSSP III are (i) to maximise the contribution of the health sector to HIV prevention, (ii) accelerate access and utilisation of HIV/AIDS care and treatment services, (iii) scale up integrated TB and HIV services and (iv) strengthen STI services and disease control. It is fortunate that a midterm review of HSSP III is being undertaken at the same time as the NMSF III and HSHSP III are being finalised. The new ideas in the health sector HIV response will therefore be incorporated in the remaining period of HSSP III or incorporated in the new strategy (HSSP IV) to be developed for the post-MDG era.

1.2.3 Health system structure and coordination in relation to HIV and AIDS

The health system in Tanzania is organised in three levels – national (central), regional and council (local government). The central level also includes the zones while the local government level is further subdivided into wards, villages, hamlets and households/family. The roles and responsibilities of each level with regard to health service delivery and utilisation are clearly described in the National Health Policy.

The organisation of health sector HIV and AIDS services is embedded within the existing health system structures. At the national level, NACP which is under the Directorate of Preventive Services is responsible for coordination and technical leadership of all health sector HIV and AIDS services. Other directorates and units of the MOHSW may support specific interventions such as workplace interventions, diagnostic services, blood safety and PMTCT but by and large respond to NACP's coordination role. The NACP on the other hand, is responsible to TACAIDS with regard to NMSF coordination.

At the regional level, the Regional Health Management Team (RHMT) is responsible for all health services in the region, including HIV and AIDS services (prevention, treatment, care and support) which are coordinated by the Regional AIDS Control Coordinator (RACC). The RACC is also responsible for the monitoring and evaluation (M&E) function related to HIV and AIDS. The RACC works closely with the Regional Reproductive and Child Health Services Coordinator (RRCHCo), the Regional Tuberculosis and Leprosy Coordinator (RTLCo) and the Regional Health Management Information Systems (HMIS) focal person. The structure at the council level is a mirror image of that at the regional level with the Council Health Management Team (CHMT) being responsible for all health services, including HIV and AIDS at the district council and community based services. The District AIDS Control Coordinator (DACC) works closely with the District Reproductive and Child Health Services Coordinator (DRCHCo), the District Tuberculosis and Leprosy Coordinator (DTLCo) and the Council Health Management Information Systems (CHMIS) focal person.

Local Government Authorities (LGAs) manage and coordinate all social services in the councils. This includes health and HIV services provided by health facilities (district hospitals, health centres and dispensaries) and community-based health services provided by community based organisations (CBOs) with support from LGAs and partners. In larger health facilities in urban centres, HIV and AIDS interventions such as HIV testing and counselling, care and treatment, outreach and blood safety are implemented by separate departments or units of the respective health facility, which may assign specific tasks to some of its health workers, for example the HIV Care and Treatment Clinic (CTC) coordinator or the Home based care (HBC) coordinator. In lower level health facilities, particularly in rural settings, available health personnel provide any and all services at different times and locations of the health facility.

1.3 National policies, legal frameworks and strategies that guide the HIV and AIDS response

The Health sector response to HIV and AIDS is guided by health sector specific and multisectoral HIV and AIDS policies, laws and strategic frameworks.

In the health sector, the National Health Policy (NHP) 2007, HSSP III and various health legislation and regulations will guide the MOHSW and its departments, agencies and private sector actors in implementing the HSHSP III. On the other hand, the National AIDS Policy 2001, the HIV and AIDS Prevention and Control Act (HAPCA), 2008 and NMSF III will guide the health sector response to national and international goals and commitment.

1.4 The Strategic Planning Process

Based on the experience of the process to develop the HSHSP II which solely depended on consultants, the NACP decided to adopt a participatory process that includes inputs of all key stakeholders in all stages of planning, the review of the current plan and the development of the new plan with facilitation by a small team of consultants.

A guiding team, a technical committee and a secretariat were formulated to guide and lead the process of the development of the HSHSP III. The planning process included a desk review, field visits, a stakeholders' review workshop and two HSHSP III writing workshops. The drafts compiled by the consultants were reviewed by NACP technical staff before circulation to other stakeholders for inputs and comments.

Section Two: Past Achievements in the Response

The NMSF III contains a detailed assessment of past achievements in the multisectoral and health sector response to HIV and AIDS. Also, the review report of the HSHSP II provides details of achievements in the targets set for the HSPSP II. The HSHSP III should be read together with these documents. To avoid repetition, only a summary of key achievements is provided below in order to bring into context the basis of the proposed outcomes, strategies, indicators and targets of HSHSP III.

2.1 Evolution of the Health Sector Response

By the end of the HSHSP I, achievements that had been realized till then provided a solid foundation on which subsequent strategies could build upon. Among the key features of this foundation are significant developments in the way the AIDS epidemic was being managed and controlled particularly in terms of allocation of Government own resources and other strategic interventions aimed at furthering existing efforts including expanded care and treatment, increased availability of condoms and other services such as counseling and testing which were expanded to community and household level. The epidemic was also being monitored in a more systematic manner and the data used to inform strategic direction.

HSHSP II (2008-2012) was designed to address some of the key gaps around access to services, the quality of services being provided and the sustainability of the said services. Other requirements included further increases in government spending and the forging of rigorous partnerships with development partners and other actors on the ground. Capitalizing on the health sector's comparative advantage in form of the existing health services delivery system, the HSHSP II hinged on the goal of providing *"universal access to preventive, care, treatment and support services"* to bring core HIV and AIDS services closer to the communities, making them more client-friendly and strengthening the capacity of the health system to deliver quality services. These services were integrated into routine health services at all levels as a means to deal with the challenges posed by severe shortages of Human Resources for Health (HRH) while at the same time creating a favourable environment for the prevention of new infections and the provision of appropriate treatment, care and support to all those in need.

The main ingredient required for the success of the HSHSP II was a mass of properly trained HRH to complement efforts of the existing ones whose workloads had already been extended to the maximum, to deal with the increased demand for services resulting from the various interventions that had been introduced thus far. The Human Resources for Health Strategic Plan (HRHSP) 2008-2013 was developed by the MOHSW to tackle the HRH crisis in the context of the National Five-Year Development Plan and HSPSP III. In addition to increasing the production of HRH and improving their deployment (especially to underserved areas), the HRH strategic plan also addressed issues around performance management and the reward system. HSHSP II therefore addressed only HIV specific in service training for existing health care workers.

2.2 Achievements in Key Thematic Areas of HSHSP II

Among the achievements that were realized during the HSHSP II were improvements in the general health status of PLHIV. This was a result of the introduction of antiretroviral therapy (ART), coupled with increased capacity of the health sector to manage the epidemic by providing improved HIV care, treatment and support to PLHIV. Also, the health sector improved its systems and infrastructure to support the implementation of HIV/AIDS activities in terms of diagnostics and logistics and the general management of the epidemic. Another strategic intervention which escalated prevention and control efforts even further was the integration of services to increase efficiency. Collaborative TB/HIV services and the integration of HIV and AIDS services in Reproductive and Child Health (RCH) services are

some good examples of such efforts. Apart from the integration of services, strong linkages between programs have evolved to ensure a continuum of care within health facilities and from the health facility to the community. Examples of such linkages can be seen in PMTCT, paediatrics care and Home Based Care.

The implementation of the HSPSP II resulted into stronger partnerships between the Government and development partners following the establishment of Development Partners Groups (DPGs) for AIDS and health (DPG-AIDS and DPG-Health), bilateral programs such as the President's Emergency Fund for AIDS Relief (PEPFAR) and multilateral support through the Global Fund, the World Health Organisation (WHO) and other UN programs. At the implementation level, the public, private partnerships (PPP) approach increased the potential for success as it facilitated resource sharing and complementarity of activities. There has also been stronger partnership between the providers of services and the target communities including PLHIV.

2.2.1 Prevention

The Prevention thematic area saw achievements in the prevention of new infections through focused HIV/AIDS awareness (modes and symptoms) implemented through the scale up of the PMTCT programme including related treatment services. Control of sexual transmission of HIV was enhanced by focusing on raising awareness on risky sexual behaviour including casual sexual encounters, PWID, Female Sex Workers (FSW), Men who have Sex with Men (MSM) on the one hand and alcohol use and abuse on the other. Furthermore promotion of consistent use of condoms while finding ways to deal with challenges of inconsistent availability was addressed through mainstreaming national level condom programming. Blood safety was another area that received a boost during the HSHSP II, whose implementation aimed at improving prevention efforts in health care settings but also helped to deal with issues related to stigma among voluntary blood donors. And finally, evidence based programs such as Voluntary Medical Male Circumcision (VMMC), Positive Health Dignity and Prevention (PHDP) and workplace interventions, all of which aimed at furthering prevention efforts, were strategically scaled up using different entry points and promoting complementary interventions such as male involvement, couple counselling, health facility deliveries and positive prevention to prevent the further spread of HIV infection by PLHIVs and their re-infection.

2.2.2 Care, treatment and support

The main focus of the care, treatment and support thematic area was to strengthen and scale up comprehensive care and treatment services in public and private facilities through facility based, community based and TB/HIV collaborative activities with a focus on quality improvement. Achievements at the end of the HSHSP II include, among others, the setting up of systems for ART services, the provision of services to deal with TB/HIV co-infection at facility level; strengthened and scaled up comprehensive services for PLHIVs including ART for children; and improved Home Based Care (HBC) services to ensure a continuum of care for HIV/AIDS-related services using a standard package of HBC services in all councils with strengthened linkages and referrals between the community and health facilities.

2.2.3 Cross cutting Achievements

Under the HSHSP II, cross-cutting issues included the following: laboratory services that were made available and strengthened at all levels to support other interventions namely, prevention, care, treatment and others e.g. STIs; HIV testing and counseling to improve access and use of services; improved information, education and communication (IEC), behaviour change communication (BCC) and stigma reduction through the provision of information and other evidence-based innovative approaches, e.g. training on particular aspects; and condom programming to strengthen the promotion, availability, accessibility and use of condoms.

Areas that improved significantly in this thematic area include laboratory infrastructure and equipment which in turn led to improvements in diagnostics including early infant diagnosis (EID), logistics for reagents and supplies, the monitoring of drug resistance, national laboratory quality assurance and equipment maintenance and procurement. Interventions aimed at improving supply management led to improved tracking and feedback with regard to selection, quantification, logistics management and the accompanying management information system (LMIS). Other achievements were realized through the introduction of centralized storage and the distribution of commodities and supplies through the Medical Stores Department (MSD), quality assurance, more strategic financing of interventions, Human Resource Management (HRM), rational use of drugs particularly through improved prescription practices, counseling and testing, IEC and SBCC aimed at stigma reduction and condom promotion.

2.2.4 Health systems strengthening

The main components under the health systems strengthening thematic area were planning and programme management. Improvements in national planning and programme management aimed at strengthening capacities for planning, resource allocation and utilisation, implementation and monitoring of all interventions at all levels, quality improvement, improved documentation and dissemination of best practices. National Quality Improvement Guidelines and Supportive Supervision and Mentoring Manual and Tools for HIV and AIDS services were developed to inject the quality improvement concept into service provision. Also, as part of improved programme management, there were improvements in the procurement function, supply management and pharmacovigilance systems for medicines (STI, HIV/AIDS), diagnostics and other commodities. MSD capacity and response to needs and requirements of its customers also improved. Human Resources for Health were developed to ensure comprehensive and strengthened HIV and AIDS responses at all levels of care. There were also improvements in the management of Strategic Information (SI) through rigorous M&E, biological and behavioural surveillance of STIs, HIV and AIDS; and HIV, STI and the monitoring of TB drug resistance and side effects including drugs for the treatment of opportunistic infections (OIs). Last but not least, the HSHSP II saw more vigorous prioritization of STI, HIV and AIDS research as outlined in the **National Health Sector HIV and AIDS Research and Evaluation Agenda 2010-2015**. Research undertaken has created a better understanding of the driving forces of the HIV epidemic. This new knowledge has been used in consequent planning process for different interventions initiated and implemented by NACP's implementing partners and the development processes for this strategic plan.

Section Three: HSHSP III Strategy Description

3.1 Introduction

This Third Health Sector HIV and AIDS Strategic Plan 2013-2017 (HSHSP III) is guided by the third National Multisectoral Strategic Framework for HIV and AIDS 2013-2017 (NMSF III) and the Third Health Sector Strategic Plan July 2008-June 2015 (HSSP III). The HSHSP III guides the health sector contribution towards achieving the aims of Vision 2025, the National Strategy for Growth and Reduction of Poverty (NSGRP III or MKUKUTA III) and the Five year Development Plan (FYDP) 2011/12-2015/16. Specifically, the HSHSP III provides the context for the development of HIV and AIDS annual operational plans and budgets that are reflected in the Medium Term Expenditure Framework (MTEF) of the Ministry of Health and Social Welfare and the Prime Minister's Office Regional Administration and Local Government (PMORALG), Regional Health Plans (RHP) of all regions and Comprehensive Council Health Plans (CCHP) of all Local Government Authorities (LGAs) in Tanzania. It is also in line with the regional HIV agenda and targets set by regional bodies including Southern African Development Cooperation (SADC) and the East African Community (EAC). It therefore guides the actions of all public, faith-based and private organisations in the health sector as they respond to the HIV and AIDS pandemic.

As guided by the NMSF III's ambitious targets for the elimination of new HIV infections, HIV-related deaths, and HIV stigma and discrimination aimed at improving the quality of life for all Tanzanians, the HSHSP III embraces strategies that invest in high impact interventions that will contribute towards the realisation of these targets. It sets specific health sector targets that contribute to the NMSF targets. In cases where the health sector is the sole actor, the targets in the HSHSP III are the same as those in the NMSF III. In this case, interventions in the health sector will contribute towards the achievement of the overarching impact results of the NMSF III Strategic Results Framework, namely:

- i) Elimination of new HIV infections (ZERO new infections)
- ii) Reduction of HIV related deaths (ZERO HIV related deaths)
- iii) Elimination of HIV related stigma and discrimination (ZERO Stigma and Discrimination)

3.2 National Vision and Health Sector Mission and Goals

The mission and goals of the health sector HIV/AIDS response are guided by NMSF III and HSHSP III. This means that the vision of the health sector is the same as the national vision, its mission contributes to the mission of the NMSF and its goals take into consideration the role of the health sector as defined in the National Health Policy and priorities of HSSP III.

3.2.1 Vision

An HIV free society where new infections are halted and those infected and affected by HIV and AIDS receive quality services.

3.2.2. Mission

To lead and guide the health sector in the intensification, optimisation and scaling up of quality HIV and AIDS prevention, care and treatment services to facilitate the attainment of the three Zeros.

3.2.3 Goals

- ♦ To achieve universal access to comprehensive HIV prevention, treatment, care and support services in order to significantly minimise the transmission of new HIV infections and reduce

- ♦ HIV-related mortality, stigma and discrimination
- ♦ To strengthen the capacity of the health system to support quality HIV and AIDS interventions and foster integration within the health sector

3.3 Key Principles

The key principles that will guide this strategy are based on the desire to move towards more results-based planning and management and will focus on the following:

3.3.1 Equity

Equity in access to health services aims to address unnecessary, avoidable and unfair differences in health status. The strategy takes into consideration equity-motivated interventions that seek to allocate resources preferentially to people with the worst health status or largest disease burden. This requires increased understanding and the need to influence the redistribution of resources for health.

3.3.2 Universal Access

Universal health access (or coverage) aspires at providing a specified package of health benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. This is more critical for HIV and AIDS services where the impact is greatest in the poorest segment of the population. To achieve this, the health sector will require a strong, efficient and well-run health system; a system for financing health services; access to essential medicines and technologies; and sufficient human resource capacity in the form of well-trained, motivated health workers. This strategy depends on the success of other health sector initiatives/strategies such as the HRH Strategy, the Health Financing Strategy (HFS) and the National Pharmaceutical Master Plan (NPM).

3.3.3 Gender and rights-based approach

While more women than men are seen to access HIV testing and ART services, they are on the other hand disproportionately affected by HIV and AIDS as well as other social determinants for health (higher prevalence, incidence, poverty, low education), which in turn is compounded by gender-based discrimination and violence. As guided by the NMSF III, interventions in the health sector strategy promote alignment with the "Medical Management Guidelines of Gender – Gender Based Violence (GBV) and Child Abuse."

3.3.4 Decentralisation

Continued devolution of resources and key responsibilities, including planning, organization, coordination and control of service delivery to local government authorities, health facilities and community based organisations from the centre to the districts and hospitals where health services are provided.

3.3.5 Integration

In order to leverage scarce resources and to deliver value for money and enhance sustainable quality services, Health Sector HIV and AIDS services must be integrated into shared health care delivery infrastructure so that resources (human, financial and material) and facilities are used wisely to reap economies of scale. The strategy provides for increased integration of HIV and AIDS services in the general health care system especially at the service delivery levels and health system interventions.

3.3.6 Public Private Partnership (PPP)

The Strategy promotes partnership with all stakeholders, taking full advantage of the synergies provided by each stakeholder group. In the past, the Government had not aggressively pursued PPP in health care delivery. This was due to inadequate supportive policies, infrastructure as well as human capital and skills gaps coupled with the hangover of central planning policies that made the government the sole provider and financier of health services. The development of the national PPP policy, health sector PPP strategy and recognition of PPP as a key success factor for the five year development plan 2011-2016 has changed all that. Currently, the health sector HIV and AIDS strategy promotes PPP in all aspects including financing, implementation and progress monitoring.

3.3.7 Meaningful Involvement of people living with HIV

The health sector recognises the important role that can be played by PLHIVs and has strived to ensure their involvement early in the process i.e. from the review process of the previous strategy to development of this strategy. The interventions in the current strategy provide for meaningful involvement of PLHIVs in all the implementation and monitoring of the health sector response. All actors at sub-national level, including local government authorities, health facilities (both public, faith based and private) are expected to adhere to this guiding principle.

3.3.8 Accountability

Strong, accountable and effective leadership at all levels of the healthcare delivery system is critical for the efficient implementation of this strategic plan. The strategy provides structures to ensure accountability to government, funding partners and the communities served in terms of resource utilisation, service provision and health outcomes achieved at all levels of the health sector. This will ensure that all actors are doing the right thing the right way.

3.3.9 Quality

Quality will be ensured by working according to specific standards and guidelines aimed at improving the health status of individuals and communities. Specifically, the MOHSW will work towards increasing HIV preventive measures, reducing suffering due to AIDS and increasing client satisfaction, while ensuring that services rendered are effective and efficient. The focus on quality will further be enhanced and centred on evidence-based medicine and rational public health decision making.

3.3.10 Sustainability

The strategy prioritises sustainability of interventions, results and outcomes with a focus on approaches for financing HIV and AIDS services, management of financial, material and human resources, community ownership, organizational development, service availability, coverage, and accountability to ensure the efficiency, efficacy and effectiveness of health sector HIV and AIDS interventions.

3.4 Over-arching Impact Results

The NMSF III has adopted the three long-term impact results of ZERO New HIV Infections, ZERO HIV Related Deaths and ZERO HIV Related Stigma and Discrimination (known as the three ZEROs). NMSF III has also identified four strategic areas of primary investment, four supportive areas of secondary investment, and four cross-cutting programmatic principles to lead the nation towards the three ZEROs.

The health sector HIV and AIDS response identifies three impact results, namely;

1. Elimination of new HIV Infections
2. Reduction of HIV Related Deaths
3. Elimination of HIV Related Stigma and Discrimination in health care settings

Strategies that will contribute towards the achievement of the overarching impact results mentioned earlier are organised in three groups as follows:

1. Optimising HIV prevention, treatment, care and support
2. Building smart, strong and sustainable systems to support health sector HIV/AIDS response
3. Making smart and innovative investments

HSHSP III has also identifies specific, measureable, achievable, realistic and time-bound (SMART) indicators and targets to be used in monitoring and evaluating the outcomes related to these strategies.

Section Four: Health Sector HIV and AIDS Strategic Result Areas

Overview

The HSHSP III translates the overarching impact results of the three ZEROs into health sector specific impact goals. Below is a description of the health sector impact goals including how they link with the NMSF, impact results for each goal, the respective strategic result areas and outcome results, priority strategies, indicators and targets.

4.1 Elimination of New HIV Infections

The goal of eliminating new HIV infections is based on evidence that HIV transmission can be eliminated using combined biomedical, behavioural and structural interventions applied in accordance with the epidemiologic and demographic profile and needs of those most at risk. To reach a significant and sustained reduction in the number of new HIV infections, Tanzania will adopt a more focused response, scaling up combined programmatic approaches that address both short and long term impacts and both immediate risks and underlying causes of risk.

Also, while programs supporting HIV testing, condoms, early initiation of antiretroviral therapy, STI management, and VMMC will continue to be strengthened, awareness programs will be realigned to address the social and behaviour change required to adopt safer behaviours and to create demand for appropriate services. During the implementation of the HSHSP III, services for key populations will also be initiated and/or scaled up in target locations.

Impact Result: HIV incidence rate of less than 0.16% by 2017

4.1.1 HIV Testing and Counseling (HTC)

Current Situation

There coverage and utilization of HIV testing and counseling services has continued to expand during the implementation of HSHSP II. By 2012 the percentage of women and men aged 15-49 who had ever been tested for HIV and received their test results was 62% for women and 47% for men respectively (THMIS 2011-2012). However, in the 12 months before the survey, only 30% of women and 27% of men had been tested and received the results (THMIS 2012). Only 39% females and 25% males aged 15-24 years who had sexual intercourse in the past 12 months were tested for HIV in 2010 (TDHS 2010). Furthermore, among the 3,000 couples who were tested for HIV, 5% were sero discordant (THMIS 2011-12). During the implementation of HSHSP II a number of HTC approaches were developed including Client Initiated Testing and Counselling (CITC), Provider Initiated Testing and Counselling (PITC) in the clinical setting as part of medical care and Home Based Counseling and Testing (HBCT).

Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers opportunity for PLHIVs to receive information and commodities to prevent HIV transmission to others. Despite HTC being integrated in other services, effective referral linkages between the various points of diagnosis (VCT, PITC, PMTCT, EID, TB/HIV, STI, VMMC) with care, treatment and support services need to be strengthened.

Studies have shown that community-based approaches provide HTC for more people testing for the first time and diagnose adults with relatively higher CD4 counts exceeding 350 cells/mm³. As such this will facilitate the implementation of national guidelines that aim at enrolling PHLIVs early on treatment.

The scaling up of HTC is both public health and human right imperative and must be linked to achieve universal access to comprehensive HIV prevention, treatment care and support. Also, while it is important to get more people tested and successfully referred to prevention, treatment and care services, it is vital that the pace of scale-up does not compromise quality. Meanwhile, the Government will continue to scale up the harm reduction and rehabilitation programme including Medically/Methadone Assisted Therapy (MAT) and needle exchange programme.

Outcome:

80% of women and 65% of men aged 15-49 years know their HIV serostatus and 50% are tested as couples by 2017.

Priority Strategies:

- Scale up diverse innovative approaches for quality HTC with special focus on couples, adolescents, youth, people with disabilities (PWDs) and key populations
- Strengthen risk reduction communication during counseling, encourage repeat HIV testing for HIV negative individuals and other approaches with a special focus on youth, couples, PWDs, and key populations
- Advocate for political leadership and commitment at all levels to support advocacy campaigns for the allocation of sufficient resources for HTC services
- Scale up epidemiologically targeted community-based HIV testing and counseling with linkage to prevention, care and treatment services in addition to provider-initiated testing and counseling
- Strengthen cross-referral systems and mechanisms within the continuum of care for those who test HIV positive to ensure easier access to services
- Strengthen PLHIV and key populations networks to support HTC demand creation and proactive linkage of HIV positive clients to care, treatment and support services
- Promote couple HTC and ensure that discordant couples are linked to appropriate HIV prevention, treatment, care and support services
- Promote PITC among children below 15yrs to ensure early diagnosis for children and linking them to care and treatment

Indicators:

1. Proportion of women and men aged 15-49 years who have ever tested for HIV and know their results (NMSF, THMIS, UNGASS)
2. Proportion of women and men aged 15-49 years who have tested for HIV in the past 12 months and know their results (NMSF, THMIS)
3. Proportion of individuals who test for HIV as couples (PEPFAR)
4. Proportion of individuals (all ages, including children) tested for HIV, know their results and linked to appropriate services
5. Proportion of health facilities providing quality HIV testing and counselling services according to national standards
6. Proportion of men and women 15-25 years who go for repeat testing after receiving a HIV negative result (sample survey in sentinel panel of districts - SPD)

Targets:

- 70% of women and men aged 15-49 years who have ever tested for HIV and know their results by 2017
- 50% of women and men aged 15-49 years who have tested for HIV in the past 12 months and know their results by 2017
- 50% of individuals test for HIV as couples by 2017
- 100% of individuals (all ages, including children) who received HIV Testing and Counselling (HTC) services, know their status and linked to appropriate services by 2017
- 75% of health facilities are providing quality HTC services according to national standards by 2017
- 50% of men and women aged 15-25 years with a HIV negative results go for a repeat HIV testing (in SPDs) at least once a year by 2017

4.1.2 Condom Programming

When male and female condoms are used correctly and consistently, they can play a significant role in the prevention of HIV and other STIs. However, the provision of free and subsidized condoms to people in need of them continues to be hindered by multiple challenges. Availability of condoms is still limited in Tanzania as there is a constant shortage of free condoms especially in rural areas. Unavailability of female condoms in commercial outlets has also been identified as one of the factors contributing to low knowledge levels of female condoms. Condom use is still considered by some to be a marker of promiscuity and irresponsible behaviour and there are many myths and misconceptions and concerns around their quality and effectiveness.

Condom use is a sensitive issue within most communities in Tanzania. Outlet owners do not feel comfortable selling condoms to people – for whom they think condom use is inappropriate, such as youth and some women. Married couples, particularly those who are discordant or those who are both HIV positive might feel the same way (NMSF, 2012). Although 69% of women and 77 % of men among the adult population know that the chance of contracting HIV is reduced through condom use, only 27% of both women and men who had more than one sexual partner in the past 12 months reported using a condom during their last sexual encounter (THMIS, 2012). Use of a condom during risky sex remained stable (56%) among sexually active PWIDs aged 15-24 years (TDHS, 2010, THMIS 2012). There is a need to vigorously revamp promotional efforts aimed at increasing condom use across the board for all sexually active populations.

The distribution of public sector condoms is currently limited to health facilities in such a way that in order to receive free condoms one has to go in person to the health facility during the day. There is a need to ensure comprehensive condom programming is implemented at scale through sound leadership at the national level and targeted distribution to key population. Meanwhile, there is a need to enhance efforts to create and sustain demand while ensuring an adequate supply of high quality condoms and advocate for sustainability of the outcomes of the intervention.

Outcome:

Increased utilization of condoms during high-risk sex among women and men aged between 15-49 years.

Priority Strategies:

- Strengthen leadership by coordination of partnerships, advocacy and resource mobilization for improved comprehensive condom programming
- Strengthen demand creation, access and utilization of condoms through coordination of

public-private partnerships for promotion and distribution of condoms (increasing rural access and targeted distribution of public sector condoms)

- Strengthen condom procurement and quality assurance as well as logistic management information systems
- Expand distribution networks for public sector condoms to include non-health facility access
- Establish M& E system on condoms including related social, behavioural and utilization research

Indicators:

1. Percent of women and men aged 15-19 and 20-24 who had high-risk sex in the past 12 months who reported using a condom
2. Proportion of women and men aged 15-19, 20-24, 25-49 with multiple sexual partners reporting condom use during their last sexual encounter
3. Number of targeted condom service outlets

Targets

- Increase the percentage of women and men aged 15-49 who reported having used a condom during high-risk sex in the past 12 months from 54.6% and 56.8% to 70% by 2017 among women and men respectively
- Increase the percentage of women and men aged 15-49 with multiple sexual partners reporting condom use during their last sexual encounter from 27.3% to 50% among women and 26.8% to 50% among men by 2017
- Increase the number of targeted condom service outlets at commercial rural outlets from 48% to 65%, at hotspots from 87% to 95% and to at least 70% through community based distribution outlets by 2017

4.1.3 Social and Behaviour Change Communication (SBCC)

Current Situation

For the past twenty five years, the health sector in Tanzania has focussed on creating public awareness on HIV and AIDS as well as providing services for prevention, care, treatment and support. Recently, educational programmes on HIV and AIDS through mass media have reached 48 percent men and 62 percent women among the adult population (THMIS, 2012). These efforts have undoubtedly resulted in raised levels of HIV and AIDS general knowledge/awareness to over 90% (almost 100%) in the adult population (DHS, 2010; THMIS, 2012). There is also a modest but statistically significant decline in the trend of HIV prevalence among the adult population from 7% in 2004 to 5% in 2012 (THMIS, 2012) and specifically among men, some of which might be attributed to the effect of SBCC interventions.

Knowledge of HIV status helps HIV-negative individuals make specific decisions to reduce risk and increase safe sex practices so that they can remain disease free. For those who are HIV infected, knowledge of their status allows them to take action to protect their sexual partners, access treatment, and plan for the future. However, the level of comprehensive knowledge on HIV and AIDS is still low among the adult population; standing at 50% and 42 % among men and women respectively (THMIS, 2012). On the other hand, knowledge of where to get an HIV test is high and shows an increasing trend. That notwithstanding, a significant proportion of women (33%) and men (50%) have never been tested. However, there are mixed results suggesting that HIV and AIDS related knowledge does not necessarily result to behaviour change. For example, despite knowledge that concurrent sexual partnerships are among the key drivers of HIV transmission, a comparison of results from the 2011-12 THMIS with those from the 2007-08 THMIS reveals a slight increase in the proportion of men and women having more than one sexual partner (for men, 21% and 18%, respectively; for women, 4% and 3% respectively)

and among them only 27% of both men and women reported to have used a condom during their last sexual encounter.(THMIS, 2012). Reported early sexual debut among young people, which exposes them to the risk of early pregnancy and STIs including HIV is low with 9% of young women and 10 % of young men aged 15-24 report having had sex before age 15 (THMIS, 2012).

There are social, cultural and economic issues which expose individuals to high risk behaviours that predispose them to HIV infection, however according to the situation analysis on HIV and AIDS communications in the health sector, it was revealed that implementers did not use formative research methods to identify communication issues to be addressed(NACP, 2010). It has also been noted that public awareness of some of the core interventions is low and myths and misconceptions still persist.

Specific evidence-based Social Behaviour Change Communication interventions which emphasise increasing the adaptation of safer sexual behaviour and reduction of risk taking behaviour with a focus on multiple partnerships, transactional sex, early sexual debut, condom use during high risk sex, and increasing the uptake of HIV testing services can be of great use if such interventions are delivered to the appropriate population in combination with other evidence-based HIV prevention and care services.

Outcomes:

- Increased adoption of safer sexual practices (reduced risk behaviours), increased healthier behaviours and increased uptake of comprehensive HIV and AIDS services (prevention, treatment, care and support)

Priority Strategies:

1. Strengthen demand creation and promotion of comprehensive services for HIV and AIDS prevention, treatment, care and support
2. Promote evidence based and targeted behaviour change communication interventions for youth, key populations and Most Vulnerable Children (MVCs) including their providers/care takers
3. Strengthen strategic comprehensive HIV and AIDS behavioural and social science operational research
4. Engage communities to address social norms that pose barriers to the uptake of HIV and AIDS services and protective behaviours
5. Promote youth and key population friendly HIV and AIDS services
6. Promote effective parent-child communication on issues regarding HIV and reproductive health
7. Establish an M&E system for behaviour change communication programs and promote the coordination and sharing of best practices among implementers of SBCC

Indicators:

- Proportion of women and men aged 15-19, 20-24 and 15-49 with comprehensive knowledge on HIV
- Percentage of women and men 15-24 who had sexual intercourse before the age 15
- Percentage of women and men aged 15-19, 20-24 and 15-49 who have had sexual intercourse with more than one partner in the past 12 months

Targets:

- 80% of women and men aged 15-19, 20-24 and 25-49 have comprehensive knowledge on HIV by 2017
- Early sexual debut (i.e. before the age of 15) reduced to 6% among women and 7% among men by 2017

- Multiple and concurrent sexual encounters among women and men aged 15-49 in the past 12 months reduced to 2% among women and 10% among men by 2017

4.1.4 Sexually Transmitted Infections and Malignancies

Current Situation

The coverage of STI services had increased to all hospitals, all health centres and 72% of dispensaries. However, the prevalence of untreated STIs is still high. About 4% of sexually active men and 3% of women indicated that they had recently had symptoms of STIs, but out of these only 50% of women and 62% of men sought treatment from a qualified health care provider (*THMIS 2012*). Surveillance of HIV and Syphilis infection among women attending Antenatal services indicates an overall syphilis sero-prevalence of 4.2% in 2008 (Surveillance of HIV and Syphilis infections among antenatal clinic attendees 2008).

Prevailing challenges in the management of STIs in Tanzania include inappropriate diagnosis, poor clinical management and over-the-counter or self-medication using antibiotics for STIs. A survey conducted at health facility level by NACP in 2005 showed that 67.2% of service providers made the correct choice of drugs, dosage and duration of treatment for their STI clients. HIV prevalence among women and men with a recent history of STIs was 6.1% for men and 13.5% for women, which confirms the link between STIs and HIV (*THMIS 2012*).

Efforts to scale up STI treatment and screening at ANC have contributed to increased availability of services. However, inadequate and irregular supply of syphilis test kits, drugs and other medical supplies hinder the provision of STI services to ANC attendees and their spouses and/or sexual partners.

STI services need to be strengthened with an integrated and comprehensive data recording and reporting system. There is also a need to prioritize quality assurance with regular microbial sensitivity studies and supportive supervision. Some sexually transmitted infections e.g. Human Papilloma virus predisposes women to cervical cancer. Hence, in HSHSP III, prevention, early detection and treatment of cervical cancer among women of reproductive age will be included as part and parcel of STI services in line with the National Cervical Cancer Prevention and Control Strategic Plan (2011-2015). One approach is to expand the provision of diagnostic and secondary prevention of cervical cancer using visual inspection with acetic acid (VIA) and treatment with cryotherapy and Loop Electrosurgical Excision Procedure (LEEP).

Outcome:

- STI infection rate among men and women reporting to have an STI and Prevalence of syphilis among Ante Natal Clinic attendees reduced by 50% (to 2%, 1.5% and 2.1%, respectively) by 2017

Priority Strategies:

1. Expand the coverage and quality of STI services in all public and private health facilities and targeted community outreach services
2. Strengthen surveillance anti-microbial susceptibility of common STI pathogens
3. Promote targeted and outreach services for key populations including sex workers and clients, Men who have Sex with Men (MSM), People Who Inject Drugs (PWIDs), and other vulnerable groups such as prisoners, mobile groups most at risk and in areas regarded as 'hotspots'.
4. Enhance partner notification, access to and use of STI services provided at health facilities and/or by qualified health personnel
5. Provide and promote consistent male and female condom use to STI clients

6. Strengthen prevention, early detection and treatment of cervical cancer among women of reproductive age using HPV vaccine, visual inspection with acetic acid (VIA) and treatment with cryotherapy and LEEP.
7. Strengthen data recording and reporting system

Indicators:

1. Prevalence of syphilis among pregnant women
2. Number of client with STI/RTI presenting at health facilities disaggregated by age and sex
3. Number of clients with symptoms of STI and Reproductive Tract Infection (RTI) presenting at health facilities disaggregated by age and sex
4. Percentage of clients reporting symptoms of STIs in the last 12 months who sought care at a service provider with personnel trained in STI care (THMIS)
5. Percentage of antenatal care attendees screened and treated for syphilis at first antenatal care visit
6. Number of women of the reproductive age group screened for cervical cancer due to Human Papilloma Virus using visual inspection with acetic acid (VIA)
7. Number of regional referral and district hospitals that have onsite site services for secondary prevention of cervical cancer using visual inspection with acetic acid (VIA) and treatment with cryotherapy and LEEP.

Targets:

- 50% reduction in prevalence of syphilis among Ante Natal Clinic attendees (to 2.1%) by 2017
- 50% reduction of STI infection rate among men and women reporting to have an STI (to 2% in men and to 1.5% in women) by 2017
- 90% of STI patients attending health care are appropriately diagnosed, treated and counselled according to the national guidelines by 2017
- 70% clients reporting symptoms of STI seek care in health facilities by 2017
- 100% of first visit ANC attendees receive routine syphilis screening and management to by in 2017
- 80% of women of reproductive age screened for cervical cancer using VIA by 2017
- 80% of health facilities offering both screening and early treatment services for the prevention of cervical cancer using visual inspection with acetic acid (VIA) and treatment with cryotherapy and LEEP.

4.1.5 Targeted Youth Services

Current situation

A high percentage of adolescents are sexually active and practice unsafe sex. Consequently, the majority of them are highly vulnerable to Sexual Reproductive Health (SRH) problems that include adolescent pregnancies and early child bearing, the complications arising from unsafe abortion and STIs including HIV/AIDS. Moreover, knowledge on contraceptives for pregnancy prevention is generally low among young people. The current use of contraceptive methods among sexually active young people is only twelve percent (12%).

HIV and AIDS pandemic is posing a threat to young people. HIV infection among women increases with age. While the HIV prevalence among men and women in the age group 15-19 years is 1.3% and 0.8% respectively, the percentage of women aged 20-24 infected with HIV is higher (4.4%) than that of men (1.7%) in the same age group. Also, young people face gender inequality and inequity leading to gender based violence which puts them in a compromising situation. Results from the 2011

Violence against Children (VAC) Survey show that nearly one out of three females and one out of seven males in Tanzania have experienced some form of sexual violence prior to the age of eighteen. The results further demonstrate that childhood sexual violence is associated with sexual risk-taking in adolescence and adulthood, including engaging in transactional sex, multiple sexual partners, sex with casual partners, substance abuse before or during sexual encounters, and no or infrequent use of condoms, leading to increased risk of acquiring HIV.

On average, young women begin to have sex at about age 18 while young men start having sex at about age 20. Among young women aged 15-24 years, 13% had sex by age 15 compared to 7% of young men in the same age group. 68% of young women and 65% of young men aged 15-24 know that using condoms and limiting sexual intercourse to one uninfected partner reduces the risk of contracting HIV. 18% of young women and 4% of young men aged 15-19 are married and 60% of unmarried young women and 52% of unmarried young men aged 15-24 have never had sexual intercourse.

Access to adolescent friendly reproductive health services (AFRHS) is still a major challenge in Tanzania. A study conducted by UMATI in 2008 showed that only 30 % of service delivery points (SDPs) in the country meet the national standards for AFRHS. At the time of the study, 60 percent of health care providers had not received orientation on the provision of information and counseling to adolescents and only 11 percent had been trained on adolescents' sexual and reproductive health rights and AFRHS. Moreover, less than 40 % of the SDPs had IEC materials for adolescents and only about 39 percent were in possession of guidelines and procedures for serving adolescents. The study further showed that only 16 percent of SDPs had designated areas for adolescents and 52 percent had no information management system for adolescent health. About 47.8 percent used special registers to capture information on adolescents, 34 percent used HMIS tools (MTUHA) and 13 percent used special forms.

As a result, the Government through the MOSHW has developed and is implementing standards for adolescent-friendly reproductive health services in all health settings. The MOHSW is also contributing towards the reduction of GBV and VAC in selected high prevalence regions.

Outcome: 75% adolescents and youth aged 10 – 24 years access and utilize STI/RTI/HIV/AIDS and RH services and have access to proper information.

Priority Strategies:

- Increase access to and utilization of integrated quality reproductive health services by adolescents
- Expand coverage of ASRH friendly services and the quality of STI services in all public and private health facilities
- Increase access to HIV services to adolescents with referral pathways for suspected abuse, violence, exploitation or neglect

Indicators:

1. Proportion of services delivery point providing ASRH friendly services
2. Proportion of health care workers trained on ASRH
3. Number of adolescents receiving ASRH-HIV services

Targets:

- Number of health facilities providing adolescent friendly services increased from 30% to 80% by 2017

- HIV prevalence among women and men aged 15-19 and 15-24 years reduced from 1% to 0.8% and 3.2% to 2.2% respectively by 2017
- Number of service providers trained on adolescent reproductive health (ARH) increased by 50% in 2017

4.1.6 Voluntary Medical Male Circumcision (VMMC)

Current Situation

The prevalence of male circumcision (MC) among males aged 15-49 years is 72% with considerable variation between regions (THMIS 2012). Ecological comparisons have shown a pattern of lower HIV prevalence in areas where circumcision is a common practice than in areas where it is not commonly done. Since evidence suggests that MC can reduce HIV transmission by up to 60%, the government of Tanzania has prioritized and is scaling up VMMC in twelve regions (Geita, Iringa, Kagera, Katavi, Mara, Mbeya, Mwanza, Njombe, Rukwa, Shinyanga, Simiyu and Tabora). VMMC has been reasonably accepted especially among boys in the targeted regions and it has been noted that VMMC campaigns are more successful when they are conducted during the dry season and at times that are convenient to adults. VMMC also provides an important opportunity for HIV counselling and testing and as an entry point for access to early HIV care and treatment services by males. It could also serve as an entry point to recruit voluntary non-remunerated regular blood donors and is a gateway to reach adolescents which form a large segment of the male population, with broader HIV prevention and health needs among young men who don't often interact with health services. In this regard, HIV-negative males aged 10-34 years are given priority for free comprehensive VMMC services as an HIV prevention strategy.

VMMC services were introduced in year 2010 and by December 2012, in the twelve regions undertaking VMMC, 611 service providers were trained and over 400,000 (14%) men were provided with the comprehensive VMMC package. At the same time, VMMC services have been integrated with OPD and SRH services. The national target is to circumcise 2.2M male by 2017.

Challenges that have been observed during the scale up of VMMC services include low enrolment of adult men with a predominance of young boys who may not be sexually active. If this trend is allowed to continue it will hamper the attainment of the intended rapid reduction in HIV transmission. Another crucial problem was shortage of HIV test kits which made some VMMC clients to miss the opportunity provided by the HIV testing and counselling component of the VMMC package. Experience gained during implementation of VMMC services has shown that higher numbers of circumcised males were reached during mass campaigns in comparison to those circumcised at health facilities. In order to have sustained VMMC services it is crucial that regions and councils plan, budget and build capacity for VMMC services.

Outcome: 80% of sexually active men (10-49 years) in 12 priority regions access VMMC services by 2017

Priority Strategies:

- Strengthen health systems for the delivery of quality, integrated and safe VMMC
- Use all SBCC opportunities to promote access and utilization of VMMC services at both community and health facility settings
- Promote Provider Initiated VMMC in existing HIV prevention and health service outlets
- Ensure effective post-circumcision counselling and referral of circumcised males to appropriate services including care and treatment services
- Promote comprehensive male circumcision for HIV prevention in addition to other HIV prevention measures
- Ensure safe disposal of VMMC instruments and waste products

Indicators:

1. Number of males (10-49yrs) receiving VMMC services at health care facilities in the last 12 months
2. Number of facilities providing a minimum package of VMMC for HIV prevention services within the reporting period
3. Number of circumcised clients experiencing at least one moderate or severe adverse event (AE) during or following surgery, within the reporting period
4. Number of male circumcision surgeries performed according to national standards during the last 12 months

Targets:

- 2.8 million clients receiving VMMC services as part of HIV prevention at health care facilities by 2017
- All (100%) primary health facilities in 12 target regions provide quality VMMC services by 2017
- Less than 1% of circumcised clients experience at least one moderate or severe adverse event (AE) during or following surgery by 2017

4.1.7 Preventing Biomedical Transmission of HIV and other blood borne pathogens**4.1.7.1 Adequate and Safe Blood Supply****Current Situation:**

The overall prevalence of HIV infection among voluntary blood donors decreased from 2.6% in 2009 to 1.6% in 2010 with prevalence among male and female blood donors standing at 2.6% and 2.4% in 2009 and 1.6% and 1.7% in 2010 respectively. There is a very slight difference in HIV prevalence among male and female blood donors (*UNAIDS report 2012*). However, between 2009 and 2010 the zonal transfusion centres were collecting only 33.7% of the estimated blood needs for the country. Most of the units of blood collected in the zonal blood transfusion centres was collected from voluntary non remunerated blood donors and screened for HIV as per WHO quality assurance procedures.

Given that access to safe blood transfusion is an essential component of modern health care, the MOHSW has established national blood programmes to ensure the availability of safe blood and blood products through a nationally coordinated blood transfusion service that is coordinated by the National Blood Transfusion Services (NBTS) using an integrated strategy to promote the provision of safe and adequate supplies of blood to reduce the risks associated with blood transfusion. Safe blood transfusion is where 100% of all donated blood is screened for transfusion transmissible infections (TTIs) per WHO quality assurance procedures. In Tanzania, the aim is to move towards 100% safe transfusion by 2017 from the current 35.7% by screening all blood donated and monitoring all blood transfused, even if not collected through the NBTS system.

The MOHSW has successfully mobilized donor support for National Blood Transfusion Services (NBTS). Six zonal blood banks have been established and are functioning in Dar es Salaam, Mbeya, Moshi, Mtwara, Mwanza and Tabora. There is also increased mobilization and awareness among new and regular blood donors. However there is a need to secure sustainability by increasing allocation of local funding (public and private) and an increased focus on activities for mobilization blood donors (especially among young people linked with HIV prevention), blood collection, and processing of blood components.

A priority action to prevent biomedical transmission by building on the success of zonal level blood program services and enhancing the capacity of lower level facilities to screen and store safe blood has already been taken..

Outcome: Unsafe blood transfusions eliminated in all health facilities in Tanzania mainland (from the current 35.7%) by 2017.

Strategies:

- Increase capacity of NBTS zonal centres to screen all blood collected through the NBTS network or by individual health facilities in Tanzania for HIV and other transfusion-transmissible infections (Hepatitis B and C viruses, and syphilis) as per WHO guidelines
- Explore innovative approaches for increasing and retaining voluntary, non-remunerated, repeating blood donors including community initiatives, public private partnerships and the establishment of youth blood donor clubs that integrate HIV prevention, life skills, sports/recreation and blood donation
- Ensure all zonal NBTS have robust internal quality control procedures and participate in accredited external quality assurance programs for HIV testing and tests for other transfusion-transmissible infections (including syphilis and hepatitis B and C).
- Collaborate with NBTS to ensure sustainable mechanisms for the collection, processing and distribution of safe blood and blood products in Tanzania
- Expand existing blood transfusion services at district and regional levels to have adequate storage and distribution capacity
- Promote linkages between blood donation services and HTC services by referring HIV negative individuals as potential volunteers and link blood collection to national campaigns for Counselling and Testing in schools and VMMC
- Promote the linkage between blood donation services and care, treatment and support services for HIV positive clients

Indicators:

1. Percentage of donated blood that is screened for HIV per WHO quality assurance procedures
2. Percentage of national blood requirements (i.e. 400,000 units of blood) donated by voluntary non-remunerated, repeating blood donors
3. Percentage of HIV positive blood donors that are linked with support services for HIV prevention, treatment, care and support
4. Number of blood donor clubs that combine HIV prevention and blood donation promotion activities by district.

Targets:

- 100% of donated blood is screened for HIV per WHO quality assurance procedures by 2017
- 80% of national blood requirements (i.e. 400,000 units of blood) is donated by voluntary non-remunerated, repeating blood donors by 2017
- 80% of HIV positive blood donors are linked with support services for HIV prevention, treatment, care and support by 2017
- At least 16 blood donor clubs in each district by 2017

4.1.7.2 Infection Prevention and Control (IPC)

Health workers face double risk of HIV infection. First, they are at risk of HIV infection from occupational injuries and secondly, as part of community members whereby risky behaviour may expose them to HIV infection (Shisana *et al.*, 2004; Connelly *et al.*, 2006).

WHO estimates that 2.5% of HIV infections among health workers are a result of needle prick injuries (WHO, 2011). The prevalence of occupational exposure among surveyed Health Care Workers in the past 12 months was 47.9% with splashes and needle-stick injuries (Mashoto *et al.*, 2012). Health workers

are also at a higher risk of HIV infection because they are likely to have contact with contaminated instruments. A study conducted in 14 health facilities with 430 workers found that 52.9% of common accidents and injuries were from needle pricks followed by splash of blood (21.7%) from patients. (Manyere et al). However, it should be noted that in Tanzania most HIV infections among health workers are acquired through sexual activities (NACP, 2006).

Unsafe injections are reported to significantly contribute to the spread of HIV/AIDS, Hepatitis B and C and other infections such as osteomyelitis and abscesses all of which are transmitted through the use or re-use of unsterile needles and syringes. It has been estimated that 47 percent of injections prescribed and administered annually to patients, clients or consumers in Tanzania are unsafe. The resolution on auto disable (AD) syringes by Ministers of Health of the East, Central and South African Community in March 2007 was endorsed by Tanzania which is among pioneer countries using AD syringes in Africa. Additionally, the Medical Stores Department (MSD) procures only AD syringes for public health facilities and the expanded program for immunization.

Priority actions to prevent the transmission of blood borne diseases through unsafe injections aim to significantly reduce demand for injections from patients, clients or consumers and build the capacity of clinicians and prescribers to appropriately prescribe injections in the public and private health sector while ensuring an uninterrupted supply of AD syringes and safe disposal of sharps. To ensure surgical safety and infection prevention control in general, posters of national surgical safety checklist (before induction of anaesthesia, before skin incision and before the patient leaves the theatre) will be updated and posted in all health facilities both public and private where surgery is performed.

Outcome: Transmission of HIV and blood-borne pathogens through medical procedures in health care settings eliminated by 2017

Priority Strategies:

- Strengthen Quality Improvement team for IPC at all workplaces
- Ensure implementation of Standard Operating Procedures (SOP) and record keeping for improved PEP case management
- Build capacity for workplace IPC in health facilities at all levels
- Establish a mechanism for the provision of vaccination against Hepatitis B, Hepatitis C and other pathogens (as vaccines become available) to all HCWs
- Promote confidential referral for HIV testing and counselling and PEP for HCWs reporting occupational exposures to reduce stigma and discrimination
- Strengthen health care waste management and disposal mechanisms
- Establish a mechanism for the provision of risk allowance to health care workers in all facilities

Indicators:

1. Number and percentage of public and private health facilities implementing comprehensive IPC as per national guideline
2. Number and percentage of public and private health facilities using AD syringes for therapeutic or vaccination purposes
3. Number and percentage of health facilities where all syringes, needles and other sharps are safely disposed
4. Percentage of the general population that is aware of the risk of transmission of blood borne pathogens through unsafe injections
5. Percentage of public and private health facilities with stock outs of AD syringes

Targets:

- 100% of public and private health facilities implement national IPC, surgical safety and PEP initiatives by 2017
- 100% of public and private health facilities use AD syringes for therapeutic or vaccination purposes according to WHO guidelines by 2017
- 100% of health facilities are equipped with infrastructure to safely dispose all syringes, needles and other sharps by 2017
- 80% of members of the general population are aware of the risk of transmission of blood borne pathogens through unsafe injections by 2017
- Zero percentage of public and private health facilities have stock outs of AD syringes by 2017

4.2 Reduction of HIV related mortality

The HIV prevalence of 5.3% (THMIS 2011-12) for adults aged 15-49 years in Tanzania indicates that there will be more PLHIVs requiring ART during the next five years, hence the importance of care and treatment services. ART will serve both as a prevention strategy against new HIV infections as well as for reducing AIDS related deaths. Efforts will be directed to the scaling up of ART for people who are eligible in areas that have not been reached before, i.e. scaling up care and treatment services to health facilities not currently providing these services with emphasis on integration of services. Tanzania has adopted Option B+ where all HIV infected pregnant women are started on lifelong ART without the need for an initial CD4 cell count, and continue after delivery. Following delivery, the HIV exposed infants are followed up for HIV confirmation, prophylaxis and treatment. Hence eMTCT is included under strategies for reduction of HIV related mortality. Early infant diagnosis (EID) is an integral part of eMTCT which involves the transportation of CD4 samples from respective health facilities to a designated laboratory for testing and the sending back of results to health facilities through district and regional laboratories.

Infected children will be enrolled in care and treatment clinics as per national guidelines. However, the coverage of Paediatric HIV care and services in Tanzania has been extremely low and therefore efforts will be made to scale up the identification of infected children at paediatrics entry points to facilitate early initiation of ARV, retention of children on treatment and the promotion of adherence to ART.

TB-HIV collaborative activities, including implementation of Isoniazid Preventive therapy and co-infections and co-morbidities such as Hepatitis B, and non-communicable diseases (NCDs) such as Cancers, Hypertension, Diabetes, Coronary Heart disease and injuries which were not fully addressed by the HSHSP II, will be addressed in the HSHSP III. PLHIV on treatment require community support which will be stepped up by strengthening lost to follow up activities the linking of clinical services and community support.

The HSHSP III will contribute towards the above national impact goal by provision of (facility based) eMTCT, Pediatric ART, and Adult and Adolescent care and treatment services to achieve the following impact results:

4.2.1 Elimination of Mother To Child Transmission and Keeping Mothers Alive**Current situation**

During the implementation phase of the HSHSP II (2008-2012), the PMTCT country strategy shifted from scale up coverage to the elimination of new HIV infections necessitating the need to review the PMTCT strategic plan after conducting a bottleneck analysis. 97% of all RCH health facilities in the

country were providing PMTCT services by the end of 2012; 96% of which had integrated PMTCT in Maternal and Newborn Child Health (MNCH) services. According to the Costed eMTCT Plan (2012-2015), an estimated 89% HIV positive mothers received ARVs for PMTCT and 11% of pregnant women with advanced HIV were put on ARVs for life.

While the 2010 TDHS shows that 96% of women have had at least one ANC visit, only 43% had attained the recommended minimum of 4 ANC visits and only 50% delivered in health facilities. Although service coverage was high, 24% HIV positive pregnant women who attended ante-natal clinics were not reached by PMTCT services. The bottleneck analysis also indicated that only 21% of male partners attended the services despite efforts to engage them. Other notable challenges were the erratic supply of PMTCT commodities, weak linkage between PMTCT facilities and community based services, poor referral systems and inadequate integration of MNCH services with other HIV and AIDS services. To eliminate the transmission of HIV infection from mother to child and keep mothers alive, Tanzania is implementing a 3-year elimination plan (eMTCT 2012-2015) which in addition to other things, initiates lifelong ART for pregnant and lactating women.

Outcome result:

Mother to child transmission of HIV reduced to below 5% by the year 2017.

Priority strategies:

- Strengthen national, regional and district capacity to effectively plan, manage, implement and coordinate eMTCT interventions
- Provide antiretroviral therapy to all HIV positive pregnant women and breastfeeding mothers in RCH sites
- Strengthen human resource capacity and systems to deliver quality and integrated comprehensive eMTCT services at all levels of service delivery
- Scale up innovative approaches and best practices to enhance male and community involvement in eMTCT services
- Strengthen meaningful involvement of PLHIVs in accessing and supporting HIV and AIDS services at all levels

Indicators

1. Percentage of pregnant and lactating women who received counselling on HIV, had an HIV test during ANC, and received the results (THMIS)
2. Percentage of women who had initial HIV negative test during pregnancy receiving a repeat test
3. Percentage of RCH services integrating ART i.e. (Option B+)
4. Percentage of HIV positive pregnant women who receive ARVs to reduce risk of MTCT and keeping mothers alive (treatment)
5. Percentage of male partners of pregnant women who know their HIV status

Targets

- 80% of pregnant women receive counselling on HIV, have an HIV test during ANC, and receive their results by 2017
- 90% of women who had initial HIV negative test during pregnancy receiving a repeat test
- 80% of RCH services integrating ART i.e. (Option B+) by 2017
- 90% of HIV positive pregnant women initiated and retained on ART by the year 2017
- 75% reduction of new HIV infections among women by 2017 (source UNAIDS 2012)
- 90% reduction in number of HIV associated maternal death during pregnancy delivery and puerperium by 2017 (global eMTCT target)

4.2.2 Early Infant Diagnosis of HIV

Current Situation

The MOHSW, with support from its partners has established DNA-PCR laboratories for EID of HIV at the Central Pathology Laboratory (CPL)/Muhimbili National Hospital (MNH), Bugando Medical Centre (BMC), Kilimanjaro Christian Medical Centre (KCMC) and the Mbeya Referral Hospital (MRH). In addition, DNA-PCR testing capacity is available at the National HIV laboratory Quality Assurance and Training Centre (NHLQATC,) and Muhimbili University of Health Sciences (MUHAS). Each of the DNA-PCR laboratories has been assigned a set of regions to serve. Dried Blood Samples (DBS) are transported from respective health facilities to a designated laboratory for testing and results sent back to health facilities through district and regional laboratories. All 5 DNA-PCR laboratories participate in external quality assessment (EQA) from CDC-Atlanta and in-house DBS Proficiency Testing (PT) from the NHLQATC. At present, the HIV DNA 1.5 Amplicor system is used for DNA-PCR. The plan is to optimise the DNA PCR testing system through the introduction of the CobasAmpliprep/CobasTaqman (CAP/CTM) system. Equipment is in place and technicians from all the five laboratories have already been trained on the CAP/CTM system.

Health workers at RCH clinics that are providing PMTCT services were trained in the collection, packing, storage and transportation of DBS samples for EID to the designated referral hospital laboratory. The use of an electronic database and SMS technology in the DNA-PCR laboratories for sending results to SMS printers has shortened the time it takes to release results to the sites. At present, all regional and district hospitals and a few health centres and dispensaries have been provided with SMS printers. However, only 23% (4,832) of all RCH facilities providing PMTCT services are offering EID services as of the end of 2012 (PMTCT, 2012 report). Transportation of DBS is not uniform and it is sometimes done in an ad-hoc manner. In some cases, hospital vehicles are used and some regions use courier services (mostly EMS or DHL), an activity that is supported financially by implementing partners. Although there is an opportunity for councils to utilize the 'movement fund' budget line in the CCHP to refund HCWs for sample transportation, this does not uniformly happen. There seems to be lack of clarity of the roles in PPP in addressing the long DBS turn-around time (TAT).

Outcome:

The EID turn-around time (TAT) from when the sample is taken from the client to when the test results reach the client or care giver is reduced to less than four (4) weeks by 2017

Priority Strategies:

- ♦ Improve pre-analytical quality assurance (sample collection, labelling and packaging) of DBS to avoid rejection at the testing laboratory
- ♦ Strengthen the coordination and management of EID related activities at all levels to provide a seamless continuum from collection, transportation, testing and taking appropriate action after test results reach client
- ♦ Explore different approaches including public-private partnership (PPP) opportunities for establishing a reliable and sustainable system for transporting DBS samples to referral laboratories for DNA-PCR testing
- ♦ Strengthen and expand use of SMS technology community systems and other innovations for sending DBS results from DNA-PCR testing laboratories to health facilities and from health facilities to clients or care givers.
- ♦ Improve the system for monitoring the supply and availability of laboratory reagents and DBS supplies to avoid stock outs
- ♦ Link DBS collection with routine immunization schedule at 4-6 weeks (PENTA) and at 15-18 months with Measles Booster and integrate EID in RCH outreach activities

Indicators:

1. Percentage of HIV exposed infants tested with DNA-PCR within 2 months of age¹
2. Percentage of PMTC facilities that collect DBS for EID
3. Percentage of health facilities in each council that transport DBS sample to the district within 1 week of collection
4. Percentage of DBS samples received by DNA-PCR testing laboratory within 1-2 weeks of collection from infant
5. Percentage of DBS samples rejected at DNA-PCR testing laboratories
6. Percentage of health centres that have working SMS printers for receiving DNA-PCR results
7. Percentage of DBS tests that have TAT reduced to less than 4 weeks from when the sample is collected to results back to client/caregiver

Targets:

- 90% of infants and children born to HIV infected pregnant women receive a virological test within 2 months of birth by the end of 2017.
- 90% of health facilities in each council that transport DBS samples to district to do so in one week by 2017
- 90% of DBS to be received by DNA-PCR testing laboratory within 2-4 weeks of collection from infant by 2017
- Less than 2% of DBS samples rejected by zonal DNA PCR labs by 2017
- 75% health centres have working SMS printers by the end of 2017
- 75% of health facilities have TAT for DBS test of 4 weeks or less from when the sample is collected to results back to client/caregiver by 2017

4.2.3 Paediatric HIV/AIDS Care and Treatment**Current situation**

In HSHSP II, following the example set in the National HIV/AIDS Care and Treatment Plan (NCTP) 2003-2008, the target for children on ART was set based on a percentage of all PLHIV on treatment. Based on limited information available this target was set at 20% in NCTP and 18% in HSHSP II. This target has never been achieved in the period covered by NCTP and HSHSP II. The adoption of the SPECTRUM modelling approach by MOHSW/NACP has made available data estimates that can be used to set targets. Based on SPECTRUM modelling output, the number of children 0-15 years living with HIV in Tanzania (number of cases of Paediatric HIV) by December 2012 was estimated to be 231,343. In the same period, the number of children eligible (or in need of ART) was 129,128.

By the end of 2012, a total of 86,929 children were enrolled in care and treatment clinics with 50,980 HIV positive children ever initiated on ARVs and 32,407 currently on ART. Hence, the coverage of Paediatric HIV care and services in Tanzania is extremely low with only 25% of children in need of ART reached by 2012. The national average of children under 15 years of age receiving ART has remained at less than 8% while the national target was set at 18% of all PLHIV. Only 3 regions managed to reach 100% of children in need of ART (care and treatment report number 3). Factors that contribute to low coverage of paediatric ART include (i) the weak integration of PMTCT services within the child immunization clinics and other child programs, (ii) low coverage of EID services, (iii) low levels of PITC for children presenting to healthcare facilities, (iv) frequent stock outs of HIV testing kits along and (v) weak linkages to care and treatment services for children identified as HIV positive.

¹ For national reporting, MOHSW will include two disaggregations: infants who received in first 2 months, and 2-12 months. Infants tested should only be counted once.
For national reporting, MOHSW will also track those who were tested and who received the results.

It is estimated that at the end of 2017, there will be about 198,400 children living with HIV and in order to reach at least 70% (of these, the HSHSP III will need innovative approaches and proactive action in order to move towards universal access for ART to all HIV positive children under 15 years of age.

Outcome:

All children under 15 years old living with HIV are put on ART and 90% are retained by the year 2017

Priority strategies:

- Strengthen case identification strategies to all Paediatric entry points in order to enhance early ART initiation for HIV positive children under 24 months
- Strengthen linkages between RCH and CTCs, or initiation and maintenance of paediatric ART within RCH clinics that are implementing PMTCT Option B+
- Scale up implementation of PITC in all health facilities attending children (RCH clinics, hospital paediatric wards)
- Strengthen mechanisms such as facility and community based linkages and adherence support packages to increase retention in care and treatment services
- Strengthen coordination and accountability structures for effective scale-up of paediatrics ART coverage from national to district level
- Promote PPP to support comprehensive eMTCT and paediatric HIV and AIDS interventions
- Integrate paediatric HIV treatment and care services into both eMTCT and child survival programs
- Strengthen availability of nutritional treatment for severe malnutrition (F75, F100 and Plumpy'nut) in health facilities at different levels

Indicators:

1. Percentage of HIV infected infants and children enrolled into care and treatment
2. Percentage of infants and children with HIV known to be on treatment 12 months after initiation of ART
3. Percentage of HIV infected infants and children enrolled for C&T assessed for nutritional status, Counselling and supplementation (proposed-quality indicator, using TFNC tools) at least once every quarter
4. Percentage of health facilities providing paediatric care and treatment linked with PMTCT, RCH, IMCI and community HBC programs
5. Percentage of children admitted to hospital or receiving care at OPD who are tested for HIV
6. Percentage of children admitted at hospital or receiving care at OPD who test HIV positive

Targets:

- 90% of children under 2 years of age living with HIV initiated on ART by the end of 2017
- 70% of children between 2 to 15 years of age living with HIV initiated on ART by the end of 2017
- 10% of children on ART initiated on 2nd line ART regimen by the end of 2017
- 90% of HIV infected children enrolled for C&C assessed for nutritional status, Counselling and supplementation at least once every quarter
- 90% of all HIV-infected infants, children and adolescents are accessing quality, comprehensive HIV/AIDS services by 2017
- 75% of children admitted to hospital or receiving care at OPD are tested for HIV by 2017

4.2.4 Decentralised and integrated HIV and AIDS Care and Treatment Services for adolescents and adults

Current situation

The HSHSP II had set a target of providing ART to 440,000 eligible PLHIVs by December 2012. The number of health facilities providing HIV and AIDS Care and Treatment services had increased to 1,176 out of 6,342 facilities in 2012 from a mere 700 in 2008. Also, a total of 1,135,348 PLHIVs were enrolled in C&T cumulatively by 2012 of which 663,884 eligible PLHIV were cumulatively started on ART. At the end of 2012 there were 432,293 (97% of the target) PLHIV retained (currently) on ART (NACP Report number 2, 2012) representing 69% (or 60%) of the total estimated adults and adolescents PLHIV. During the referred period, the national average adult HIV prevalence rate declined from 5.7% to 5.1% (THMIS 2007/08 & THMIS 2012) and regions with high HIV prevalence had correspondingly higher enrolment rates. In addition to the enrolment achievements described earlier, the majority of PLHIVs are no longer in a moribund state on first attendance; their health status has improved compared to the pre ART phase and there is a general increase in acceptance of care and treatment services.

These remarkable achievements were made despite the numerous barriers to rapid scale up and provision of quality HIV care and treatment services. These include inadequacy of HRH in quality and quantity. Those currently trained for ART care were not evenly distributed. In some parts of the country inadequacy of supplies including drugs for OIs, laboratory reagents and HIV test kits and lack of regular maintenance of machines such as CD4 were noted, which in turn resulted in inadequate testing. The health system infrastructure was stressed by the increasing number of clients. Ongoing efforts for tracing LTFU and reintegrating them to care, integration of HIV care and treatment with other general (HTC, TB, RCH) and CBHC services and other health system strengthening initiatives need to be expanded in order to achieve goals of HSHSP III.

Outcome:

80% of all eligible PLHIVs are put on and retained on appropriate ART regimen by the year 2017

Priority strategies:

- Increase the number and capacity of health facilities providing quality HIV and AIDS care and treatment services and distribute them equitably so as to increase access
- Strengthen clinical management of HIV diseases; reduce adverse effects; increase adherence to treatment and mechanisms for early identification of PLHIVs experiencing ART treatment failure and switching them to appropriate second line regimen
- Promote creative and innovative approaches to increase retention of clients, improve yield of tracing lost to follow up clients and reduce double counting of already registered clients during enrolment while preserving human rights and dignity (e.g. use electronic CTC1, mobile technology, treatment support groups),
- Strengthen community response, integration and linkages to health services to support HTC uptake, client follow-up and reporting, taking into account special needs of adolescents and youth living with HIV
- Strengthen services for adolescents living with HIV (e.g. peer support groups, improving rates of early HIV disclosure, etc)
- Strengthen integration and linkages to reproductive and child health services specifically family planning
- Strengthen interventions for treatment as prevention targeting specific groups, e.g. discordant couples, key populations and pregnant and lactating women

Indicators

1. Number of PLHIV newly initiated on treatment (New on ART) in the past 12 months
2. Percentage of eligible men and women aged 15-19, 20-24 and 25+ years currently receiving antiretroviral therapy (Current on ART)
3. Number of men and women aged 15-19, 20-24 and 25+ years in HIV care receiving at least one clinical service during the reporting period on quarterly basis (Current in care)
4. Percentage of men and women aged 15-19, 20-24 and 25+ years on second line ART (in accordance with national guidelines) in a given time period (Care & Treatment Card2)
5. Percentage of men and women aged 15-19, 20-24 and 25+ years with HIV known to be on treatment 12 months after initiation of ART
6. Percentage PLHIV on ART patients monitored using viral load as standard of care
7. Percentage of infected partners of discordant couples initiated on ART

Targets

- 13,000 eligible PLHIV initiated on ART per month
- 90% (or 1,068,799 clients) of eligible PLHIV currently on ART by the end of 2017
- 50 % of PLHIV on care receiving at least one clinical services on a quarterly
- 10% of clients put on 2nd line ART regimen by the end of 2017 (a proxy for the % of patient in need of 2nd line treatment)
- 90% of PLHIV are alive and on treatment 12 months after initiation of ART by 2017
- 50% of PLHIV on ART monitored using viral load
- 50% of infected partners of discordant couples initiated on ART

4.2.5 Co-infections and co-morbidities in PLHIVs**Current situation**

Co-infections and Co-morbidities that occur in PLHIVs include TB/HIV, HIV/Hepatitis, HIV/Non Communicable Diseases, and other Opportunistic Infections. By the end of 2008, collaborative TB/HIV activities had been established in over 90% of all health facilities in the country. According to the NTLP Annual 2011 report, 95% of TB/HIV co-infected patients received CPT, 86% PLHIVs were screened for TB while 38% were treated for both TB and HIV. 88% of TB patients were screened for HIV at TB clinics and 38% were found to be HIV infected.

Implementation of Isoniazid Preventive Therapy (IPT) among PLHIV began with 20 (mid 2011) health facilities in the country and there is a plan to scale up gradually. The current conventional TB diagnostic tools are not sensitive enough to detect TB among HIV patients and that caused a slow initiation of IPT among PLHIVs. Although active TB screening among PLHIVs is taking place at HIV points of service, there is still inadequate follow up of TB suspects mainly due to health system weaknesses.

Other co-infections and co-morbidities such as Hepatitis B, Cancers and other NCDs were not fully addressed by the HSHSP II (2008-2012), this strategic plan (HSHSP III 2013-2017) will address these important ailments.

Outcome: Morbidity and Mortality of PLHIVs attributed to TB, NCDs and other co-morbidities reduced by 50% by the end of year 2017

Priority strategies:

- Improve understanding of HIV co-infections and co-morbidities in Tanzania (research and surveillance)

- Strengthen TB/HIV integration and improve interventions at all levels to reduce the burden of HIV among TB patients and TB among PLHIVs
- improve identification of paediatric TB cases through active case finding for children exposed to adults with active TB
- Incorporate TB/HIV activities into PMTCT Option B+ and eMTCT to improve outcomes for the mother and infant
- Strengthen pharmacovigilance for ARVs, anti-TB and other medicines provided to PLHIVs.
- Improve prevention, screening and provide appropriate management for NCDs, Hepatitis and other co-morbidities among PLHIVs in an integrated manner.

Indicators²:

1. Number and percentage of HIV + patients receiving Cotrimoxazole prophylaxis
2. Number and percentage of HIV positive patients who received TB treatment
3. Number and Percentage of HIV-positive patients that received treatment for both TB and HIV
4. Number and percentage of TB patients initiated on ART
5. Number and percentage of HIV positive patients starting IPT during the reporting period

Targets

- 90% of HIV +patients receive Cotrimoxazole prophylaxis by the end of 2013, 95% by the end of 2015 and 98% by the end of 2017
- 5% of HIV positive patients receive TB treatment by the end of 2013, 10% by the end of 2015 and 17% by the end of 2017
- 5% of estimated HIV-positive incident TB cases that receive treatment for both TB and HIV by the end of 2013, 10% by the end of 2015 and 15% by the end of 2017
- 90% of TB patients who are HIV positive initiated on ART
- 30% of HIV positive patients starting IPT during the reporting period by the end of 2013, 40% by the end of 2015 and 50% by 2017

4.3 Elimination of Stigma and Discrimination

Stigma and discrimination continues to pose a challenge as it limits many people from getting tested for HIV, taking up HIV prevention and treatment, disclosing their HIV status, and participating in national HIV responses. The double stigma faced by some key populations who are at higher risk of infection drives them away from HIV services. HSHSP III will focus on comprehensive programs that benefit both people living with HIV and those vulnerable to HIV infection e.g. people living members of key populations. Moreover, Tanzania ought to include capacity-building for health care providers to identify and meet the needs of PLHIV and members of key populations. HSHSP III will strive to curb un-accepting or judgemental attitudes against PLHIVs and ensure that individuals living with HIV or staying in AIDS affected households have the same opportunities to access and receive health services as other members in the general population.

Impact Result: PLHIVs (including key populations) and individuals (OVC, elderly) staying in AIDS affected households have the same opportunities in accessing and receiving health services as the general population by 2017.

² A guide to Monitoring and Evaluation for collaborative TB/HIV activities (WHO, PEPFAR and UNAIDS: 2009)

4.3.1 Reduction of Stigma and Discrimination against PLHIV in health care settings

Current Situation

There has been an increase in knowledge and health seeking behaviour for HIV prevention, treatment and care in Tanzania. This is a result of community sensitization and mobilization efforts by government agencies, civil society organizations including faith based organizations. Evidence of better health after ART and the birth of more HIV negative babies among PMTCT clients is a clear testimony that HIV/AIDS can be defeated. This has influenced positive health care seeking behaviour for HIV services. However, according to recent studies (stigma index study and PHDP study) conducted by NACOPHA in 2011 and 2012 respectively, nearly one third (28%) of people living with HIV expressed having been stigmatized and experienced discriminatory acts due to their HIV status. Such acts resulted into serious loss of confidence and low esteem among PLHIV which also affected them psychologically. Of those who accessed health care services, nearly half of them (43.9%) had inadequate counselling for reproductive options, about 13% were told by providers not to have children and 15% are not sure if their results were kept confidential by health care providers. Such acts impinged on the sexual and reproductive health rights of PLHIVs. Nearly 40% decided not to have children; more than 24% opted for not having sex, nearly 20% decided not to marry. More than 14% were coerced to use other infant feeding options while nearly 10% were coerced on delivery methods. Over 19% of eligible mothers did not receive PMTCT services.

In communities, overall, over 25 percent of women and 40 percent of men expressed accepting attitudes towards people living with HIV (THMIS 2012). This implies high level of stigma against PLHIVs which may be associated with increased self stigma among PLHIVs as was indicated in the stigma Index that nearly 85% had low esteem and 63.4% blamed themselves for having contracted HIV. Although Tanzania adopted universal access to ART, more than 35% of eligible PLHIVs (those with a CD4 count less than 350) do not access ART services, which can also be attributed to stigmatization.

Working in close collaboration with its partners, the MOHSW has successfully built the capacity of health care providers to deliver quality HIV services to PLHIVs. This has resulted in the enrolment and retention of a reasonable proportion of estimated PLHIVs. As the country strives to reach the national goals on 3 zeros, It is important for such efforts to be realized in promoting access to HIV prevention, treatment, care and support to all eligible PLHIVs as well as promoting a shared responsibility towards those not living with HIV. The HSHSP III will ensure the mainstreaming of health related human rights of PLHIVs and persons made vulnerable by HIV and AIDS as guaranteed by policy and legal instruments are realized.

Outcomes:

- Accepting attitudes towards PLHIVs and members of key populations related to health service accessibility on all counts increased from 25% among women and 40% among men to 80% for both groups by 2017
- Equal access to health services by PLHIVs as the rest of the population (including key populations) and/or people affected by HIV and AIDS by 2017

Priority Strategies

- Promote and scale up the implementation of positive health, dignity and prevention for PLHIVs
- Engage community, health care providers and PLHIVs in understanding and addressing HIV stigma and discrimination
- Institute measures to address gender inequality and gender based violence (GBV) to facilitate safe disclosure
- Institutionalize annual assessment of the stigma index in health services

Indicators

1. Percentage of PLHIVs experienced non stigmatizing attitudes from Health care providers (stigma Index, PHDP)
2. Percentage of HIV and AIDS Care and Treatment clinics that work with PLHIV Peer Educator
3. Percentage of PLHIVs reached with a minimum package of PHDP
4. Percentage of women and men aged 15-49 expressing specific accepting attitudes toward people with HIV/AIDS [THMIS, NMSF]
5. Number and percentage of councils and/or health facilities producing annual stigma index reports
6. Percentage of men and women reporting GBV related to HIV disclosure at a health facility

Targets (aspiration targets set to be revised after year 1 of implementation)

1. Over 80% of PLHIVs experiencing non stigmatizing attitudes from Health care providers by 2017
2. 80% of HIV and AIDS Care and Treatment clinics work with PLHIV Peer Educator by 2017
3. Over 50% of PLHIVs reached with a minimum package of PHDP
4. 50% of women and 60% of men aged 15-49 expressing specific accepting attitudes toward people with HIV/AIDS by 2017
5. 80% of councils have more than half of its health facilities producing annual stigma index reports by 2017
6. Reduced percentage of women and men reporting GBV related to HIV disclosure at a health facility by 2017

4.3.2 Health Sector Workplace Interventions

Data on the magnitude of HIV and AIDS epidemic among health workers in-terms of morbidity and mortality is limited, although it is suggested that the rate of HIV infections among employees in the health sector is at least as high as that of the general population. For example, an anonymous screening for HIV was done in Lindi Region for 586 Health workers and the HIV prevalence was found to be 13.3 % (Lindi Regional Hospital Annual Report, 2009). Similar results were found in Mbeya and Bombo Regional Hospitals in Tanga region where the prevalence was 13 % and 12.9 % respectively (TGPSH, 2004; TGPSH, 2005).

The MOHSW in collaboration with various stakeholders worked together to design and implement workplace programmes, develop HIV and AIDS workplace guidelines, develop training tools for health workers, print and distribute guidelines and training manuals to all councils and train a total of 709 health workers from all regions and councils. Furthermore, advocacy and dissemination of the program was conducted at all levels, during which a total of 20 heads of the department, 23 Regional Medical Officers (RMOs) and 18 national Trainers of Trainers (TOTs) were trained. In addition, a total of 450 workers and their families were reached through awareness creation on the prevention and control of HIV and AIDS and behaviour change.

To address challenges of HIV and AIDS in the working population, the government through NMSF (2003-2007) directed each sector to develop a workplace intervention programme. In response, the Ministry of Health and Social Welfare established a Workplace Intervention Programme for health workers and developed a strategic Plan for the prevention and control of HIV and AIDS in the workplace for 2006-2011 and recently, strategic plan II for 2013-2017. The strategic Plan focused on four thematic areas, creating an enabling environment; prevention and control of HIV and AIDS infections in health care settings; Care, treatment and support to infected and affected health workers and their families and impact mitigation of HIV and AIDS among infected and affected health workers; and monitoring and evaluation.

Outcome: Increased access of comprehensive workplace interventions in the health sector focused on care, treatment and support of employees, employers and their families affected with HIV and AIDS

Priority Strategies:

- Strengthen and sustain HIV and AIDS workplace interventions for Health workers and Social Welfare workers in public, private and informal sectors
- Provide sustainable care, treatment and support to health care workers and their families living with HIV and AIDS
- Manage and mitigate the impact associated with HIV and AIDS for affected and infected health care workers
- Ensure implementation of Government Circular No 2 (2006) for Public Servants on provision of services for PLHIVs at all level
- Operationalize the monitoring and evaluation system into health care settings to ensure smooth implementation of workplace intervention (WPI) countrywide

Indicators:

1. Number of workplace programmes implemented at workplaces
2. Percentage of HCWs who know their HIV status
3. Number of HCWs who receive management support according to Government Circular No 2 of 2006 for Public Servants
4. Number of workplace social, network groups and economic support groups established for PLHIVs

Targets

- 50% of workplace programs conducted at all levels of the health care system
- 50% of HCWs who know their HIV status by 2017
- All HCWs who disclose HIV status receive management support according to Government Circular No 2 of 2006 for Public Servants by 2017 (no baseline)
- At least 5 workplace social groups, network groups and economic groups formed by 2017

4.3.3 HIV/AIDS Services for Key Populations

Current Situation

Tanzania has adopted the international definition of Key Populations (KPs), a term referring to populations that may be key to the epidemic's dynamics and therefore key to the national response. Tanzania has adopted the international definition and included additional groups relevant in the Tanzania context. These include MSM, sex workers, people who inject drugs (PWID). Recent studies conducted in various regions in Tanzania showed high HIV prevalence among KP groups, as infection rates ranged from PWID 51% (Nyandindi 2011), FSWs 31.4% (NACP 2010) and MSM 42% (Shio and Nyoni 2010, Leshabari 2013) – TACAIDS, 2012. These rates are very alarming and calls for effective strategic HIV prevention interventions. In the Tanzania context, other population groups that deserve special consideration in HIV programming include prisoners, long-distance truck drivers, people with disabilities (of all forms), fishermen communities, mining communities, women and children.

KPs are populations that are at higher risk of being infected or affected by HIV, who face societal barriers to accessing general HIV prevention and care interventions, who play a key role in the way HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. KPs are also at a higher risk of acquiring other infections such as syphilis, Hepatitis B and Hepatitis C and others, due to the high risk behaviours among them.

The prevalence of HIV among KPs is higher than that in the general population. In Dar es Salaam, HIV prevalence among FSWs is 31.4% which is three times higher than that of women in the general population in the city. (NACP, MoHSW HIV BBSS 2010). The number of FSWs who reported regular use of a condom with a regular client was 69.3% (NACP, MoHSW HIV BBSS 2010). Men who have ever paid for sex nearly doubled (15%) in 2012 from 8% in 2007 and 53% of them used a condom during their most recent paid sexual encounter (THMIS 2012).

The PWID epidemic is fuelled by increased drug trafficking and worsening economic conditions in Tanzania (Ross, 2008). It is estimated that there are at least 25,000 PWIDs in Tanzania and that 51% of the PWID population is HIV positive. HIV prevalence among female PWIDs is higher (Kilonzo 2010, Nyandindi 2011). About 53% of male PWIDs reported sharing needles compared to 24% of their female counterparts. Most female PWID are also involved in high risk sexual activities and 94% reported having had sex within the last 30 days. (Williams ML, McCurdy SA, 2009). Of these, 84% traded sex for money and 28% traded sex for drugs. During the last sexual encounter 69% of female PWIDs reported having used a condom, compared to only 28% of men.

Most of the existing programs designed for HIV prevention, care, treatment and support target the general population and were reportedly "blind" to the special needs of KPs and most vulnerable groups. KPs in Tanzania are a highly marginalized group. There is a need for special interventions to reach out to these groups with comprehensive preventive, treatment, care and support services. There is also an urgent need for national estimates of KPs as well as their relative proportional contribution to new HIV infections, to inform targeted planning and resource mobilization.

Outcome: At least 65% of councils provide access to comprehensive facility and community based health services for HIV prevention, treatment, care and support to key populations by the year 2017

Priority Strategies:

- Scale up comprehensive, evidence-based programs to address the health needs of KP
- Advocate for an enabling environment to facilitate access to services and promote health seeking behaviour of KPs
- Promote public- private partnerships with appropriate stakeholders working with KPs
- Strengthen the implementation of evidence based prevention interventions for KPs at national and sub-national levels
- Increase the evidence base and strengthen the M&E system to inform policy makers and program implementers to track interventions for key populations (M&E)
- Promote positive attitudes among health care providers towards provision of HIV services to key populations

Indicators:

1. Prevalence of HIV among members of KPs (UNGASS, PEPFAR)
2. Percentage of members of KPs who reported using a condom during their last high-risk sexual encounter (UNGASS)
3. Percentage of members of KPs who have tested for HIV in the last 12 months and who know their results (UNGASS)
4. Number and percent of KPs reached with individual and/or smaller group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (comprehensive services)
5. Percentage of KPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission
6. Proportion of targeted Health facilities which provide KP friendly services

Targets

- 50% reduction in prevalence of HIV among members of key populations by half by 2017
- 80% of members of KP who reported using a condom during their last high-risk sexual encounter by 2017
- 80% of members of KPs who have tested for HIV in the last 12 months and who know their results by 2017
- 80% of KPs reached with individual and/or smaller group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required (comprehensive services) by 2017
- 80% of KPs who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission by 2017
- 100% of targeted Health facilities (N=420) in the country (disaggregated by council and region) providing comprehensive and friendly KP services by 2017

Section Five: Build Strong and Sustainable systems to support the Health Sector HIV/AIDS Response

5.1 Interaction of the HIV and AIDS Response and Health Systems Building Blocks

Strong health systems are critical in the health sector HIV and AIDS response. HIV and AIDS also affects various components of the health system by either increasing needs or workload or by reducing health workers or drawing away other resources. In the HSHSP II and many of the previous strategies, HIV and AIDS services have also contributed to strengthening health systems such as lab services, training of health workers and strengthening commodity management at national, regional, district and health facility level. In order to leverage scarce resources and to deliver value for money, Health Sector HIV and AIDS services must be integrated into shared delivery infrastructure so that personnel and facilities are used wisely to reap economies of scale. The strategy provides for increased integration of HIV and AIDS services in the general health care system especially at the service delivery levels and health system interventions.

According to the WHO, the health systems components include: (i) Service delivery (ii) Human resources for health (iii) health information system (iv) medicines and technology (v) health financing and (vi) leadership and governance. In this section, only some components of the health system are addressed. It does not mean that the others are not important or necessary. However, as a process to foster integration, the HSHSP III is closely aligned to HSP III that addresses most of the components such as district and regional services, human resources for health, health financing and health management information system, health infrastructure that have separate strategic plans that address the needs of all health interventions sector wide.

This strategy recognizes the need for the HIV program to support the improvement of health infrastructure including drug stores and warehouses, diagnostics, renovation and refurbishment for better provision of HIV and other health services.

5.2 Service delivery

5.2.1 Quality Improvement of HIV/AIDS services

Current situation

Quality issues have been mainstreamed under the Directorate of Quality Assurance of the Ministry of Health and Social Welfare. Each program has Quality Improvement (QI) unit to ensure continuous quality improvement. The National AIDS Control Program developed the National Essential Health Sector HIV and AIDS Intervention Package (NEHSHIP 2010) with core services specified for each level of the health service delivery. Other important documents developed include the National guidelines for QI of HIV and AIDS services the manual and tools for comprehensive supportive supervision and mentoring and the training packages. At regional, council and facility levels, a circular was sent out to guide the establishment of quality improvement teams. As an entry point for QI of HIV and AIDS services, the MOHSW through NACP developed the health facility assessment tool which is used to assess health facilities before being approved to provide care and treatment services.

Despite the efforts to ensure quality service delivery by MOHSW, delivery of optimal quality services is hampered by a number of barriers which include; inadequate number of skilled human resources for health, inadequate data recording and reporting, inadequate supportive supervision and mentoring,

inadequate infrastructure and maintenance, inadequate availability of essential medicines and other commodities. .

In HSHSP III, QI teams at regional, council and facility level will be established or revitalised and ensure they remain active. The NACP defines an active QI team as one that has finished at least one QI cycle in the quarter. The QI cycle means covering the four steps of QI Model: i.e. 1. Identify what needs to be improved 2. Analysing what needs to be done 3. Developing hypothesis on what needs to be done 4. Implementing the change process a) Plan b) Do c) Study d) Act. A web based QI knowledge management systems will be established where all actors will be able to access and deposit QI knowledge. The web based system will also be used by NACP to monitor the systematic documentation of QI activities by the actors (health facilities, councils or regions)

Outcome: 75% of all hospitals and 50% of frontline primary health care facilities (health centres and dispensaries) demonstrate and document evidence in quantitative indicators of quality HIV and AIDS services

Priority strategies:

- Institutionalise patient-centred quality improvement as an integral part of HIV and AIDS service provision and general health care
- Develop simplified cadre-specific Standard Operating Procedures for providers and managers at different levels of health facilities
- Strengthen the integration of HIV and AIDS interventions with other health services
- Strengthen the capacity of HCW's to identify, prioritize alternative ways of Improving Quality of Services at all levels of healthcare delivery system
- Facilitate the operationalization of supportive supervision and mentoring at all levels in line with national guidelines
- Strengthen the capacity of service providers in data management at all levels of health services delivery
- Create a knowledge management system for managing and sharing evidence of quality improvement to spread improved practices to other health facilities, councils or regions.

Indicators

1. Percentage of health facilities with active QI teams i.e. completing at least 1 QI cycle per intervention per quarter)
2. Percentage of Regional and Council Health Management Teams (RHMT and CHMT) with active QI teams
3. Percentage of R/CHMTs integrating HIV and AIDS supportive supervision and mentoring in their routine activities
4. Number of health facilities, councils or regions with systematic documentation of quality improvement activities, research and evaluation studies through a web based national QI knowledge management system

Targets

- All regional hospitals, district hospitals, RHMTs and CHMTs have active QI teams by 2017
- All R/CHMTs integrate HIV and AIDS supportive supervision and mentoring in their routine activities
- A web-based national QI knowledge management system established by NACP or a partner research or academic institution accessible to all stakeholders by 2015

2.2 Community Based HIV/AIDS Services

Current situation

In Tanzania Community Based HIV and AIDS Services was formally introduced by the MOHSW as Home Based Care Services mainly for bedridden patients. Due to the advancement in the management of HIV and AIDS, the scope of HBC changed significantly, from taking care of bedridden clients to ambulatory. Up to the end of December, 2012, these services expanded to reach 134 councils where a total of 275,547 clients benefitted from these services. The coordination of HBC services in regions and districts has improved significantly following the introduction of regional and Districts HBC coordinators respectively. With increased partner support, 9719 HBC service providers were trained and resulted to increased coverage of services. However, the coverage of Community Based HIV and AIDS services (CBHS) is still partial. Only 134 out of 156 councils have been reached. Country wide, only 4,707 (35%) health facilities have CBHS in their catchment areas. Other challenges include; irregular supply of HBC kits, diminishing funding, poor linkage between CBHS and other facility based HIV interventions including and Treatment, PMTCT and HTC. Inadequate community involvement and participation of PLHIV, poor retention of Community Based HIV and AIDS Services providers, and unsustainable CBHS were other challenges faced in the provision of CBHS.

Outcome: People living with HIV in all councils have access to quality comprehensive Community Based HIV Services integrated with other services.

Priority strategies:

- Expand scope of Home Based Care to Comprehensive Community Based Services for HIV and other chronic disease and apply innovative approaches to increase coverage to all councils through a public-private partnership approach
- Strengthen effective linkages and referrals between community based and clinical services to ensure a continuum of comprehensive and integrated services for PLHIVs across and retention in care of HIV positive individuals (including chronically ill?)
- Strengthen PLHIV support groups, improve collaboration with PLHIV clusters to coordinate HIV interventions and facilitate early linkage of PLHIV to support groups
- Work with and enhance the capacity of community structures in the provision of Community Based HIV and AIDS Services with the active involvement of PLHIVs
- Strengthen community health systems to support HIV intervention in the Community (eMTCT, paediatrics HIV and AIDS care, TB/HIV collaboration, HTC, PHDP, Key Population and ART).

Indicators

1. Number of adults and children living with HIV who receive Community Based HIV and AIDS Services
2. Percentage of villages with community based HIV services and formalised CBS Providers
3. Percentage of LTFU clients followed up and linked back to health facility services by Community Based HIV and AIDS Services Providers.
4. Percentage of PLHIV support groups involved in supporting Community Based HIV and AIDS Services Package.
5. Percentage of councils that allocated and spent own source funds for Community Based HIV and AIDS Services.

Targets

- 571,092 adults and children living with HIV who receives Community Based Services by end 2017.
- 65% of villages have Community Based HIV and AIDS services by the end of 2017.

- 90% of LTFU clients followed up and linked back to health services by Community Based HIV and AIDS Services providers 2017
- 90% of PLHIV support groups involved in supporting Community Based HIV and AIDS Services package 2017.
- 60% of Councils spending own sourced funds for Community Based HIV and AIDS Services 2017.

5.3 Medicine and Technology

The ultimate goal of interventions in this section is to secure continued access to quality and affordable medicines, diagnostics and other commodities of needed for the national HIV response to eliminate new HIV infection and reduce HIV related death.

5.3.1 Procurement, Supply Chain Management and Pharmacovigilance (national level)

Current Situation

The process for ensuring uninterrupted supply of medicine, diagnostics and other health commodities required for HIV and AIDS intervention starts with the selection of the commodities to be used. During HSHSP II, good coordination and collaboration with development partners and implementing partners through clinical and supply chain committees led to timely adoption of the revised WHO guideline into the national guideline for the management of HIV and AIDS, facilitated the selection of commodities to be procured and introduced a phased approach for replacing medicines and diagnostic tests to accommodate changes in the treatment regimen or testing algorithm. Consumption data was used to facilitate better quantification, procurement planning and pipeline monitoring for ARVs. However, there were some challenges including inadequate storage space at MSD Zonal stores, district hospital and lower health facilities and the delayed disposal of expired or recalled drugs and reagents which compound the challenges of space. In addition, in-adequate availability of data for quantification and the lack of sufficient funds for HIV rapid test kits, drugs for OIs and STIs, laboratory reagents for haematology and chemistry tests led to stock outs and disruption of service provision.

As for HRH, the secondment of supply chain monitoring advisors at zonal MSD stores greatly improved the supply chain management system. Recruitment of similar dedicated positions is necessary at MSD, regional and district level.

The HSHSP II aimed at strengthening the National Pharmacovigilance system for tracking and providing feedback on adverse drug reactions associated with HIV and AIDS, STI and OIs medication. The system for recording, reporting, analyzing and disseminating pharmacovigilance data is weak and the information is not adequately utilised at health facility level.

Among the key issues to be addressed in HSHSP III to ensure an uninterrupted supply of laboratory diagnostic reagents in accordance with existing testing protocols include improved coordination for quantification and forecasting of laboratory supplies, deployment of electronic data management systems, improved post market surveillance, local use of Pharmacovigilance data and introduction of end user surveys. Also, plans to strengthen or improve financing (for ARVs and diagnostics), infrastructure (at MSD and health facilities) and logistics management unit of NACP will be set in motion.

Outcome: Continuous availability of quality HIV and AIDS commodities (Antiretrovirals, HIV Rapid test kits, Laboratory reagents, Medicines for Opportunistic Infections and related supplies) to the end user at the right quantity, time, place and cost.

Priority Strategies:

- Strengthen Logistic Management Unit for HIV and AIDS commodities (Lab reagents, HIV Rapid Test Kits, ARV and OIs) at National level.

- Stepwise increase of government own funds for procurement of ARVs, HIV rapid test kits and laboratory reagents for HIV/AIDS management.
- Improved coordination for the quantification, budgeting and procurement of ARVs, medicines for OIs and laboratory c supplies needed for HIV and other related services.
- Deployment of electronic data management technologies countrywide (including lower health facility levels) for logistics data capturing, tracking and reporting.
- Improve post market surveillance of HIV and AIDS commodities.
- Strengthen monitoring of commodity availability to the end user through client end-user verification surveys
- Improve Rational use of Medicines (RUM) and the use of Pharmacovigilance information for monitoring and management of adverse drug reactions to anti-retroviral and opportunistic infections medicines at all levels (needs an indicator)

Indicators:

1. Per cent of health facilities that have experienced stock-out of selected tracer items in HIV program in the last 3 month
2. Proportion of GOT expenditure from own funds on procurement of ARVs, HIV rapid test kits and diagnostics
3. Proportion of Hospitals and HCs implementing electronic logistics data management system
4. Proportion of districts and regions with logistics managers
5. Proportion of health facilities with at least one clinical staff trained on rational use of HIV medicines
6. Number of sites reporting on ADRs to TFDA

Targets:

- Less than 1% of health facilities experience stock-out of selected tracer items for HIV and AIDS services in the last 3 months by 2017
- 25% of all expenditure for procurement of ARVs, HIV rapid test kits and diagnostics is from GOT own funds by 2017
- 100% of Hospitals and HCs implementing electronic logistics data management system by 2017
- 100% of health facilities have least one clinical staff trained on rational use of HIV medicines by 2017

5.3.2 Supply Chain Management, Facility Commodity Management, Rational Use of Medicine and Pharmacovigilance (regional and District level)

Current Situation

At the sub-national level, ordering for ARVs, OI medicines, HIV test kits and laboratory reagents is done by health facilities and Council Health Management Teams. MSD Zonal stores have lists of approved users who can order and collect medicines, diagnostic supplies and other HIV related commodities from MSD. There is inadequate storage space at district hospital and lower health facilities. The huge amount of expired drugs and delayed disposal of expired or recalled drugs and reagents compounds the challenges of space. In addition, lack of accurate data for quantification and implementation of activities that require test kits but were not included in the forecast leads to frequent stock outs and disruption of testing. However there is a big gap between consumption and reported number of tests or drugs administered.

In order to address the above, HSHSP will focus on improving sub-national and health facility logistic and supply management systems including evidence based ordering systems, proper storage and stock management systems, rational use of medicines and Pharmacovigilance.

Outcome: Continuous availability of quality ARVs, OI medicines, HIV test kits, laboratory reagents and other HIV and AIDS related health commodities to the end user at all service delivery points.

Priority Strategies:

- Improve HIV and AIDS commodity management (budgeting, infrastructure, record keeping, ordering and reporting, quality, storage and human resource) at regional, council and facility level
- Integrate management of HIV and AIDS commodities in the general health system at the region and district level
- Improve Rational use of Medicines (RUM) and the use of Pharmacovigilance information for monitoring and management of adverse drug reactions to anti-retroviral and opportunistic infections medicines at all levels
- Improve human resource capacity for supply chain management (including creating new funded posts for logistics managers) at regional, district and facility level

Indicators:

1. Proportion of councils allocating adequate funds for improving commodity management
2. Percentage of ordering facilities submitting logistics reports within a specified time limit in a given quarter.
3. Percentage of Health Facilities appropriately utilizing guidelines for the management of HIV and AIDS.
4. Proportion of health facilities utilizing Pharmacovigilance reports at a facility level

Targets:

- 80% of councils allocating adequate funds for improving commodity management by 2017
- 100% of ordering facilities submitting logistics reports within a specified time limit in a given quarter by 2017.
- 100% of Health Facilities appropriately utilizing guidelines for the management of HIV and AIDS by 2017.
- 50% of hospitals utilizing Pharmacovigilance reports at a health facility level by 2017.

5.3.3 Laboratory Systems and Services

Current Situation

During the implementation of HSHSP II, the aim was to strengthen laboratory systems at all levels to support prevention, care, treatment and other interventions for STIs, HIV and AIDS. There has been considerable progress improving laboratory infrastructure and equipment at all (national, regional and council) levels. Laboratory buildings of all regional hospitals have been renovated, remodelled and in some cases new buildings have been erected. This has provided adequate space to organize patient and workflow. In addition, all referral, regional, district (council) hospitals (including designated council hospitals) and selected Faith based organization (FBO) and private hospitals have been provided with equipment for carrying out CD4 counts, haematology and clinical chemistry tests. Referral hospitals and some selected regional hospitals have been provided with high volume equipment that is able to process a large number of test samples. The availability of this laboratory equipment has improved quality of care not only for HIV and AIDS services, but for all health care services in general as most of

the tests done using the laboratory equipment provided (with the exception of CD4 counts) are not specific to HIV and AIDS.

The national laboratory quality assurance scheme is functioning well under the leadership of the NHLQATC. Also, the Strengthening of Laboratory Management Toward Accreditation (SLMTA) approach adopted to improve the quality of laboratory services has been expanded to 30 laboratories in the country (at regional and district level). Even though interventions are not specific for HIV laboratory services, the impact on laboratory quality is cross cutting. In addition, final stages to establish capacity for HIV drug resistance testing at the NHLQATC are in progress.

Currently, the guideline for the clinical management of HIV and AIDS does not clearly stipulate the use of Viral Load testing for routine ART monitoring. Therefore clinicians depend on clinical (emergence of OIs) and immunological markers (falling CD4 Count) to monitor HIV treatment failure. These are late markers of treatment failure compared to virological markers (viral load testing). This resulted in in-adequate quantification and procurement of reagents thus limiting capacity for Viral Load testing. Furthermore, assessments of staff at HIV testing sites have shown lack of competence in HIV testing among non-lab personnel.

The HSHSP III will aim to address these shortcomings by improving laboratory infrastructure at the district level and introducing the use of viral load for monitoring treatment failure beginning with high volume sites at zonal and regional referral hospitals. With the availability of point of care (POC) technology, viral load tests can be made available even at primary health care levels (health centre or dispensary). Finally, the successful SLMTA approach should be expanded to cover all district hospital laboratories, and its scope should also include HIV specific laboratory tests. The strategy should also address competence of staff in all HIV testing sites (HIV Rapid Test and POC technology)

Outcome: Quality laboratory services for HIV and AIDS accessed by PLHIV at all levels of service delivery points countrywide.

Priority Strategies:

- ♦ Expand and improve laboratory infrastructure (Building and Equipment) at the district and lower health facilities and the national health laboratory standard supply list in accordance to emerging technologies and increase use of POC technology at district and lower health facilities.
- ♦ Expand the scope of the SLMTA approach to include strengthening of HIV laboratory quality assurance systems and coverage to district and lower health facilities.
- ♦ Improve national capacity for early detection of HIV/AIDS treatment failure and monitoring HIV drug resistance.
- ♦ Strengthen coordination between diagnostic services and HIV/AIDS services at national, regional and council levels to foster integration and improve management of HIV diagnostics services

Indicators:

1. Percent of health centres and dispensaries with capacity to perform HIV clinical laboratory tests (using laboratories or POC technology)
2. Percent of laboratories enrolled in SLMTA process that achieved star rank according to the WHO/AFRO (SLIPTA) quality assurance standards
3. Percent of national and zonal laboratories accredited according to international standards (ISO 15189)
4. Number of health laboratories with capacity for providing viral load testing disaggregated by

level of health facility and by type of testing platform (conventional or POC) at national, zonal, regional and council level

5. Number of surveys conducted on HIV drug resistance in which samples were tested at NHLQATC
6. Number of district and regions with timely submission of LIS reports to regional and national level respectively

Targets:

- 100% of health centres and 10% dispensaries have capacity to perform HIV clinical laboratory tests using laboratories or POC technology by 2017
- 100% of regional and 50% of district level laboratories enrolled in SLMTA process and achieved star rank according to the WHO/AFRO (SLIPTA) quality assurance standards by 2017
- 50% of national and zonal laboratories accredited according to international standards (ISO 15189) by 2017
- 2000(N=4000) health laboratories (of which 240 hospitals, 633 health centres and 1,127 which is equivalent to 20% of dispensaries provide viral load testing using conventional or POC by 2017

5.3.4 Laboratory Equipment Maintenance

Current Situation

In the HSHSP II, the Ministry of Health planned to establish a functional and sustainable equipment maintenance mechanism by 2009. Implementation of this intervention has lagged behind with dire consequences on the provision of quality of services. Zonal Equipment workshops have been introduced but they are not capable of handling high-tech laboratory equipment. The Ministry has signed planned preventive maintenance (PPM) contracts with vendors for Haematology, CD4 and Chemistry analyzers. However, the implementation of these contracts has not been effective because Health Managers and staff in regions and districts do not have adequate information on these contracts.

In order for the more ambitious HSHSP III to succeed, there is a need to have a coherent planned preventive maintenance strategy for laboratory equipment. Also the coordination, supervision and follow up of PPM contracts given to vendors should be improved by placing the responsibility on Zonal Equipment Maintenance Workshops and the MOHSW Health Care Equipment Unit of the Diagnostic Services Section. In addition, the existing Laboratory Information System (LIS) that provides laboratory service data, for central level decision making should be improved and also include equipment functionality status.

Outcome: Increased “equipment uptime” (or reduced “equipment downtime”) for HIV and AIDS laboratory equipment as a result of functional and reliable Plan Preventive Maintenance (PPM)

Priority Strategies:

- Strengthen PPM system for laboratory equipment to be functional, sustainable and optimal
- Strengthen the Health Care Equipment Unit at the MOHSW and Zonal Equipment Maintenance workshops to effectively support/manage PPM of laboratory equipment
- Strengthen the Laboratory Information System to address equipment functionality for central level decision making
- Advocate for budgeting of maintenance cost of laboratory equipment in CCHP

Indicators:

1. Percentage of laboratory equipment covered by PPM system
2. Percent of lab equipment serviced according to PPM contract agreements

3. Number of zonal Equipment Maintenance workshops with capacity to support/manage PPM of laboratory equipment
4. Percentage of laboratories reporting breakdown of CD4, Haematology or Chemistry laboratory equipment
5. Rate of annual functional period of laboratory equipment

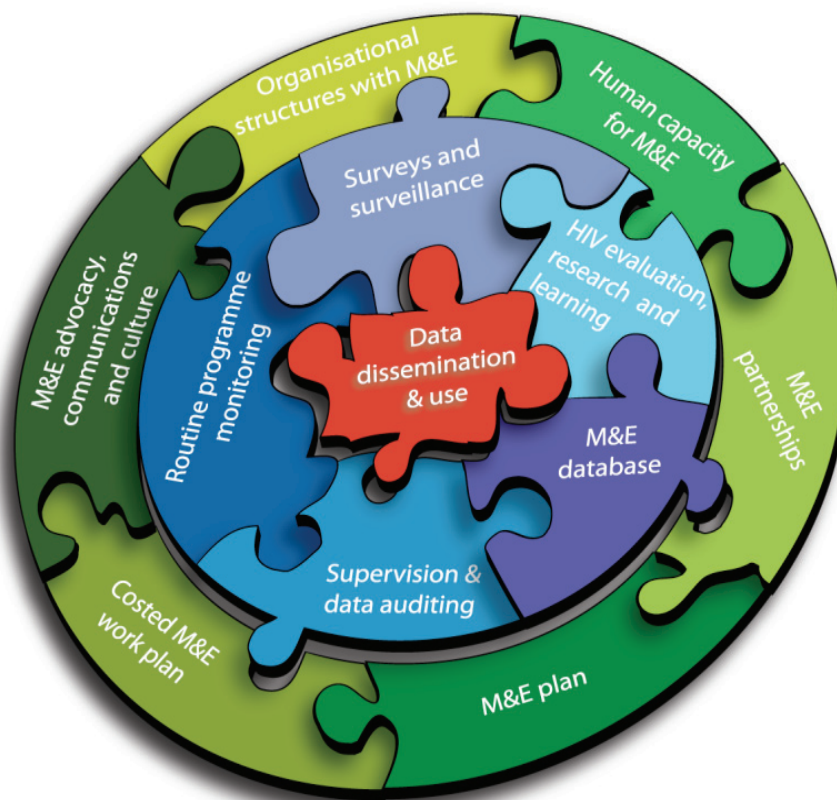
Targets:

- 100% of laboratory equipment for HIV and AIDS services covered by PPM system by 2017
- 100% of lab equipment serviced according to PPM contract agreements by 2017
- less than 2% of laboratories reporting breakdown of laboratory equipment for CD4, Haematology or Chemistry tests by 2017

5.4 Strategic Information for Monitoring and Evaluation of the Health Sector HIV Response

Reliable data and Strategic Information (SI) are critical for the formulation and delivery of effective interventions for the health sector HIV response. SI provides the basis for identification of populations at risk or in need of services, prioritizing actions to ensure equity, planning for adequate coverage, determining costs of effective interventions, monitoring progress of programmes and evaluating their success. However, generating SI is a complex process for which Tanzania, as many other low and middle-income countries (LMIC) lack adequate capacity and supporting structures. A functional monitoring and evaluation system has many intertwining elements that have organised into 12 components of a functional HIV and AIDS M&E system. This framework (shown in Figure 1) was developed by international partners and national governments and represents a standardized strategy for organizing M&E systems. These components serve to operationalize the M&E Plan and ensure collection, reporting, and quality of data for measuring the HSHSP III as outlined in the previous chapter. In Figure 1, the outer ring represents planning, human resources, and partnership components that support data recording and information use. This ring includes individuals, organizations, functions/actions, and the organizational culture, all of which are fundamental to improving and sustaining M&E system performance. The middle ring focuses on the functions of the system through which it collects, captures, and verifies data and transforms data into useful information. The centre represents the central purpose of the system, which is using data for decision making (UNAIDS, April 2008).

The final goal is to have all the components functional at all levels; however, this process will take time. Consequently, Tanzania needs to focus on a few of the components at the outset and phase in M&E investments over time to establish and operationalize all components.

Figure 1: The 12 Components of a Functional M&E System

In line with the NMSF III, the goal of MOHSW/NACP strategic information interventions is to have one agreed upon national framework for monitoring and evaluating the health sector HIV and AIDS response. The interest in and value of monitoring and evaluating the national HIV and AIDS response is driven internally by the government of Tanzania, based on the intensity of the national response and the need to provide continuous and timely information on the results of the implementation of the HSHSP II and the NMSF. Ensuring a functional M&E system is in keeping with the internationally accepted Three Ones principles to better coordinate the national HIV and AIDS response. The Three Ones principles are:

- ♦ One agreed national coordinating authority to steer the multi-sectoral response
- ♦ One agreed national strategic framework
- ♦ One agreed national M&E framework

In keeping with these principles, this M&E Plan advocates for a harmonized M&E framework, system, and reporting process. The goal of this plan is to create and strengthen a coordinated, unified, and coherent M&E system in the Tanzania MOHSW, which will ensure relevant, timely, and accurate data recording and distribution from all stakeholders.

In Tanzania, HIV evaluation and research, is guided by the National Multisectoral HIV and AIDS Research and Evaluation Agenda developed by TACAIDS and the National Health Sector HIV and AIDS Research and Evaluation Agenda 2010-2015 developed by NACP. In addition to operational research implemented by various implementers, there are many academic and research institutions that undertake HIV and AIDS research from biomedical sciences, clinical intervention trials, health systems science and impact evaluation. Research ethical approval procedures and standards are well institutionalized through Institutional Review Boards (IRB) and the National Health Research Ethical Review Sub-Committee of the National Medical Research Coordinating Committee (MRCC). The MRCC is the national health research coordinating body that ensures all health research follows country's

ethics requirements. The Committee functions include coordination of health research conducted in Tanzania. The MRCC has delegated functions of registering, ethical review, approving and monitoring of research to be carried in Tanzania to the National Health Research Ethics Review Sub-Committee (NatHREC). Research undertaken with external researchers requires the approval of the Commission for Science Technology and on the other hand, research involving external research institutions or external funding requires ethical approval from relevant external ethical review authorities.

Under HSHSP III, the twelve components of a functional M&E system will be organized into four strategic areas that will address (i) the enabling environment for M&E, (ii) routine monitoring of HIV and AIDS, (iii) HIV/AIDS Surveys, Surveillance, Evaluation and Research and (iv) Data Demand and Information Use.

5.4.1 Enabling Environment for monitoring and evaluation M&E

Current Situation

Enabling environment for M&E refers to the existence of four main components: Organisational structures with HIV M&E Functions; Human Capacity for HIV M&E; Partnerships to Plan, Coordinate and Manage the HIV M&E System, and Advocacy, Communication and Culture for HIV M&E.

NACP works with the MOHSW, TACAIDS and other partners to implement the HSHSP III. NACP has an Epidemiology Unit responsible for M&E activities with several vacant positions. At the sub-national level, there are multiple positions at the regional, district, facility and community levels with HIV M&E responsibilities, but often the same individual has several positions/responsibilities and is not adequately trained or compensated (e.g. an individual serves as a DHIS Focal person, as the DACC and is also involved in clinical work). In addition, many HIV M&E positions are externally funded with contract employees with no long-term plan in place for sustainability. In addition to some gaps in the organizational structure of individuals responsible for M&E, there is a need to enhance pre-service and in-service training to ensure that existing and newly recruited individuals have the required skill sets to conduct M&E activities.

There are comprehensive M&E plans and organizations in place for both HIV and e-MTCT. It is imperative that these vertical health programs coordinate their own M&E, HMIS and data requirement needs with the M&E Strengthening Initiative for the broader health sector. Failure to do so has resulted in growth of separate tools, initiative and interventions. Coordination between the organizations conducting M&E across health programs is imperative. Since M&E for HIV programs is a relatively new discipline, Advocacy, Culture and Communication for HIV M&E could be strengthened.

Outcome: Improved coordination and capacity for HIV M&E at all levels

Priority Strategies:

- Improve M&E organizational roles and functions at all levels in the health sector
- Strengthen coordination between government structures and implementing partners supporting HIV M&E
- Capacitate people at all levels (national and sub-national) with M&E skills
- Establish a mechanism for monitoring and planning trainings

Indicators:

1. Percentage of M&E positions at all levels (national and sub-national) filled with appropriately knowledgeable and skilled staff to handle HIV M&E functions (disaggregated by government/partner and cadre)
2. Number and percentage of regions and districts with functional M&E teams that jointly support Government and implementing partners to track interventions using the national M&E systems (i.e. acquiring and reporting data from DHIS not facility level)

3. Annual rate of retention of health workers with M&E functions in districts in the regions where Human Resource for Health Information System (HRHIS) has been installed (Global Fund Round 9 Health System Strengthening M&E Plan)
4. Percentage of health facilities with the minimum number of health workers (non-M&E staff) trained in HIV M&E (2 at dispensaries, 3 at health centres, and 5 at hospitals), disaggregated by health facility level

Targets:

- 100% of regional level M&E positions and 80% of district level M&E positions filled with staff that have appropriate knowledge and skills to handle HIV M&E functions by 2017
- 100% of regions and districts have functional M&E teams that jointly support Government and implementing partners to track interventions using the national M&E systems at national, regional and district level by 2017
- 50%³ of health workers with M&E functions are retained in districts and regions
- 100% of hospitals and 50% of health centres and dispensaries have the minimum number of health workers (non-M&E staff) trained in HIV M&E by 2017

5.4.2 Routine monitoring of HIV/AIDS**Current Situation**

Routine M&E activities consist of three main components: Routine HIV Programme Monitoring, Databases, and Supportive Supervision and Data Auditing. The routine program monitoring system provides the mechanism for collecting, managing, and reporting on inputs, activities and outputs for measuring the national response. Much work has been done to improve monitoring systems for HIV/AIDS health sector data in Tanzania in the past 4 years. Despite this progress, there are still weaknesses – the largest of which include parallel reporting systems and issues regarding the quality, accuracy and timeliness of reporting.

Tanzania's M&E system has a number of data quality assurance methods and processes and procedures for supportive supervision. National Guidelines on Management of HIV and AIDS Data Quality have been developed which include guidelines for management of data quality, supportive supervision and feedback, regular data quality audits and the production of supervision and audit reports.

Outcome:

Availability of accurate, complete and timely data at all levels

Priority Strategies:

- Enhance harmonization and linkages among HIV M&E information systems
- Capacitate people at all levels to produce high quality data
- Coordinate with partners to support data quality at facility, district and regional level

Indicators:

1. Number and percentage of health facilities submitting timely and complete HMIS reports to the district (GF HSS M&E Plan)
 2. Percentage of health facilities that received supportive supervision and mentorship on M&E
 3. Number and percentage of expected data quality assessments conducted and reports generated
 4. Number and percentage of health facilities that have functioning electronic systems
- 3 Human Resource for Health Information System (HRHIS) is currently being rolled out. Baseline expected to be established in Phase 2 Q2 of Global Fund Round 9. This strategic plan will follow their process of establishing a baseline and setting targets.

Targets:

- 100% of facilities submitting timely and complete HMIS reports to the district by 2017
- 95% of health facilities have functional electronic systems by 2017

5.4.3 HIV/AIDS Surveys, Surveillance, Evaluation and Research**Current Situation**

HIV/AIDS Surveys, Surveillance, Evaluation and Research are important non-routine M&E activities that inform the implementation of HSHSP III. The NMSF III has prioritized research to enhance investments in the strategic areas. All sectors involved in the multisectoral response have been challenged to develop, enhance, implement and disseminate research efforts that develop, promote and forge concrete linkages with its primary investment areas and their supporting interventions.

Tanzania has a well-functioning HIV/AIDS surveillance system. For the most part, the surveys and surveillance are of high quality and meet National and International standards. There are several platforms that produce data and strategic information for HIV. NACP produces regular HIV/AIDS/STIV surveillance reports from these sources. In addition there are several Health and Demographic Surveillance systems (HDSS), Clinical Surveillance Systems (CSS) and the SPDs that produce information that can be used to validate estimates from modelling systems like SPECTRUM.

In terms of HIV evaluation and research, ethical approval procedures and standards are well institutionalized. In line with National HIV and AIDS Health Sector Research and Evaluation Agenda, academic and research institutions (both public and private) undertake research across the research life cycle –from biomedical research in the laboratory, clinical intervention trials for vaccines and drugs in human subjects to health system interventions. Many of such research involve collaborations of national institutions with partner institutions North-South and South-South-North triangles. These provide opportunity for capacity building for national institutions and researchers or academicians. However, research collaboration among national academic and research institutions leading to duplication or under utilisation of expensive research infrastructure. Tanzania is one of the few countries low and middle-income countries that have capacity for conducting phase 1 clinical trials and has recently launched a Bio safety Level 3 laboratory with capacity to conduct HIV biomedical research. Increased collaboration will lead to proper utilisation of this high quality research infrastructure.

Also there is inadequate uptake of research results into policy and practice. A number of research institutions have established units responsible for Research Translation to Policy and Practice and catalysing policy delivery to scale up proven interventions to achieve health outcomes. There are ongoing capacity building efforts within and outside of NACP to strengthen capacities to conduct evaluation and research as well as conduct scientific manuscript writing. In the HSHSP III these will be expanded to include research translation and policy delivery.

Outcome:

HIV surveillance, survey and research results are timey disseminated and used to improve formulation and delivery of effective health sector HIV and AIDS Interventions

Priority Strategies:

- Create a mechanism for better communication with institutional review boards, academic and research institutions and local partners about non-routine HIV M&E activities being conducted in Tanzania.
- Promote use of existing research and surveillance systems including ANC Surveillance systems, HDSS, CSS, SPD to produce strategic information to complement modelling estimates and data from routine health information.
- Support national academic and research institutions to increase capacity undertake
- Address challenges facing HIV surveillance and surveys in the health sector.
- Create an inventory of implemented HIV research and evaluation projects.

Indicators:

1. Availability and use of national implementation framework for HIV/AIDS related surveys and surveillance and impact evaluation studies
2. Number of surveys, evaluation and research projects conducted within the existing national research, surveys and surveillance platforms (ANC, HDSS, CSS and SPD)
3. Number of implemented operational research projects emanated from National HIV & AIDS Research and Evaluation Priorities
4. Increase collaboration among local academic and research institutions to conduct collaborative HIV/AIDS research among themselves and in joint collaboration with external institutions in North-south and South-South-North partnerships
5. Percentage of planned and budgeted HIV/STI-related evaluation studies/projects that were implemented
6. Number and percentage of HIV surveillance, survey and research results disseminated within 12 months of data collection (reports signed off by MOHSW)

Targets:

- 50% of HIV surveys, surveillance and impact evaluation studies use national implementation framework and research platforms.
- Over 80% of HIV research projects implemented in the country are in line with the research priorities identified in the National HIV & AIDS Health Sector Research and Evaluation Agenda
- At least four (4) collaborative HIV research projects (one per year) involving two or more local academic/research institutions initiated by 2013
- 100% of planned and budgeted HIV/STI-related evaluation studies/projects implemented by 2017
- 100% of HIV surveillance, survey and research results disseminated within 12 months of data collection and signed off by MOHSW by 2017

5.4.4 Data Demand and Information Use**Current Situation**

At the heart of the M&E system in the NACP and Reproductive and Child Health (RCH) departments at the MOHSW is the dissemination and use of data for program improvement. The NACP/RCH M&E system currently produces the following periodic information products:

- ♦ Quarterly reports (quarterly)
- ♦ GARP Universal report (annual)
- ♦ HIV/STI surveillance report (annual)
- ♦ Care and treatment report (annual)

- ♦ ANC surveillance report (every 2 years)
- ♦ Estimation and projection report

The use of data for program planning and improvement and policy formulation is limited at the national and sub national levels, though there are some best practices.

Outcome:

HIV data and information strategically demanded and used for evidence based decision making by health workers, health managers and policy makers at all levels.

Priority Strategies:

- Capacitate people at all levels (national and sub-national) on data demand and information use.
- Capacitate people at all levels to conduct data analysis, interpretation and evidence based planning.
- Introduce and test Innovative approaches for improved data demand and information use (DDIU) for decision making including sharing information with communities served
- Strengthen feedback mechanisms at all levels.

Indicators:

1. Percentage of health facilities with at least one person trained on data demand and information use, data analysis, interpretation, feedback provision and incorporation, and evidence-based planning (Next Generation Indicators with content disaggregation, cadre, health system administrative level)
2. Percentage of health management teams (HMTs) with at least one person trained on data demand and information use, data analysis, interpretation, feedback provision and incorporation, and evidence-based planning (Next Generation Indicators with content disaggregation, cadre, health system administrative level)
3. Percentage of facilities/health management teams that were trained in DDIU that are effectively using information for evidence based planning, monitoring health outcomes, providing feedback and innovatively disseminating information, disaggregated by region and district
4. Percentage of regions and councils with effective regional/district M&E teams that conduct regular Regional M&E Fora and District M&E review process for data validation, analysis, interpretation, feedback provision and respond to data demand by higher levels and communities served

Targets:

- 90% of health facilities with at least one person trained on DDIU by 2017
- 100% of RHMT and CHMTs with at least one person trained on DDIU by 2017
- 100% of RHMT and CHMTs conduct bi-annual M&E fora and quarterly M&E review processes respectively by 2017
- 100% of RHMT and CHMTs producing and timely submitting periodic HIV and AIDS profile reports by 2017

Section Six: Smart, Evidence based and Innovative Investments

Introduction

Lessons from the implementation of HSHSP II and other related HIV strategies and interventions in the world have demonstrated new approaches and innovations that need to be considered for scale up. Tanzania has adopted a combination of efforts for a broader and meaningful involvement of PLHIVs through PHDP which will be scaled up. HSHSP III also recognizes the need to target members of key populations in combating HIV. Similarly, youth friendly services are to be prioritized. Realizing the influence of social and gender norms in spreading HIV, targeted special services and interventions such as prevention and care for victims of gender based violence will also be considered.

Overwhelming evidence on treatment as prevention points to the need for changes in treatment eligibility criteria. HSHSP III recommends a review of ART eligibility criteria starting with special groups including pregnant mothers through option B+. As it can be anticipated, more people will be started on lifelong ART during the implementation of the HSHSP III. As such, it is important to invest in more informative tests for measuring disease progress such as viral load.

6.1 Positive Health Dignity and Prevention

In considering the ongoing challenge of HIV prevention, significant gains in the treatment and care of PLHIV and attention to and funding of ARV treatment, makes it imperative for PLHIVs to be recognized as part of the 'solution'—not part of the 'problem'.

PHDP is a new paradigm in efforts to prevent HIV transmission that places PLHIVs at the centre of maintaining their health and well being within the context of human rights. PHDP stresses the importance of addressing prevention and treatment simultaneously and holistically. The public health and human rights goal of preventing new HIV infections can only be achieved when the human, sexual, and reproductive rights of PLHIVs are protected and supported; when the broader health and dignity needs of PLHIVs are met; and when access to timely and uninterrupted treatment and care encourages greater uptake of confidential voluntary counselling and testing.

The current national PHDP guidelines are developed to enable HCWs to support PLHIVs to protect themselves and others, not through fear or coercion rather through empowerment and with dignity. Ideally, a PHDP programme requires supportive legislation and policies aiming to ensure non-discrimination, reduce stigma, and change harmful gender norms.

Implementation of the PHDP framework has both public health and strategic benefits at the level of an individual PLHIV as well as the value for money on expected outcomes. Engagement of PLHIVs as both beneficiaries and active participants to promoting positive behaviours in HIV prevention will also have greater and positive outcomes in the reduction of stigma and discrimination.

6.2 HIV/AIDS services for Key Populations

KPs are populations that are at higher risk of being infected or affected by HIV, who play a key role in how HIV spreads, and whose involvement is vital for an effective and sustainable response to HIV. Members of key populations are at a significantly higher risk of HIV infection than other groups. It has been shown that in countries with a generalized epidemic, HIV prevalence is consistently higher among sex workers in the capital cities than in the general population. KPs are also at a higher risk of acquiring other infections such as syphilis, Hepatitis B and Hepatitis C. In Tanzania mainland, groups which have been documented to be at a higher risk of HIV infection include MSMs, FSWs, PWIDs,

prisoners and other mobile population groups including among others, fishermen, miners, plantation labourers, trackers.

Stigma and discrimination experienced by PLHIVs, as well as by population groups perceived to be most at risk for infection, are major obstacles to the provision of accessible services for both prevention and treatment. Moreover, legal frameworks in many countries hinder efforts to combat stigma and discrimination against PLHIVs. There are structural barriers at the policy, cultural, and institutional level including criminalization, high levels of stigma and discrimination, homophobia in health care systems, and poverty which need to be addressed. These barriers create an environment where extortion, discrimination, and violence against members of key populations are common occurrences.

The HSHSP III calls for the integration of health services for KPs aimed at fostering nonjudgmental, inclusive, and responsive health services for all. Comprehensive services for KPs will also be made available in targeted health facilities. Availability of a full range of health services utilizing a primary health care approach is a critical condition to ensure access by all. Ensuring integration of HIV and sexual/reproductive health services in primary care service delivery is particularly important to overcome stigma and discrimination. It is also important to prioritize on building the capacity of health care workers in order to enhance their knowledge and skills so that they can effectively address and integrate these issues in service delivery utilizing a human rights perspective and gender-responsive approaches. Capacity building should also increase health workers' knowledge and understanding of the physical and psychosexual health issues and concerns relevant to specific groups.

6.3 Targeted HIV and AIDS Services for Young People

Majority of young people are highly vulnerable to Sexual Reproductive Health (SRH) problems that include adolescent pregnancy and early child bearing, the complications arising from unsafe abortion, and STIs including HIV/AIDS. Moreover, knowledge on contraceptives for pregnancy prevention is generally low among young people.

Young people, including those with special needs and from the most vulnerable groups, have the right to quality health care services. Unfortunately, this right is not always guaranteed, particularly in the case of sexual and reproductive health services. Many youth in need of sexual and reproductive health care may either decline or be denied access to health services for a variety of reasons. Providers are often biased and do not feel comfortable serving youth who are sexually active; youth do not feel comfortable accessing existing services because they are not "youth-friendly" and may not meet their needs; and, often, community members do not feel that youth should have access to sexual and reproductive health services.

The HSHSP III embraces efforts to expand adolescent and youth sexual and reproductive health (AYSRH) services and to address the complex drivers of adolescents' poor SRH outcomes by targeting the barriers to health care access at the individual, social, and structural levels. The strategy recognizes the need to emphasize provider-client counseling to increase young people's SRH knowledge, skills, and health care seeking behaviours. At the social level, the approach moves beyond facility service delivery to foster an enabling community environment for adolescents to seek services, with targeted efforts to reduce bias and stigma through peer-to-peer comprehensive SRH and life skills counseling.

HSHSP seeks to ensure that a wide range of sexual and reproductive health services (SRH) that offer young people a choice are available to them, including counseling on the use of contraceptives and on sexual abuse, sexually transmitted infection (including HIV) prevention, testing and counseling services and relationship and sexuality counseling.

6.4 Treatment as Prevention

Evidence has been accumulating ever since the advent of combination ART for people with suppressed or undetectable HIV viral loads, especially those on therapy. The treatment makes PLHIVs undergoing such treatment to be less likely to transmit HIV than untreated persons. In the previous years, studies have demonstrated that PHLIVs who are on antiretroviral ART are about 20 times less likely to transmit the virus to their partners than people who are not on treatment. The definitive proof came in May 2011 when the HPTN 052 study⁴ was stopped three years earlier than planned. This study randomised the positive partner in heterosexual couples either to start taking ARVs immediately, at an average CD4 count of 436 cells/mm³, or to delay taking them till their CD4 count fell below 250 cells/mm³. The study found that people on treatment were 96% less likely to transmit HIV to their partners than untreated people.

“Treatment as prevention” is a term that is used to describe the use of antiretroviral drugs to reduce the risk of passing HIV to others. The strategy would function as a secondary benefit of ART after its primary purpose of improving an individual’s health. The rationale for this approach is that ARVs reduce viral load and higher viral loads have been linked to increased risk of passing HIV to sexual partners. HIV prevention efforts focused on people living with HIV make sense from an individual and public health perspective, and there is high-quality evidence supporting the use of ART to prevent HIV transmission. Viral load is the greatest risk factor for HIV transmission, and lowering the viral load is critical to interrupting transmission and preventing morbidity and mortality.

During the implementation of HSHSP III Tanzania will adopt this strategy in a stepwise approach, while continuing to learn from its implementation.

6.6 New Technologies

Technological innovation is changing the provision of healthcare today. In the areas of genomics, diagnostics, devices/therapeutics, and traditional healthcare IT, a number of remarkable discoveries have been made that have improved patient care exponentially. Decentralization of healthcare enables services to be delivered in a cost-effective manner.

The healthcare industry has experienced a proliferation of innovations aimed at enhancing life expectancy, quality of life, diagnostic and treatment options, as well as the efficiency and cost effectiveness of the healthcare system. Information technology has played a vital role in the innovation of healthcare systems.

HSHSP III calls for the application of new technologies in enhancing service delivery. Examples of healthcare Innovation include point of care diagnosis and monitoring equipment, data collection and communication using mobile phones and electronic systems for data collection at facility level.

6.7 Gender Based Violence

There is a growing recognition that gender norms and gender-based violence are some of the most influential factors driving HIV transmission worldwide. The epidemiology of HIV/AIDS in Tanzania shows that adult women and young girls are more vulnerable to HIV than their male counterparts. These differences stem from sexual behaviours and socially constructed ‘gender’ differences between men and women in roles and responsibilities, access to resources, and decision making power.

⁴ HPTN 052 was a large, international study which randomised 1736 male-female couples in which one partner was HIV-positive either to begin antiretroviral therapy immediately, or to wait until treatment was clinically indicated (at a CD4 count of 250 cells/mm³). The study was closed more than three years early after interim analysis of the data showed that antiretroviral treatment reduced the risk of HIV transmission from treated partner to uninfected partner by 96%. <http://www.aidsmap.com/page/1796327/>

Women are exposed to increased risk by multiple social and cultural factors that prevail in our patriarchal societies. These factors include customary norms that prevent women and young girls from discussing sexuality, a tacit acceptance of male partner infidelity, and limited decision making power. As for men, certain cultures encourage the notion of masculinity which encourages multiple sexual partnerships, violence, and substance abuse to prove their manhood.

The fear of violence prevents women from reporting violent acts to authorities, accessing PEP and HCT services, or in negotiating protective measures against HIV infection. For similar reasons, many women, especially those who are married, do not disclose their HIV status to partners and family members for fear of being mistreated.

Putting an end to GBV will take more than just the review of laws and policies. Health facilities and law enforcers need to be equipped with necessary knowledge and skills to assist and/or support gender based violence victims. During the implementation of HSHSP III, Tanzania will scale up GBV services in targeted locations and continue to strengthen linkages between health services and the police force. The fight against GBV is necessary for a life free of violence and HIV infection.

Section Seven: Leveraging Partnership

7.1 Key Stakeholders

The health Sector HIV and AIDS strategic plan implementation, monitoring and evaluation will require various stakeholders. A list of stakeholders is given below without whom HSHSPIII results will not be achieved.

- i. **Development partners** include bilateral cooperation, multilateral organisations and private foundations. According to MKUKUTA dialogue structure and mutually agreed division of labour, Development Partners are organised into the Development Partners Group for Health (DPG-Health) and for HIV and AIDS (DPG-AIDS). The complete list of DPs supporting the sectors can be found in the reports of the Annual Public Expenditure Review (PER) Health or HIV and AIDS respectively. On predictable Funding, the implementation of HSHSPIII (2013-17) will require timely financial support
- ii. **Implementing partners** are mainly the International and Local NGOs and Faith Based Organisations and other Civil Society Organisations.
- iii. **Research Institutions** which include but not limited to; National Institute Medical Research (NIMRI) Ifakara Health Institute (IFI), Muhimbili University of Health Alliance Sciences (MUHAS), Kilimanjaro Christian Medical Centre (KCMC) and Bugando Consultant Hospital (BCH).
- iv. **Other stakeholders** include; Tanzania Food and Drug Authority (TFDA), Tanzania Food and Nutrition (TFN), Medical Stores Department (MSD), PHLB, Prime Minister Office Regional Administration and Local Government (PMO-RALG).
- v. **Regional and Council Health Management Teams** with their health facilities at all levels i.e. Hospitals, Health Centres and Dispensaries, both public and private.
- vi. **Community** covering families, Community based and PLHIV Organisations, Detailed roles and responsibilities appear in section 7.2.

7.2 Roles and responsibilities

7.2.1 Ministry of Health and Social Welfare

- i. Coordinate partners and supervise those implementing Health Sector HIV Strategic Plan III (2013-17) in the country.
- ii. Mobilize and advocate necessary resources for HSHSPIII (2013-17).
- iii. Provide overall technical leadership guidance, advice, Monitoring and Evaluation on the implementation of HSHSPIII (2013-17)
- iv. Ensure availability of essential Medicines and necessary supplies by facilitating efficient procurement, storage and distribution to all levels of service delivery.
- v. Facilitate effective development, recruitment and deployment of skilled health workers at health facilities in collaboration with PMO-RALG, the President's office-Public services management (PO-PSM) and Ministry of Finance.
- vi. Ensure availability of harmonized and integrated Health Management Information system (HMIS).
- vii. Ensure adherence to guidelines, standards and regulations.

- viii. Promote and oversee operational research on Health Sector HIV Prevention, Care and Treatment and support Services.

7.2.2 National AIDS Control Program (NACP)

The Role of the NACP is to;

- i. Coordinate and oversee implementation, monitoring and evaluate of Health Sector HIV prevention, Care, treatment and support services.
- ii. Advocate for the implementation of Health Sector HIV Strategic Plan III (2013-17).
- iii. Collaborate with various stakeholders at all levels for planning and implementation of the HSHSPIII (2013-17)
- iv. Facilitate capacity development at all levels by developing guidelines, protocols and training packages for HSHSPIII (2013-17)
- v. Facilitate the integration of Health Sector HIV Prevention, Care, and Treatment and support Services with other Health Services.
- vi. Promote quality improvement of Health Sector HIV Prevention, Care, Treatment and Support services at all levels
- vii. Design, develop and implement social and behaviour change communications to promotion uptake of health sector HIV and AIDS interventions country wide
- viii. In collaboration with the procurement unit, facilitate procurement, distribution, monitoring and evaluation of HIV and AIDS commodities.
- ix. Design and develop a monitoring and evaluation framework and ensure availability of recording and reporting tools for HSHSPIII (2013-17)
- x. Facilitate integration of HIV information system within the national M&E strengthening initiative and strengthen and promote effective and efficient data collection, analysis and utilization of HIV and AIDS information at all levels
- xi. Organise and coordinate the promotion of Health Sector HIV Prevention, Care and Treatment Services best practices.
- xii. Organize and Coordinate Health Sector HIV Prevention, Care, and Treatment and support operational research in collaboration with research institutions.
- xiii. Conduct operational research for Health Sector HIV Prevention, Care, and Treatment and Support services.

7.2.3 Research and academic Institutions

- 1. Research and academic institutions have role of planning, conducting researches and disseminating findings to key stakeholders in the country as part of improving Health sector HIV Prevention, care, treatment and support services
- 2. Jointly coordinate synthesis of new knowledge from research and support MOHSW/NACP to translate to policy and practice
- 3. Support MOHSW/NACP to catalyse the national scale up of proven interventions and best practice through development of tools and methodologies.
- 4. To establish, maintain, use or avail to MOHSW research and surveillance platforms for national evaluation of HIV and AIDS Interventions.

7.2.4 Medical Store Department (MSD)

- i. Ensure availability of HIV and AIDS commodities for the country through timely and appropriate procurement, storage and distribution of HIV and AIDS commodities
- ii. Monitor and evaluate commodities throughout the supply chain system.
- iii. Ensure availability of updated stock status information for all commodities.

7.2.5 Tanzania Food and Drug Authority (TFDA)

- i. Registration of medicines, medical devices, foods and cosmetics
- ii. Quality assurance
- iii. Enforcement of laws and regulations for food and medicines.
- iv. Post marketing surveillance of HIV related commodities
- v. Public information sharing/awareness on safety of medicines, medical devices , foods and cosmetics
- vi. Setting standards for in country marketing of health products

7.2.6 Tanzania Food and Nutrition Centre (TFNC)

- i. Provide information and education on nutritional to PLHIV
- ii. Provision of nutrition supplements (RUTF) to PLHIV
- iii. Promote operational research on nutrition to PLHIV
- iv. Develop national nutritional guidelines to PLHIV
- v. Coordinate other organisation implementing nutritional interventions to PLHIV

7.2.7 Private Health laboratories Board (PHLB)

- i. Assuring the Quality of health laboratory products and supplies.
- ii. Coordinating evaluation and validation of health laboratory products and supplies.
- iii. Approve and register health laboratory products and supplies after evaluation

7.2.8 National Health Laboratory Quality Assurance and Training Centre (NHLQATC)

- i. Monitor quality of laboratory throughout the country in supporting HIV and AIDS care and treatment and other health care interventions
- ii. Prepare and distribute laboratory proficiency testing materials
- iii. Serve as an HIV referral laboratory and drug resistance test.

7.2.9 Prime Minister's Office Regional Administration and Local Government (PMO-RALG)

- i. Facilitate effective recruitment and deployment of skilled health workers at health facilities in collaboration with MOHSW and Presidents Office-Public Services Management.
- ii. Collaborate with various stakeholders at all levels for planning and implementation of Health Sector HIV Prevention, Care, Treatment and Support Services.
- iii. Design and develop planning guidelines (MTEF, Opportunities and Obstacles to Development)

7.2.10 Tanzania Commission for AIDS (TACAIDS)

- i. Formulate national policy guidelines for the response to the HIV and AIDS epidemic and the management of its consequences in mainland Tanzania
- ii. Mobilize, disburse and monitor resources and ensure their equitable distribution.
- iii. Provide oversight to multisectoral HIV and AIDS response in the Country
- iv. Promote research, information sharing and documentation on HIV and AIDS
- v. Promote high level advocacy and education on HIV and AIDS prevention and control
- vi. Develop a strategic framework for planning National HIV and AIDS Response within the overall national strategy (NMSF).

7.2.11 Regional Health Management Teams (RHMT)

- i. Lead the overall health sector response to HIV and AIDS at the regional level
- ii. Coordinate, supervise, monitor and evaluate Health sector HIV prevention, care, treatment and support services and partners in the region.
- iii. Provide technical support to CHMTs for incorporation into CCHP and implementation of Health Sector interventions for HIV Prevention, Care, Treatment and support at the district/council level.

- iv. Promote capacity development of health care providers for provision of Health sector HIV prevention, care, treatment and support services at the district level.
- v. Ensure availability and adherence to national guidelines and standards for Health sector HIV prevention, care, treatment and support services
- vi. Support CHMTs to collect, compile, analyse, interpret and disseminate data of health sector HIV and AIDS services.
- vii. Receive, compile, analyse, use and disseminate Health sector HIV prevention, care, treatment and support services data from the councils and send to the National Level.
- viii. Mobilize and Coordinate partners and resources for implementation of Health sector HIV prevention, care and treatment and support services in the region.

7.2.12 Council Health Management Teams (CHMT)

- i. Lead the overall health sector response to HIV and AIDS at the council level
- ii. Coordinate and collaborate with stakeholders the planning and implementation of Health sector HIV prevention, care, Treatment and support services in the Council.
- iii. Plan and incorporate HSHSPIII (2013-17) activities into the CCHP then into the council plan
- iv. Implementation, Monitoring & Evaluation and Supervision of Health sector HIV prevention, care, Treatment and support services activities at the Council level.
- v. Ensure availability and adherence to national guidelines and standards for Health sector HIV prevention, care, Treatment and support services
- vi. Ensure availability of HIV commodities and maintenance of equipment
- vii. Provide technical support to health facilities (district hospital, health centres, dispensaries) including voluntary agencies and private health facilities in the council for quality Health sector HIV prevention, care, Treatment and support
- viii. Develop capacity of service providers for quality Health sector HIV prevention, care, Treatment and support services.
- ix. Ensure mechanism for community involvement in Health sector HIV prevention, care, Treatment and support services in place.
- x. Facilitate the incorporation of Health Sector HIV prevention, care, Treatment and support services into the village plans through O and OD planning process.
- xi. Strengthen HMIS by Compiling, disseminating and use Health sector HIV prevention, care, Treatment and support data for service improvement.

7.2.13 Health facilities (Hospitals, Health Centres and Dispensaries)

- i. Provide health Information and education on HIV infection to the clients.
- ii. Provide Health sector HIV prevention, care, Treatment and support Services according to the national guidelines (CTC, HTC, HBC, etc.)
- iii. Ensure collection of data, analysis, use and dissemination and send to high level.
- iv. Ensure timely ordering of essential HIV commodities
- v. Contribute to prevention, health, dignity services for people living with HIV
- vi. Ensure mechanism for referral and linkage with Community Based HIV and AIDS Services.
- vii. Coordinate and supervise Community Based HIV and AIDS Services.

7.2.14 Community

- i. Implement the Health Sector HIV Strategic Plan III (2013-17) according to their capacities.
- ii. Support community resource mobilization and allocation for implementation of HSHSP III (2013-17).
- iii. Implement Home Based HIV and AIDS services package.
- iv. Plan for implementation of HIV and AIDS services at community level.

- v. Plan for home visits, community awareness meetings, and support for referrals (such as transport support).
- vi. Promote male involvement and participation in Health sector HIV prevention, care, Treatment and support services.
- vii. Establish family Support Groups to educate women, provide mentoring and support and ensure women receive the highest possible quality of care.

7.2.15 Development Partners

- i. Coordinate amongst themselves (e.g. Development Partner Group for AIDS and for Health i.e. DPG-AIDS and DPG-Health) and ensure representation at the national Coordination Group for the HSHSP III set up by the MOHSW.
- ii. Provide direct and indirect budget support to the prioritized areas in the Health Sector HIV Strategic Plan III (2013-17)
- iii. Use existing government systems to track resources and monitor aid effectiveness

7.2.16 Implementing Partners

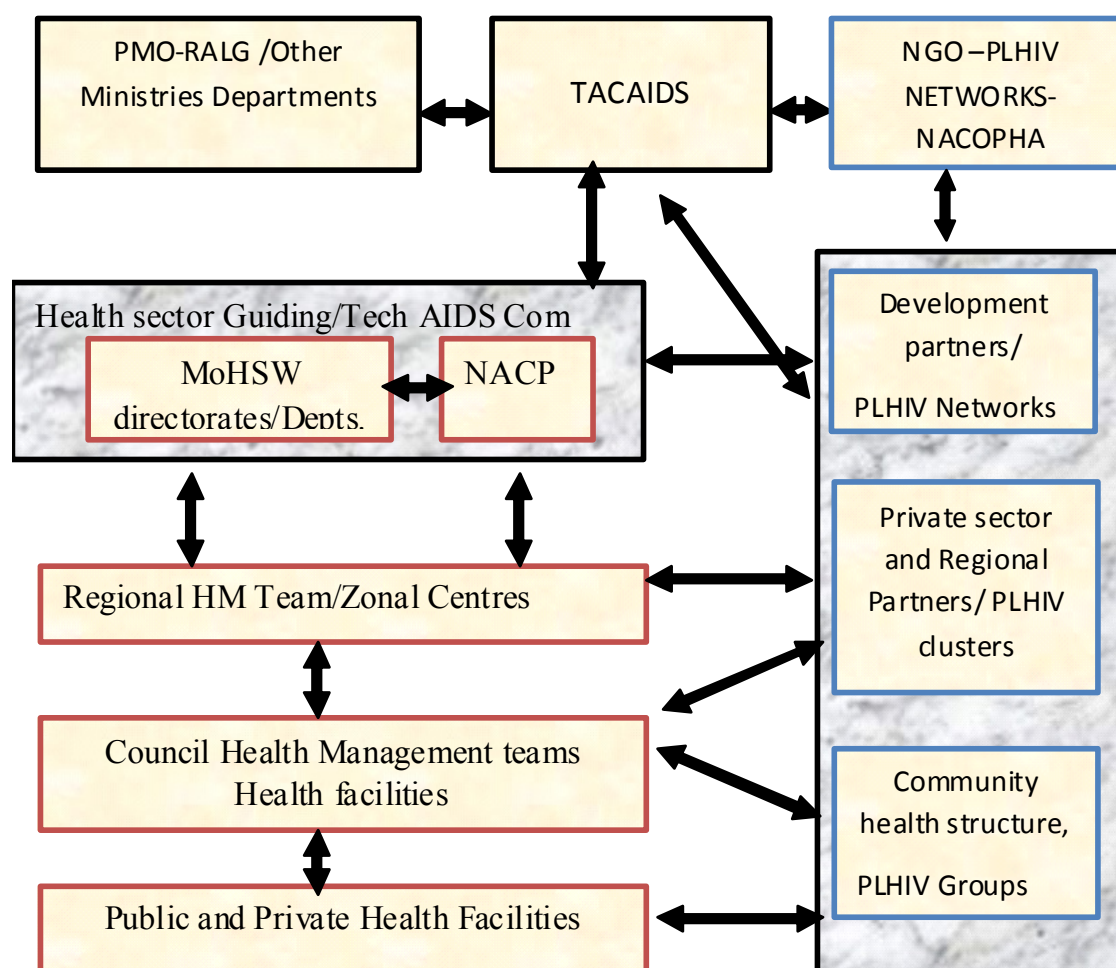
- i. Assist Regions and Districts to identify needs and gaps for strengthening expansion and improving quality of Health sector HIV prevention, care, Treatment and support Services.
- ii. Assist districts and regions to translate the HS HSP III (2013-17) into regional specific, actionable /effective comprehensive plans.
- iii. Work with districts to ensure that Health sector HIV prevention, care, Treatment and support services are prioritized and their respective funding allocations are reflected in the CCHP.
- iv. Develop innovations that can be tested and shared with RHMTs and CHMTs and MOHSW to improve implementation of the Strategic plan, uptake and outcomes of services.
- v. Assist the MoHSW in building capacity of CHMT and RHMT and NGO/FBOs to effectively plan, manage, implement and monitor the program.
- vi. Provide technical support to RHMTs and CHMTs for implementation of training, supportive supervision and mentoring.
- vii. Collaborate with RHMTs and CHMTs to ensure availability of HIV commodities at all levels.
- viii. Build and develop a solid blood sample transportation system for diagnosis and patient monitoring (DBS, Viral load and CD4) in collaboration with MoHSW, RHMTs and CHMTs
- ix. Support RHMTs and CHMTs to collect, compile, analyse, interpret and disseminate data of health sector HIV and AIDS services
- x. Strengthen a multidisciplinary team at facility level in collaboration with CHMTs.

7.3 Linkages for HSHSP III

Linkages during the implementation of HSHSP III are necessary for achieving results. Within the health sector, linkages with other programmes, units, sections and departments is crucial for HSHSP III as many components of health system strengthening are implemented through the HSHSP III. In particular, close linkages will be fostered with the sections responsible for M&E, HRH, Diagnostic (Laboratory services) and RCH Services or programs for PMTCT and NBTS.

Closer coordination between TACAIDS and NACP is required, because NMSFIII has used investment framework, where a greater portion of programs and interventions are health related, i.e. eMTCT/ Children, Care and treatment and support, Key Population, Condom Programming, behaviour change and Medical Male circumcision. Greater linkage is required between TB program and PMTCT section with NACP. For cost effectiveness these would preferably be coordinated under one system. NACP needs to link with other Sectors' 5 year HIV and AIDS strategic plans. At the national level NACP links with TACAIDS, NACOPHA, PMO-RALG and Development partners are key for policy, guidelines and

resource mobilization. Regions and Councils need to develop operational plans so as focus on regional HIV prevalence, HIV drivers and health infrastructure. The lower level health facility is key to connecting the clinical services and community based health service through the in-charge, community leadership and PLHIV support groups. See the figure below



7.4 Public Private Partnership

The value of promoting partnership in the achievement of the HSHSPIII cannot be overemphasized; it includes but is not limited to sharing of ideas, resources and gaining access to the skills across the health sector and beyond. During implementation of the various interventions, partnerships help to reduce cost and time and provide opportunities to reach a wider client community. Pockets of innovative approaches in promoting interventions to eliminate HIV infection and reduce AIDS related mortality and stigma can be scaled up so that partnerships can facilitate creative ways of sharing lessons. The NMSFIII has identified three outputs for partnerships i.e.

- i. Establish a Public-Private Sector mechanism for dialogue and commitment towards the national response to HIV and AIDS⁵
- ii. Sensitize and build capacities of private sector players in the formal and informal sectors to identify roles and mechanisms for implementing the three zeros

⁵ General population, young people in and out of school, key population groups and other vulnerable populations such as uniformed services, transport workers, mining and fishing communities will be targeted.

- iii. Monitor and support private sector operators in the national response to HIV and AIDS.

These results will cut across health sector service levels, and will be pioneered by the national level, RHMT and CHMTs. The costing and implementation of this strategy will largely depend on the government and her partners. Partners will be expected to provide support in capacity building, human resource development, technical assistance and sharing of best practices as detailed in the roles and responsibilities of various partners listed above.

The private sector which mainly includes Faith Based Health Facilities and Private for Profit and Not for Profit Health facilities offers a unique alternative to defray costs by offering preventive and care HIV services. In turn, the MOHSW will continue to offer referral, consultancy services, and secondment of health care workers to private hospitals.

In order to strengthen PPP, the MOHSW will ensure policy guidelines and standard operating procedures are disseminated and available to partners. Where appropriate, memorandum of understanding between MOHSW and partners will be developed at appropriate levels to define specific roles and responsibilities, joint planning, supervision, accountability, participation and reporting. To encourage transparency between partners, regular reviews, open communication and the sharing of financial reports should be promoted.

Private sector involvement in resource mobilisation

As already noted in the roles and responsibilities, the not for profit as well as profit making companies could play a greater role in providing resources for the realisation of HSHSPIII results. However, the engagement of private foundations and organisations (e.g. BMGF, Abbott Fund, WJCF/CHAI, BMAF), and government social security funds such as NSSF, PPF, GEPP, PSPF and local private companies requires health sector leadership preferably at national, regional and council level. These organisations have corporate social responsibilities, but they need to be given clear goals as to what their financial contributions can achieve. They need to be given clearly defined activities before they provide their support. The health managers need to develop short proposals and submit them to private companies. The key principles should be building mutual trust, transparency and trust with the private sector, regardless of the level they are operating. The proposals should have clear and well stated results and areas of engagement. For instance the financing of delivery kits for a specific dispensary or maternal health service. The charity walks organised by Barclays Bank, AMREF and CCBRT this year are cases in point.

The MOHSW needs to have appropriate answers to the sector interested in supporting HSHSP III, in case they need to know why they should support part of the interventions in HSHSPIII when they are already paying taxes. Fund raising activities and charity walks where the companies can market their products would be appropriate similar to what is already happening when a person or team climbs Mountain Kilimanjaro for HIV and AIDS support by a gold mining company.

The MOHSW partnership desk should attempt to build skills for health managers on partnership building approaches. The MOHSW can use existing models that are working, where the companies can channel their resource through a reputable local organisation that has experience in HIV and AIDS and has worked with the MOHSW before like BMAF, AMREF, Care International. This would work on behalf of the MOHSW to promote trust, transparency and accountability in terms of quality and timely reporting. Communication Companies (mobile phone companies) could play a major role by charging a minimal amount of money for every SMS or call which would be channelled to support specific HSHSPIII interventions like drugs for opportunistic infections. Communication companies could also be

requested to support HIV and AIDS messages e.g. Couple counselling, discordant couples, promotion of female condoms, ART adherence and male involvement while promoting their product.

Other Private groups will have access to state of the art training and technical assistance to enable them to provide quality services to clients. Private facilities will be encouraged to report their data through the district as per other partners.

A mechanism will be agreed upon to address any challenges that may arise as a result of building partnerships, these may include clashes in management culture and practices, and delays in decision making as a result of excessive consultation.

Section Eight: Implementation of the Strategy

Governance structures to oversee the implementation of strategy are found at three levels:-National, Regional and Local government authority

8.1 National level Governance Structures

8.1.1 The Prime Minister's Office

The Prime Minister's Office plays a pivotal role in the national response to HIV and AIDS. It hosts TACAIDS, the Inter-Ministerial Technical Committee on HIV and AIDS and the Tanzania National Coordinating Mechanism (TNCM) for the Global Fund for AIDS, Tuberculosis and Malaria (GFATM). The Prime Minister's Office (PMO) has the responsibility for coordinating MDAs' response to HIV, a function performed through the Inter-Ministerial Technical Committee on HIV and AIDS. The PMO provides oversight, guidance and financial support to TACAIDS and the TNCM.

- (i) Inter-Ministerial Technical Committee on HIV and AIDS
 - ♦ The IMTC on HIV and AIDS coordinates the response to HIV by Government Ministries, Departments and Agencies (MDAs')
 - ♦ The IMTC is chaired by the Permanent Secretary PMO and involves Permanent Secretaries from all sector Ministries involved in the response.

(ii) The Tanzania Commission for HIV and AIDS

The Tanzania Commission for HIV and AIDS was established by the Act of Parliament No. 22 of 2001. The Commission, which is under the Prime Minister's Office, is mandated to coordinate the national response to HIV and AIDS. This responsibility also mandates the Commission to develop and review as well as coordinate the implementation of the National HIV and AIDS Policy and translated it into National Multisectoral HIV and AIDS Framework that guides all Stakeholders including Ministry of Health and Social Welfare in the National Response. Other mandates include:

- ♦ Developing a strategic framework for planning all HIV AND AIDS control programmes and activities within the overall national strategy.
- ♦ Fostering national and international linkages among all stakeholders through proper coordination of all HIV and AIDS control programmes and activities within the overall national strategy.
- ♦ Mobilising, disbursing and monitoring resources and ensuring their equitable distribution.

iii) The Tanzania National Coordinating Mechanism (TNCM)

The TNCM is a governance mechanism established under the Directive of GFATM and mandated to provide oversight to global Fund resource mobilization through proposal writing, grants implementation and reporting. TNCM Secretariat supports TNCM to function effectively and is led by TNCM Secretary who reports to Permanent Secretary, Prime Minister's Office. The Secretariat and the Secretary are housed at TACAIDS. A significant amount of GF grants support HIV and AIDS, Malaria and TB programmes implemented mainly by the Health Sector and partners.

8.1.2 Ministry of Health and Social Welfare

The MoHSW is mandated for formulation of health and social welfare policies and monitoring and evaluating their implementation as well as ensuring that all Tanzanians access quality health and social

welfare services. With regard to HIV and AIDS, the Ministry of Health leads the health sector response to HIV and AIDS. It houses the NACP which is responsible for providing technical leadership and coordination of the health sector response, managing resources for implementing HIV prevention, HIV and AIDS care and Treatment and supportive crosscutting and health system interventions in the health sector. The governance structures under the MOHSW include:

(i) MoHSW Senior Management Team (SMT)

The senior management team of the MOHSW is lead (chaired) by the Permanent Secretary (PS) and attended by the Chief Medical Officer (CMO), all directors of Ministerial departments and directors of Agencies and Units under the MOHSW. It is responsible for providing oversight and management guidance to all health programmes and activities. All plans (including strategic plans) and budgets are approved by the SMT.

(ii) SWAp Technical Committee (TC-SWAp)

The MOHSW has established a dialogue structure to guide the Sector Wide Planning Approach (SWAp) for the health sector. This provides an opportunity for involving all key stakeholders including development partners and civil society to participate in guiding the health sector reforms and interventions. At the top of the dialogue structure is the Joint Annual Health Sector review which brings together all key stakeholders once a year to review progress made in the health sector and set/approve priorities for the next year. It is an important tool for resource mobilisation and accountability. In between the JAHSR, there is the SWAp committee and Basket Funding Committee that bring together the Ministry leadership with all partners who have signed SWAp agreement or basket Funding agreement with the GOT. The JAHSR and SWAp committee have delegated the role of providing governance support to the SMT of MOHSW to the TC-SWAp. The TC-SWAp is under the chairmanship of the PS-MOHSW.

8.2 Governance Bodies at the Regional level

(i) Regional Consultative Committee

The Regional Consultative Committee is the highest governance body at the regional level. The Regional Commissioner chairs the RCC and the Regional Administrative Secretary is the secretary. It involves all departmental heads at the regional level

The functions of the RCC are to:

- ♦ Coordinate stakeholders' meeting on HIV prevention, care, treatment and support services
- ♦ Provide technical support for the dissemination of policies, guidelines, standards and regulations in HIV prevention care, treatment and support services to respective councils
- ♦ Conduct advocacy to regional and district heads and decision makers on HIV prevention, care, treatment and support services

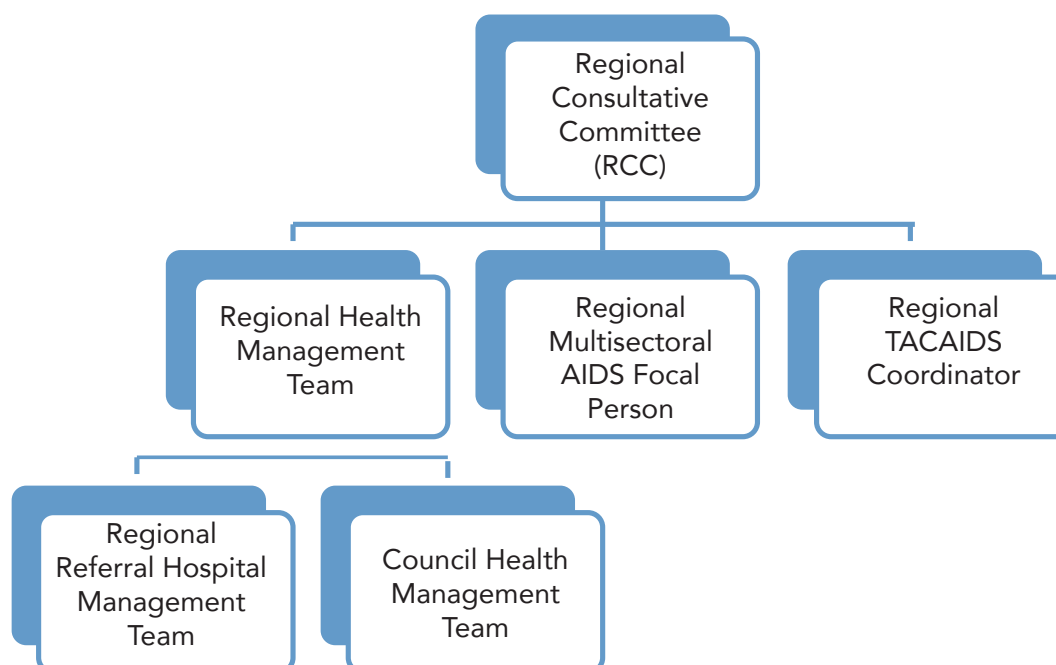
In addition, the regional consultative committee is responsible for:

- ♦ Advising the region on the political, economic, defence and security issues
- ♦ Reviewing and approving regional plans and budget
- ♦ Discussing and advising on regional development issues

With respect to HIV and AIDS, the Regional Multisectoral AIDS Focal Person employed by the Regional Secretariat is a member of the RCC and represents all issues regarding HIV and AIDS (NMSF III and HSHSP III). The regional TACAIDS Coordinator and the RACC provide inputs with regard to multisectoral and health sector HIV and AIDS Intervention

8.3 Local Government level

The governance structure at local government level has three levels of coordination (council, ward and village) as shown in the illustration below:



8.4 Organisation structure of the National AIDS Control Programme and Linkages at regional and Local Government level

i. Organisation Structure of NACP

The organisation structure of NACP will be revised for effective implementation of HSHSP III. This will be based on key functions to be undertaken, job analysis and a performance assessment system for all key positions in management and technical leadership of the health sector response. The functions include:

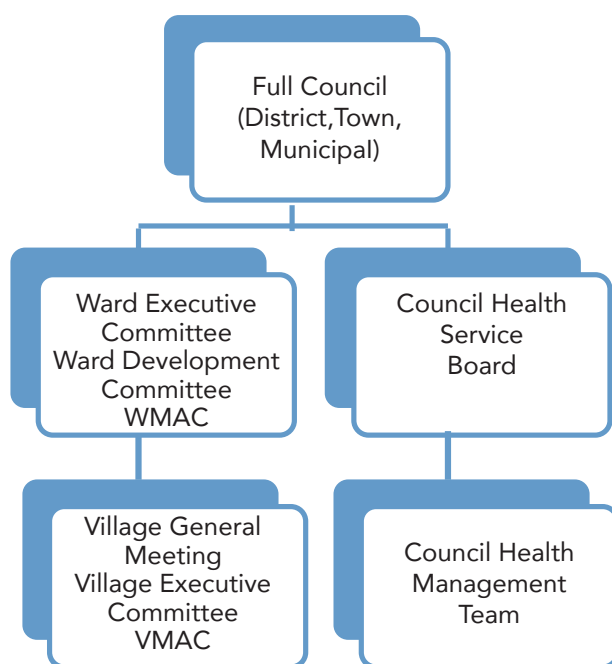
- a. Programme management
- b. Technical leadership of key intervention areas
- c. Supportive health systems
- d. Administrative support functions (Admin, HR, Procurement, Finance)

ii. Regional level

At the regional level, the RHMT reports to the regional secretariat. Within the RHMT the RACC will be responsible for all health sector HIV and AIDS activities. The RACC will work closely with Regional HIV Focal Person of the Regional Secretariat and Regional TACAIDS Coordinator.

iii. Council level

The CHMT is responsible for Health sector HIV and AIDS activities at the council and community level. The DACC works closely with Council HIV/AIDS Coordinator (CHAC) who is responsible for the multi-sectoral activities and is the secretary of the Council Multi-sectoral AIDS Committee (CMAC). The position of the Council Social Welfare Officer (SWO) has been transferred to the



health sector. Hence, the SWO, DAC and the CHAC collaborate in supporting the community based interventions and PLHIV groups.

8.5 Coordination structures and processes

In order to foster integration within the health sector, coordination of HSHSP III will be entrusted to existing structures within the SWAP dialogue structure. Hence, there will be active participation of NACP in the Disease Specific Programmes Technical Working Group (TWG-7) - and in the M&E TWG both reporting to the TC-SWAP).

Also NACP will strengthen its participation in the TACAIDS TWGs and Joint Thematic Working Group (JTWG).

A National Steering Committee for health Sector HIV Response will be established to replace the National Advisory Committee. This committee

will be chaired by the Chief Medical Officer (CMO) and the Programme Manager, NACP will serve as Secretary. Members will be drawn from development partners, TACAIDS, PMORALG, the UN family, PLHIV groups, NGOs, CSOs and chairpersons of NACP sub-committees. In order to address diversity of expertise and partners involved, the following five sub-committees are being proposed:

- ♦ Sub-Committees
 - a. Prevention,
 - b. National Task Team (NTT) for eMTCT and PedART
 - c. Treatment and Care
 - d. Logistics
 - e. ME and Research

8.6 Financing of the Strategy

Financing of HSHSP III will depend on

- i) Government, (MOHSW-Health Financing Strategy, TACAIDS-AIDS Trust Fund, Local Government contribution)
- ii) Development partners (including Global Fund and PEPFAR)
- iii) Public Private partnership (PPP)
- iv) Community self financing

Government funding will be realised through the MTEF of MOHSW, PMORALG and CCHP of the local government authorities. The source of the funding is from government taxes, World Bank Credits and Development partners who support through Budget support. The MOF releases budget guidelines at towards the end of November or early December with budget ceiling for each sector. These guidelines depend of Government priorities (central and sectoral). The Five year development plan highlights the priorities in the health sector and in the HIV and AIDS sector. Both have bearing from the HSHSP III. The MOHSW is in the process of finalising the Health Sector Financing strategy. This will be an important document for mobilising resources for HSHSP III through MOHSW and PMORALG.

Some development partners fund the health sector through basket funding. While funds contributed to the Health Basket fund (HBF) are not earmarked, in most cases only a few would be allocated to

HIV and AIDS since it is seen to have separate funding mechanisms. Health Basket funds are however available to support health systems that also benefit HIV intervention like Diagnostic services, RCHS, M&E and human resources for health. NACP will engage with sections, units and programmes funded by basket funds to ensure that health systems interventions that support HIV and AIDS services are fully covered.

Global Fund and PEPFAR are major global initiatives that finance HIV and AIDS interventions. PEPFAR funds through separate mechanism (outside GBS or HBF). PEPFAR funds through a National Partnership Framework coordinated by TACAIDS and is guided by the PEPFAR blue print. Most of the PEPFAR funds are channelled through implementing partners (international and local). There has been an increasing tendency to use local partners. NACP will engage the implementing partners to ensure that the proposals submitted for PEPFAR funding are in line with HSHSP III. The funding from the Global Fund for AIDS, TB and Malaria (GFATM) on the other hand is coordinated by the Tanzania national Coordinating mechanism (TNCM). The approach of Global Fund Rounds is being replaced by a new mechanism of strategic application. This HSHSP III and the annual operational plan is therefore the resource mobilisation strategy for both Global Fund and PEPFAR as it is for government funding. Other sources of funding will be self generated revenues from local government councils and community initiatives. This will be role of the CHMTs and RHMTs to identify these opportunities and tap them.

The government has approved the PPP strategy to mobilize additional resources from the private sector to complement public funding. In the operationalization of HSHSP III, efforts will be made to tap resources from the private sector (corporate, businesses and individuals) to support HIV and AIDS Intervention at different levels.

Finally, the Tanzania Government is in the final stages of establishing the AIDS Trust Fund (ATF). The sources of funds will be annual government allocation, contribution from development partners (domestic and external) and investment. The ATF will be managed through a board of trustees and secretariat. Priorities will be according to NMSF III. Funds will be available for all sectors. Health sector funding will be based on HSHSP III priorities. It will start operating in next financial year (2014/15) with an initial budget of \$300million.

8.7 Operational Plans

In the results chain framework this strategic plan has addressed the Impact and outcomes only. Each year, NACP will prepare an annual operational plan that will be aligned to the government financial year. The health sector annual operational plan will feed into the MTEF of MOHSW and PMORAG and CCHPs of each council. Implementing partners will be required to ensure that all interventions and activities implemented at the national, regional and council level are included in the Annual operational plan.

Periodic reviews (quarterly, half-yearly and annual) of the annual operational plans by the implementers will lead to progress reports submitted to a higher level. The councils will submit quarterly reports to RHMT and the regions will submit quarterly to NACP. NACP on the other hand will prepare half-yearly and annual national report and submitted to CMO and TACAIDS.

Section Nine: Monitoring and Evaluation Plan

9.1 Indicators and Targets

During the development of indicators and targets for the HSHSP III, the following key documents were referred to: Global Health Sector Strategy on HIV 2011-2015, the Global Fund M&E Toolkit Fourth Edition, PEPFAR Next Generation Indicators, Millennium Development Goals (MDGs), THMIS, TDHS, HSSP III, NMSF III, HSHSP II, UNGASS/UN High Level Meeting 2011. Priority indicators were chosen by consultants and presented to key stakeholders during the HSHSP III writing workshop. They were further refined by NACP in consultation with program staff.

The Tipping Point – Incidence to Treatment Ratio (see matrix at the end of this strategic area).

1. Ratio of new HIV infections to increase in new patients on treatment

Elimination of new HIV infections

1. Percentage of young people aged 15–24 who are living with HIV
2. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
3. Percentage of women and men aged 15–24 who had higher-risk sex in the last 12 months who reported using a condom the last time they had sexual intercourse
4. Percentage of young women and men aged 15–24 who have comprehensive knowledge about AIDS

Reduction of HIV related mortality

1. Percentage of adults and children with HIV known to be on treatment X months after initiation of ART (X= 12, 24, 36, 48, and 60 months)
2. Estimated percentage of child HIV infections at 18 months from HIV-positive women delivering in the past 12 months
3. Percentage of PLHIV who experienced/perceived stigma when accessing health services
4. Number and percentage of HIV- infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV
5. Number and percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth
6. Number and percentage of eligible adults and children currently receiving antiretroviral therapy
7. Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV
8. Percentage of LTFU clients followed up and linked back to health services by Community Based HIV and AIDS Services Providers

HIV among Key Populations

1. HIV and AIDS prevalence among key populations
2. Number and percentage of key populations at risk reached with individual and/or smaller group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required
3. Percentage of key populations who reported using a condom during their last high-risk sexual encounter
4. Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected

Health Systems to Support Health Sector HIV/AIDS Responses

1. Percentage of health facilities that have experienced stock-out of at least one tracer item in the last 12 months
2. Percentage of laboratories that meet the national quality assurance standards
3. Number and percentage of health facilities submitting timely and complete reports to the district
4. Percentage of facilities/health management teams that have been trained that demonstrate competence in applying DDIU in the work setting

The targets were set during a meeting of the consultants and subsequently in consultation with NACP and the appropriate program areas (e.g. PMTCT). After reviewing available data for baseline, strategic and funding priorities, and other available targets (e.g. eMTCT National Plan, NMSF etc.) targets were set based on feasibility and taking into account changes in programs (e.g. option B+). The levels of the targets are set to achieve the linked higher-level results and, therefore, a change in one or more of the targets affects the others. The targets will be reviewed on an annual basis. However, it is important to emphasize the need to obtain baseline data where it does not exist through setting up and strengthening existing systems.

Note: A detailed description of the indicators including the numerators and denominators, targets (baseline, midterm and end line and sources of data are presented in the Annex at the end of the strategy document.

9.2 Reporting

In order to monitor the progress of HSHSPIII implementation at all levels, sub-national reports will be prepared and sent to NACP on an annual basis. HIV District and Regional Reports will be integrated into the health sector District and Regional Health Profiles in phases over the course of HSHSPIII. Until the development of the fourth Health Sector Strategic Plan (HSSPIV) in 2015, HIV District Reports will report on the two HIV indicators currently included in DHIS (District Health Information System), in addition to a selection of other HIV service delivery indicators as shown below. HIV District Reports will be sent to the regional level, and regions will aggregate and submit HIV Regional Reports to the national level. When HSSPIII expires in 2015, these additional HIV indicators should be absorbed into the annual District and Regional Health Profiles, and by 2017 when HSHSPIII expires, full integration of HIV and Health Sector data will have been achieved.

Indicators to be reported on in the interim HIV District and Regional Profile Reports:

- Percent of HIV- infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of (included in the District Health Profile)
- Percentage of eligible adults and children currently receiving antiretroviral therapy (adults on treatment included in the existing District Health Profile)
- Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results
- Number and percentage of health facilities that have experienced stock-out of at least one tracer item in the last 12 months

CHMTs and RHMTs may identify additional indicators of local relevance and include in the profile reports, but the nationally selected indicators above must be included.

CHMTs and RHMTs will also prepare a brief narrative describing progress in implementing HSHSPIII, challenges, and plans for addressing the challenges in the next year to accompany the profile reports.

9.3 Mid-Term Review

Mid-term review will be costed for and conducted in 2015, over the first two years after implementation of the strategy. The mid-term review will assess accomplishments against expected results. This will allow for review of strategies and indicators and for making adjustments to the health sector HIV response. Simultaneously, prioritised evaluation studies will be done as documented in the National HIV Research and Evaluation Agenda. All activities during mid-term review will be outsourced to national or international organisations/consultants who will work closely with staff from MOHSW (NACP, M&E), RHMT and CHMTs. The selected indicators need to have baseline values for performance monitoring of trends. NACP will ensure that the baseline values are available by end of 2013. Where the values come from non-routine sources such as surveys and surveillance, cost for collecting these in-house or outsourced will be costed and budgeted for in the first half of FY 2013/2014.

9.4 End-Term Review/evaluation

The end-of-term review will be done in 2017 by outsourced national or international consultants/organisations. The final evaluation needs to be costed for. The evaluation will provide evidence to inform stakeholders involved in planning of the next Health Sector HIV Strategic Plan.

9.5 Costed M&E Plan

A costed M&E plan will be developed as an annex and it will include the specific and costed HIV M&E activities of all relevant stakeholders and identified sources of funding. This plan will be used for coordination and assessing progress of M&E implementation throughout the year. The costed M&E plan will be located in a supplemental document to the M&E Plan and will be updated every two years.

ANNEX: Description of Priority indicators for HSHSP III 2013-2017
The Tipping Point – Incidence to Treatment Ratio

Indicator Description	Numerator/Denominator	Disagg. Freq./Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator/ Indicator Source
1 Ratio of new HIV infections to increase in new patients on treatment	Number of new adult infections in a 12 month period / Increase in adult patients on treatment in the same 12 month period	None Annual	2011 2.0	Mid (2015): TBD End (2017): TBD	Numerator comes from Spectrum estimates of new adult infections in the past 12 month period. Denominator is derived from new adults on treatment in the past 12 month period. Targets set based on projections and ART coverage targets.	MOHSW, NACP Numerator: Spectrum model Denominator: routine programme data	Impact PEPFAR Blueprint

Prevention (Elimination of New HIV Infection)

Indicator Description	Numerator /Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator/ Indicator Source
1 Percentage of young people aged 15-24 who are living with HIV	Number of people aged 15 – 24 years who were tested to be HIV positive / Total population in the age group 15 – 24 years during the survey period	Age: 15-19 20-24 THMIS interval (4-5 years)	2012 THMIS 15-19: 1.0 20-24: 3.2	Mid (2015): 15-19: 0.9% 20-24: 2.8% End (2017): 15-19: 0.8% 20-24: 2.2%	Targets based on THMIS trends.	TACAIDS, NBS THMIS	Impact GARP 2013 WHO Global HSHS GF M&E Toolkit

Indicator Description	Numerator /Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
2 Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results	Number of women and men aged 15–49 who received an HIV test in the last 12 months and who know their results / Total number of women and men aged 15–49 surveyed	Sex, Age: 15-19 20-24 25-49 2-3 years	2012 THMIS Men: 26.5% Women: 30.3%	Mid (2015): Men: 30.7% Women: 35.1% End (2017): Men: 33.8% Women: 38.7%	Targets represent a 5% annual increase from 2012 THMIS baseline.	TACAIDS, NBS TDHS and THMIS (Alternate every 2-3 years)	Outcome GARP 2013 GF M&E Toolkit WHO Global HS HIV Strategy
3 Percentage of women and men aged 15–24 who had higher-risk sex in the last 12 months who reported using a condom the last time they had higher-risk sexual intercourse	Number of women and men aged 15–24 who reported using a condom during sexual intercourse with a non-marital and non-cohabiting sexual partner in the last 12 months / Number of men and women who reported having had sex with a non-cohabiting, non-marital sexual partner in the last 12 months	Sex, Age: 15-19 20-24 2-3 years	2012 THMIS and MDGs Men: 56.8% Women: 54.6%	Mid (2015): Men: 64% Women: 63% End (2017): Men: 70% Women: 70%	Target increases based on THMIS trends.	TACAIDS, NBS TDHS and THMIS (Alternate every 2-3 years)	Outcome HSHSPII GARP 2013 GF M&E Toolkit

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
4 Percentage of young women and men aged 15–24 who have comprehensive knowledge about AIDS	Number of respondents aged 15–24 years who gave the correct answer to all five questions ¹ / Number of all respondents aged 15–24	Sex, Age: 15–19 20–24 2–3 years	2012 THMIS Men: 46.7% Women: 40.1%	Mid (2015): Men: 55% Women: 50% End (2017): Men: 65% Women: 60%	Target increases based on THMIS trends.	TACAIDS, NBS TDHS and THMIS (Alternate every 2–3 years)	Outcome GARP 2013 GF M&E Toolkit

Reduction of HIV Related Mortality

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
1 Percentage of adults and children with HIV known to be alive and on treatment X months after initiation of ART (X= 12, 24, 36, 48, and 60 months)	Number of patients (adults and children) who are alive and on ART X months after start of ART (X= 12, 24, 36, 48, and 60 months) / Total number of patients (adults and children) who started ART who were expected to achieve 12-month outcomes within the reporting period	Sex, Age: <15 15+ Cohort data reported annually	2010 Cohort Data: 74%	Mid (2015): 80% at 12 months End (2017): 80% at 12 months	Targets adapted from WHO HIV Drug Resistance Early Warning Indicator targets.	MOHSW, NACP ART registers, CTC2 electronic database, cohort analysis report form	Impact HSHSPII GARP 2013 GF M&E Toolkit PEPFAR NGIs

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
2 Estimated percentage of child HIV infections at 18 months from HIV-positive women delivering in the past 12 months	The numerator is the estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women / Estimated number of HIV positive women who delivered in the previous 12 months	None Annual	2013 Progress Report on the Global Plan: 15%	<u>Mid (2015):</u> 4% <u>End (2017):</u> 2%	2015 target adapted from Elimination of Mother to Child Transmission Plan. 2017 target set based on MOHSW experience and knowledge of program capacity. Dependent on universal coverage of Option B+	NACP, MOHSW Numerator and denominator from Spectrum model.	Impact GARP 2013 GF M&E Toolkit
3 Percentage of PLHIV who experienced/perceived stigma when accessing health services	Number of PLHIV who reported experiencing stigma when accessing services / Total number of PLHIV surveyed		13%	<u>Mid (2015):</u> 9% <u>End (2017):</u> 5%		TACAIDS, MOHSW, NACP, NACOPHA Stigma Index	Outcome

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
4 Number and percentage of HIV- infected pregnant women who received ARVs to reduce the risk of mother-to-child transmission of HIV	Number of HIV- infected pregnant women who received ARVs to reduce the risk of MTCT in the last 12 months / Estimated number of HIV- infected pregnant women in the last 12 months, based on ANC surveillance	New to ART, Already on ART Annual	77% (73,955) (number from program data, percentage is 2012 figure from 2013 Progress Report on the Global Plan)	Mid (2015): 98% (89,880) End (2017): 100% (86,670)	2015 target from Elimination of Mother to Child Transmission Plan. 2017 target set based on MOHSW experience and knowledge of program capacity. Numbers are 98% and 100% of Spectrum estimates for years 2015 and 2017.	RCH clinics, NACP, MOHSW Program data for numerator; Spectrum estimates for denominator.	Output GF M&E Toolkit WHO Global HS HIV Strategy GARP 2013 PEPFAR NGIs
5 Number and percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once* / Number of HIV-positive pregnant women giving birth in the last 12 months	Infants who received in first 2 mos Annual	26,608 (2012 PMTCT Data) 27.4%	Mid (2015): 80% End (2017): 85%	2015 target adapted from Elimination of Mother to Child Transmission Plan. 2017 target set based on MOHSW experience and knowledge of program capacity. Denominator calculated from Spectrum.	RCH clinics, NACP, MOHSW Early Infant Diagnosis (EID) testing laboratories for the numerator, Spectrum estimates for the denominator	Output GARP 2013 GF M&E Toolkit PEPFAR NGIs

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
6 Number and percentage of eligible adults and children currently receiving antiretroviral therapy	Number of adults and children eligible for ART receiving ART / Estimated number of eligible adults and children ²	Sex, Age: <1 1-4 5-14 15+ Annual	<u>2012</u> Adults: 60.4% (432,293) Children: 25.1% (32,414)	<u>Mid (2015):</u> Adults: 85% (747,153) Children: 60% (71,733) <u>End (2017):</u> Adults: 95% (854,988) Children: 80% (105,147)	Numerator from program data, denominator from Spectrum estimates. 2015 and 2017 targets set based on NACP experience and knowledge of program capacity.	MOHSW, NACP For the numerator: facility based ART registers. For the denominator: HIV estimation models such as Spectrum	Output GARP 2013 GF M&E Toolkit WHO Global HS HIV Strategy

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
7 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Number of adults with advanced HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year / Estimated number of incident TB cases in people living with HIV (Annual estimates of the number of incident TB cases in people living with HIV in high TB burden countries are calculated by WHO and are available at: http://www.who.int/tb/country/en)	Sex, Age: <15 15+ Annual	2012 38%	Mid (2015): TBD End (2017): TBD	Both numerator and denominator produced by TB program data.	NACP, NTLP Numerator: Facility antiretroviral therapy registers and reports; programme monitoring tools Denominator: Estimates of incident TB cases in people living with HIV (WHO TB Statistics http://www.who.int/tb/country/en)	Output GARP 2013 GF M&E Toolkit WHO Global Health Sector HIV Strategy
8 Percentage of LTFU clients followed up and linked back to health services by Community Based HIV and AIDS Services Providers	Number of LTFU clients who were followed up and linked back to health services by CHBC / Total LTFU clients	None	2012 TBD by special assessment	Mid (2015): TBD End (2017): TBD		NACP Patient Appointment Register, Patient Tracking Register	Output

HIV Among Key Populations

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
1 HIV and AIDS prevalence among key populations	Number of key populations that are HIV-infected / Population size of key populations	KP category, Time since initiation of risk behaviour (bands TBD) Every 3–5 years	SW: 31.4% MSM: 42.0% PWID: 51.0% SW (NACP Dar IBBS) MSM (Nyoni Dar Study) PWID (Nyandindi Dar Study)	Mid (2015): SW: 31.4% MSM: 42.0% PWID: 51.0% End (2017): SW: 31.4% MSM: 42.0% PWID: 51.0%	Programs are focusing on prevention and treatment; prevalence held flat to account for few new infections and few AIDS deaths.	MOHSW, NACP, KP implementing partners Integrated biological and behavioural surveillance (IBBS) and KP size estimates	Impact HSHSP II
2 Percentage of key populations at risk* reached with individual and/or smaller group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of key populations at risk reached with individual and/or small group level preventive HIV interventions that are based on evidence and/or meet the minimum standards required / Total estimated number of people from key populations at risk	KP category Collected continuously, aggregate in time for reporting	TBD	Mid (2015): 25% End (2017): 50%	These targets were adapted from Zanzibar's ZHSHSP. They are limited in that Zanzibar's epidemic is concentrated in KPs.	TACAIDS, MOHSW, NACP, KP Implementing Partners Program records for numerator, IBBS for denominator	Output GF M&E Toolkit PEPFAR NGIs

Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
3 Percentage of key populations who reported using a condom during their last high-risk sexual encounter	Number of SWs who reported using a condom with most recent client; MSM who reported using a condom at last anal sex with a male partner; PWID who reported using a condom at last sex / Total estimated number of key populations	KP category Every 3 years	SW: 83.3% MSM: 43.2% ³ PWID: Unknown	<u>Mid (2015):</u> SW: TBD MSM: TBD PWID: TBD <u>End (2017):</u> SW: TBD MSM: TBD PWID: TBD	Baselines come from Dar es Salaam; as data becomes available from additional IBBS conducted elsewhere in Tanzania, it will be included as well. NACP seeking guidance from KP M&E consultant for targets.	TACAIDS, MOHSW, NACP, KP stakeholders IBBS	Outcome GARP 2013
4 Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	Number of people who inject drugs who report injecting drugs in the last month and using sterile injecting equipment the last time they injected drugs / Number of people who inject drugs who report injecting drugs in the last month	Sex, Age (<25/25+) Every 3 years	62.9% (from ZACP IBBS 2007)	<u>Mid (2015):</u> 70% <u>End (2017):</u> 80%	Baselines come from Zanzibar; as data becomes available from additional IBBS conducted elsewhere in Tanzania, it will be included as well. Targets were adapted from Zanzibar's ZHSHSP	TACAIDS, MOHSW, NACP, KP stakeholders Behavioural surveillance or other special surveys	Outcome GARP 2013 GF M&E Toolkit

Medicine and Technology

	Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/ Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
1	Percentage of health facilities that have experienced stock-out of at least one tracer item⁴ in the last 3 months	Number of health facilities that have experienced stock-out of at least one tracer item in the last 12 months / Number of health facilities providing Care and Treatment	Admin level? Quarterly	5% (for ARV regimen stockouts, not a single drug, i.e. substitutions not considered a stockout) -SCMA Monthly Reports	<u>Mid (2015):</u> 0% <u>End (2017):</u> 0%		MOHSW Health facility surveys Tools being modified to capture this data -SCMA reports -LMIS reports	Output GF M&E Toolkit
2	Number and percentage of laboratories that meet the national quality assurance standards	Number of laboratories which meet quality assurance standards / Number of laboratories in the SLAMT program	Number of stars (5 star system) Annual	30 facilities in process of accreditation	<u>Mid (2015):</u> 105 <u>End (2017):</u> 155		MOHSW, NACP, National Transfusion Blood Service (NBTS), NHLQATC, PHLN, Diagnostic Unit MOHSW reports	Output HSHSP II

Strategic Information

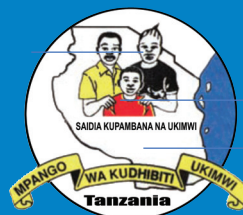
	Indicator Description	Numerator / Denominator	Disagg. Freq./ Timing	Baseline	-Mid-term -End-term Targets	Assumptions/ Method of Calculation	Resp. Institution Data Source	Type of Indicator Indicator Source
1	Number and percentage of health facilities submitting timely and complete cohort and quarterly reports to the district per quarter	Number of health facilities submitting timely and complete reports / Total number of facilities providing care & treatment	District and Region Cohort and quarterly reports Quarterly	989 facilities, 89% (2012 Q4 quarterly reports) Cohort: 5 out of 21 regions	Mid (2015): Quarterly: 100% Cohort: 80% End (2017): Quarterly: 100% Cohort: 100%	Targets adapted from Global Fund Round 9 M&E Plan.	MOHSW, NACP Routine Program Data	Output GF Round 9
2	Percentage of facilities/ health management teams demonstrating competence in applying DDIU in the work setting	TBD / Total number of facilities/health management teams that have been trained	Cadre, CHMT, RHMT TBD	N/A	TBD		MOHSW, NACP Special survey; to be incorporated in Supportive Supervision tools	Outcome PEPFAR NGIs

References:

1. African Union, (2012) Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response in Africa, African Heads of State and Government, Addis Ababa: African Union Commission.
2. Campbell, J. C. (2002), Health consequences of intimate partner violence. *Lancet*, 359 (9314), 1331-6. Clift, S., Watson-Jones, A., Kanga, L., Ndeki, L., & Changalucha, A. (2003), Variations of HIV and STI prevalences within communities neighbouring new goldmines in Tanzania: Importance for intervention design. *Sexually Transmitted Infections*, 79, 307-312.
3. Haram, L. (2005), AIDS and risk: the handling of uncertainty in northern Tanzania. *Cult. Health Sex.*, 7 (1), 1-11.
4. Health Policy Initiative, Tanzania. (2013), Analysis of Policy, Legal, and Regulatory Framework for Task Shifting in Tanzania, Dar es Salaam: Futures Group.
5. Ifakara Health Institute. (2013), Draft report on heterosexual anal intercourse. Dar es Salaam: TACAIDS.
6. IPPF, UNAIDS, and NAP, (2012), People Living with HIV Stigma Index.
7. Kalichman, S. C., Simbayi, L. C., Kaufman, M., Cain, D., & Jooste, S. (2007), Alcohol Use and Sexual Risks for HIV/AIDS in Sub-Saharan Africa: Systematic Review of Empirical Findings, *Prevention Science*, 8, 141-151.
8. Luke, N., & Kurtz, K. M. (2002), Cross-generational and transactional sexual relations in sub-saharanafrica: Prevalence of behavior and implications for negotiating safer sexual practices. Washington, D.C.: Population Services International and International Center for Research on Women.
9. Maswanya, E. S., Mutalem, P. P., Shayo, E. H., Kisoka, W. J., Kilima, S. P., Mbilinyi, D. R., et al. (2010), Drivers of HIV/AIDS Epidemics in Tanzania Mainland: "Case Study of Makete, Temeke, Geita, Lindi, Kigoma, & Meru Districts, National Institute for Medical Research, Tanzanian Commission for AIDS, and UNAIDS, Dar es Salaam: NIMR/TACAIDS/UNAIDS.
10. Mhamba, R., Lindeboom, W., Omondi, F., & Leach, V. (2007), Social Protection in the Context of the MVC Programme in Tanzania: An Assessment of the Impact of Implementing the MVC Programme and Operation of the MVC Funds and the Potential for Scaling up to Provide National Coverage of Social Protection for Children, Ministry of Health and Social Welfare, Department of Social Welfare, Dar es Salaam: MoHSW.
11. Ministry of Finance and Economic Affairs, (2010), National Strategy for Growth and Reduction of Poverty II, Dar es Salaam: Ministry of Finance and Economic Affairs.
12. Ministry of Health and Social Welfare, (2011), HIV/AIDS/STI Surveillance Report Number 22, Dar es Salaam: MoHSW.
13. Ministry of Health and Social Welfare, (2008), Human Resource for Health Strategic Plan 2008 – 2013, Dar es Salaam: MoHSW.
14. Ministry of Health and Social Welfare, (2012), Human Resources for Health Country Profile 2011, Dar es Salaam: MoHSW.
15. Ministry of Health and Social Welfare, (2011), National Management Guidelines for the Health

Sector Prevention and Response to Gender Based Violence. Dar es Salaam: MoHSW.

16. Ministry of Health and Social Welfare, (2007), Primary Health Services Development Programme - MMAM 2007-2017, Dar es Salaam: Government Printer.
17. Ministry of Health and Social Welfare, (2011), Public Expenditure Review - Human Resources for Health, Dar es Salaam: MoHSW.
18. Ministry of Health and Social Welfare, National AIDS Control Programme, (2012). HIV Behavioral and Biological Surveillance Survey Among Female Sex Workers in Dar es Salaam, 2010. Dar es Salaam: MoHSW.
19. Ministry of Health and Social Welfare, National AIDS Control Programme, (2012), National Guidelines for the Management of HIV and AIDS. Dar es Salaam: Government of Tanzania.
20. National Bureau of Statistics and ICF Macro, (2011), Tanzania Demographic and Health Survey 2010, Dar es Salaam: NBS and ICF Macro.74
21. National Bureau of Statistics, Ministry of Finance and Office of Chief Government Statistician, President's Office, Finance, Economy and Development Planning Zanzibar. (2013). 2012 Population and Housing Census: Population Distribution by Administrative Areas, Dar es Salaam: NBS and OCGS.
22. Nyoni, J. E., & Ross, M. W. (2013), Condom Use and HIV-related behaviors in urban Tanzanian men who have sex with men: a study of beliefs, HIV knowledge sources, partner interactions and risk behaviors, *AIDS Care* , 25 (2), 223-9.
23. Prime Minister's Office, TACAIDS,(2013), National HIV and AIDS Policy, Dar es Salaam: Prime Minister's Office.
24. Roll Back Malaria and the World Health Organization, (2003), The Abuja Declaration and the Plan of Action. The African Summit on Roll Back Malaria, Geneva : Roll Back Malaria/WHO.
25. TACAIDS, (2012), Country Progress Reporting, Part A: Tanzania Mainland. UNAIDS.
26. TACAIDS, (2010), Gender Operational Plan for HIV Response in Mainland Tanzania. Dar es Salaam: TACAIDS.
27. TACAIDS, (2012), NMSF II Evaluation Report. Dar es Salaam: TACAIDS.
28. International,(2008), Tanzania HIV/AIDS and Malaria Indicator Survey 2007-08, Dar es Salaam:
29. UNAIDS, (2004), "Three Ones" agreed by Donors and Developing Countries. The 3 by 5 Initiative, Washington D.C.: UNAIDS.
30. UNAIDS,(2010), Operational plan for the UNAIDS action framework: addressing women, girls, gender equity and HIV, 25th Meeting of the UNAIDS Programme Coordinating Board, Geneva: UNAIDS.
31. UNAIDS, Ministry of Health and Social Welfare, (2013, July), Spectrum Estimates, Demographic and AIDS modules.
32. UNGASS, (2010), Tanzania country progress report.
33. UNICEF, U.S. Centers for Disease Control and Prevention and Muhimbili University of Health and Allied Sciences. (2011). Violence Against Children Report, Dar es Salaam: United Republic of Tanzania.
34. Wamoyi, J., Wight, D., Plummer, M., Mshana, G. H., & Ross, D. (2010), Transactional sex amongst young people in rural northern Tanzania: an ethnography of young women's motivations and negotiation. *Reprod. Health* , 7 (2).



Ministry of Health and Social Welfare

National AIDS Control Programme

P.O. Box 11857 Dar es Salaam

Tel:-+255 22 2131213; Fax:- +255 22 2138282

E-mail: info@nacp.go.tz

Website: www.nacp.go.tz