



THE UNITED REPUBLIC OF TANZANIA

PRIME MINISTER'S OFFICE

**TANZANIA THIRD NATIONAL
MULTI-SECTORAL STRATEGIC
FRAMEWORK FOR HIV AND AIDS
(2013/14 – 2017/18)**

NOVEMBER, 2013





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November, 2013

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Drugs Therapy
ARV	Antiretroviral Drugs
ATE	Association of Tanzania Employers
ATF	AIDS Trust Fund
BCC	Behaviour Change Communication
CBO	Community Based Organization
CHAC	Council HIV and AIDS Coordinator
CMAC	Council Multi-sectoral AIDS Committee
CMO	Chief Medical Officer
CSO	Civil Society Organization
CSR	Corporate Social Responsibility
CTC	Care Treatment Centre
DACC	District AIDS Control Coordinator
DP	Development Partner
DPG-AIDS	Development Partners Group on HIV and AIDS
EAC	East African Community
EID	Early Infant Diagnosis
eLMIS	Electronic Management Information System
eMTCT	Elimination of Mother to Child Transmission
FBO	Faith Based Organization
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund to fight AIDS, TB and Malaria
GLIA	Great Lakes Initiative on HIV and AIDS
GOT	Government of Tanzania
HBC	Home-Based Care
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSHP	Health Sector HIV and AIDS Strategic Plan
HTC	HIV Testing and Counselling
ILS	Integrated Logistics System
JAST	Joint Assistance Strategy for Tanzania
JTWG	Joint Technical Working Group
KP	Key Populations

LGA	Local Government Authority
LGMD	Local Government Monitoring Database
M&E	Monitoring and Evaluation
MDA	Ministry, Departments and Agencies
MDG	Millennium Development Goal
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini
MoCDG	Ministry of Community Development, Gender and Children
MoEVT	Ministry of Education and Vocational Training
MoF	Ministry of Finance
MoST	Ministry of Science and Technology
MoHSW	Ministry of Health and Social Welfare
MoLYDS	Ministry of Labour, Youth Development and Sports
MoU	Memorandum of Understanding
MSM	Men who have sex with Men
MTCT	Mother to Child Transmission
MTEF	Medium Term Expenditure Framework
MVC	Most Vulnerable Children
MVP	Most Vulnerable Population
NACOPHA	National Council of People Living with HIV and AIDS
NACP	National AIDS Control Programme
NBTS	National Blood Transfusion Services
NCPA	National Costed Plan of Action for Children
NEPAD	New Partnership for Africa Development
NGO	Non-Governmental Organization
NHAREA	National HIV and AIDS Evaluation and Research Agenda
NSGRP	National Strategy for Growth and Reduction of Poverty
HSV	Herpes Simplex Virus
NIMR	National Institute for Medical Research
NMSF	National Multi-sectoral Strategic Framework
NSPF	National Social Protection Framework
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PAF	Performance Assessment Framework
PEP	Post-Exposure Prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PLHIV	People Living with HIV
PHCDP	Primary Health Care Development Plan

PHDP	Positive Health Dignity and Prevention
PMO	Prime Minister's Office
PMO-RALG	Prime Minister's Office, Regional Administration and Local Government
PMTCT	Prevention of Mother to Child Transmission
PO-PSM	President's Office, Public Service Management
PWID	People Who Inject Drugs
RACC	Regional AIDS Control Coordinator
RAS	Regional Administrative Secretary
RBM	Results Based Management
RBPP	Results Based Performance Planning
RFA	Regional Facilitating Agency
RCH	Reproductive and Child Health
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for AIDS
TACTF	Tanzania AIDS Control Trust Fund
TAIFO	Tanzania AIDS Interfaith Forum
TB	Tuberculosis
TDHS	Tanzania Demographic Health Survey
TDV	Tanzania Development Vision 2025
THIS	Tanzania HIV Indicator Survey
THMIS	Tanzania HIV and Malaria Indicator Survey
TIENAI	Tanzania Informal Economy Network on AIDS Initiative
TLPP	Tanzania Long-Term Perspective Plan
TNCM	Tanzania National Coordinating Mechanism
TOMSHA	Tanzania Output Monitoring System for HIV and AIDS
TPSF	Tanzania Private Sector Foundation
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNITAID	United Nations Innovative Financing Mechanism
USG	United States Government
VCT	Voluntary Counselling and Testing
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

FOREWORD

For more than three decades, Tanzania has made concerted response to the HIV and AIDS epidemic, which nevertheless continues to claim the lives of thousands of her people, and threaten national, social, and economic development. We are confronted with a generalized epidemic, with HIV prevalence averaging at 5.3% on the Mainland, but with noticeable variations between regions. The devastating impact of the epidemic is felt in all sectors and causes widespread suffering among individuals, families and communities across the country. Due to HIV and AIDS, Tanzania has a significant number of orphans who require support. The epidemic has also exacerbated the burden of poverty in our country.

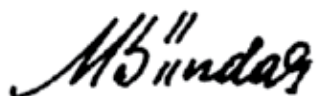
During the period from 2001 to 2012, the annual budget for the Multi-sectoral response to the epidemic increased from 17 billion to over 500 billion Shillings, comprising of both donor and domestic funds. There are signs of hope as prevalence appears to be stabilizing, with expectations that this trend will continue in the coming years. However, there are regions where HIV prevalence seems to be increasing. Overall, it is inspiring that our multi-sectoral efforts to control the epidemic are succeeding, creating the possibility of an AIDS-free generation. Improved access to care and treatment has brought much relief and hope to thousands of People Living with HIV (PLHIV). The government will continue with HIV prevention efforts, expanding HIV care and treatment, and consolidating HIV programmes with other services for easy access.

The launch of a voluntary HIV testing campaign by the President of the United Republic of Tanzania, His Excellency Dr. Jakaya Mrisho Kikwete in July, 2007, calling out to all adults to ascertain their HIV status, was testimony of government's commitment to contain the epidemic. This commitment must be sustained and enhanced throughout the implementation of NMSF III to achieve the goals of Zero New HIV Infections, Zero AIDS-related Deaths, and Zero Stigma and Discrimination. In order to sustain the financial resources required to achieve the overarching results, the Government of Tanzania is also in the process of exploring feasible financing mechanisms that will support the country's long-term response to the HIV and AIDS epidemic.

An AIDS-free Generation is feasible through a comprehensive HIV program which includes prevention, care, treatment, program strengthening, and effective policies. It is the responsibility of every one of us, individually and collectively, to prevent new HIV infections. We therefore appeal to the country as whole to ensure that the next generation is free from HIV, through prevention measures, regular testing and treatment in the case of infection to eliminate mother to child transmission.

This Framework is a broad National Strategic Plan designed to guide the country's multi-sectoral response to the epidemic. It calls for scaling up of the comprehensive, national response in prevention, care, treatment, and impact mitigation, in a way that is responsive to issues of gender. It emphasizes the prevention of new HIV infections, with a special focus on women, youth and key populations at higher risk of HIV. It also focuses on the necessary quality in the continuum of care for PLHIV and stewardship for the nation's most vulnerable children. All sectors -public, private, faith-based organizations, civil society organizations, and community based organizations are urged to prepare their own strategic plans with well-

focused interventions that align to this Framework, paying attention to their comparative advantages within their sectors. The government will continue to create an environment that is conducive for all stakeholders to play their roles effectively in the control of the epidemic. We appeal to all sectors, national and international partners to join hands with the government in implementing this Framework so that we can significantly reduce the spread of HIV in our country by 2018.



Mizengo P. Pinda (MP)

PRIME MINISTER

November, 2013

Dar Es Salaam

ACKNOWLEDGEMENTS

The successful development of the Third National Multi-sectoral Strategic Framework (2013/14–2017/18) involved a long consultative process with stakeholders. The successful completion of this document was made possible by the joint efforts of organizations and individuals whose participation needs to be acknowledged. First, thanks are due to the National Multi-sectoral Strategic Framework on HIV and AIDS Steering Committee, and the Technical Working Groups in the five NMSF thematic areas.

We would like also to thank all Development Partners for their financial support and technical assistance, national and international consultants, Government Ministries, Departments and Agencies, Regions and Districts; representatives from Civil Society Organizations, formal and informal sectors, Faith-Based Organizations and religious leaders for their valuable contributions towards completion of this document. Overall coordination by the staff of TACAIDS involving long working days was crucial to the success of this process.

We are also grateful to all those who generously contributed their time to enable us gather crucial data for our country's future planning. We acknowledge the support from all national leaders under the guidance of His Excellency, Dr. Jakaya Mrisho Kikwete, The President of the United Republic of Tanzania, towards the implementation of the NMSF II. It is our expectation that the same support will be provided for this NMSF III.

“Let us now join together, mobilize the necessary resources and implement the strategies as outlined in this document”



Dr. Fatma H. Mrisho

EXECUTIVE CHAIRMAN

TANZANIA COMMISSION FOR AIDS

EXECUTIVE SUMMARY

The Third National Multi-Sectoral Strategic Framework for Mainland Tanzania 2013/14-17/18 (NMSF III) provides a common understanding for all HIV and AIDS stakeholders and reflects current normative guidance in the national response effort. Development of the NMSF III has incorporated the evaluations of the previous NMSF II (2008-2012) and recent epidemiological analyses of HIV in Tanzania. The NMSF III recognizes that while the national average adult HIV prevalence rate has declined over the last ten years, HIV transmission rates among key populations, women, and in certain regions are not being adequately controlled. Further, there has not been a significant decline in overall HIV prevalence over the periods covered by the last two THMIS surveys. The comprehensive needs of People Living with HIV (PLHIV) are often not being met; stigma and discrimination still prevail; and the coordination of the national response is not resulting in all necessary services being available to those who need them. It is with this in mind that the NMSF III aims towards the long term goals of elimination of new HIV infections, deaths from HIV, and HIV-associated stigma and discrimination. Specifically, the NMSF III aims to achieve the following three over arching results by 2018: a HIV incidence rate of no more than 0.16% (from a baseline of 0.32% in 2012), a significant reduction in AIDS-related deaths, and a reduced HIV related stigma and discrimination among People Living with HIV and AIDS in the society.

These will be achieved through the following outcomes:

- Proportion of eligible PLHIV on care and treatment increased and sustained.
- Increased access and quality of HIV Testing and Counselling (HTC)
- Elimination of Mother to Child Transmission (eMTCT).
- Increased male and female condom use by men and women during risky sex.
- Elimination of blood borne transmission of HIV.
- Reduced risky behaviour of sexual intercourse among the general, infected, most-at-risk and vulnerable populations.
- Increased prevalence of Voluntary Medical Male Circumcision (VMMC).
- Increased access to services and quality of treatment of Sexually Transmitted Infections (STIs)
- Community Based Care and Support Interventions respond to HIV within their local context.
- HIV mainstreamed in sector-specific policies and strategies.
- Reduction of all HIV and AIDS related stigma and discrimination.

The NMSF III will achieve these outcomes through targeted priority investment in five strategic areas of primary investment and six supporting areas of secondary investment, and employing five cross-cutting programmatic principles.

The Strategic Areas of Primary Investment will include:

- Comprehensive Antiretroviral Therapy (ART)
- HIV Counselling and Testing ,
- Elimination of Mother to Child Transmission
- Comprehensive Sexuality, Gender, and Health Education and Services; and
- Condom Provision and Programming.

The supporting areas of secondary investment cover the following::

- Voluntary Medical Male Circumcision (VMMC)
- Provision of Safe Blood
- Treatment of Sexually Transmitted Infections (STIs)
- Targeted Behaviour Change Communication (BCC) across the strategic programmes designed to increase the demand for services, enhance knowledge, and lead to positive changes in risky behaviours at personal, community and national level.
- Community Based Care and Support; and
- Mainstreaming of HIV and AIDS interventions.

Cross-Cutting Programmatic Principles

Five Cross-Cutting Programmatic Principles will be employed throughout the programme components of NMSF III namely:

- Integration,
- Demand Creation,
- Human Rights,
- Gender and
- Programme Strengthening.

Achieving the NMSF III results towards the three zeros, strategic decisions will need to be made with limited resources to ensure that the highest impact interventions and the most appropriate populations based on epidemiology receive the greatest priority in investment. This will require communication and coordination among all stakeholders to align priorities and strategies under a common framework grounded in mutual accountability, gender, equality and human rights. Sustaining this effort will also require investing in the skills, systems, and infrastructure sustaining the national response throughout the period of the NMSF III and until Tanzania is able to realize an AIDS free generation. NMSF III also aims to be responsive to new scientific data and evolving international guidelines. For example, WHO is expected to update its consolidated HIV guidelines (The Use of Antiretroviral Drugs for Treating and Preventing HIV Infection) every two years; NMSFIII will be reviewed at the mid-term and any changes may then be adapted as necessary, based on new data and international guidelines.

CHAPTER ONE

1 Introduction, Context, and Principles of the NMSF III

1.1 INTRODUCTION

The Third National Multi-sectoral Strategic Framework (NMSF III) for HIV and AIDS in Tanzania provides a common understanding for all HIV and AIDS stakeholders: government, civil society, the private sector, and development partners to work together towards achieving the expected results. The NMSF III is not intended to replace or duplicate other sectoral HIV and AIDS strategies. Rather, the NMSF III provides the context within which other sectoral strategic plans and budgets should be formulated, monitored, and coordinated.

Multi-sectoral development planning in Tanzania includes targets related to HIV incidence, prevalence, HIV care and treatment services, and HIV stigma and discrimination in the current medium and long term plans. The Tanzania Five Year Development Plan includes a target to “increase and strengthen services for care and treatment of people living with HIV and AIDS to reach 800,000 by 2015/16 (Tanzania Five Year Development Plan,2011).” In the Tanzania Long-Term Perspective Plan (LTPP) 2011/2012-25/26, the HIV objectives for the health sector include reaching a “national prevalence rate of about 1.5 percent” as well as “having a society in which our children can grow up free from the threat of HIV and AIDS and which cares for and supports all those who are still infected and affected by HIV and AIDS (LTPP 2012).” The NMSF III also sets ambitious targets for the elimination of new HIV infections, HIV-related deaths, and HIV stigma and discrimination in order to improve the quality of life for all Tanzanians. The static HIV prevalence target has been replaced by a dynamic target ratio, relating incidence to treatment coverage Treatment targets have been elaborated through the adoption of improved guidelines and programmes; and stigma and discrimination targets set on the basis of routine nationally representative studies.

1.2 NATIONAL VISION, MISSION AND GOAL

The National HIV and AIDS Policy has adopted the following vision, mission and goal for the HIV national response.

1.2.1 Vision

An HIV-free society where new infections are halted and people living with HIV and those affected by HIV and AIDS receive quality services.

1.2.2 Mission

To guide the intensification and scaling up of quality HIV and AIDS prevention, care, treatment and support services and impact mitigation interventions that are evidence-informed and locally appropriate through multi-sectoral collaboration.

1.2.3 Goal

To ensure that the acquisition of new infections is significantly minimized, those who are living with HIV have access to high quality, stigma-free services, and the negative personal and societal impacts of HIV and AIDS are mitigated.

1.3 REGIONAL AND GLOBAL COMMITMENTS

The Government of Tanzania is a signatory to regional and global commitments regarding HIV and AIDS, health and development.

1.3.1 Regional Commitments

- In the 2001 Abuja Declaration, Tanzania committed to allocating at least 15% of the national budget (or 0.7% GNP) to improve the health sector (The Abuja Declaration and the Plan of Action, 2003).
- The Tunis Declaration on Value for Money, Sustainability and Accountability in Health aimed to increase domestic funding through cooperation between Ministries of Health, Ministries of Finance, technical and financial partners (Tunis Declaration, 2012).
- MASERU Declaration on the fight against HIV and AIDS in the Southern Africa Development Community (SADC) Region of 4th July 2003 recognizes the need for regional effort to fight HIV and AIDS using multi-sectoral approach.
- The African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria in Africa establishes the commitment of African leaders to strengthening country ownership to secure health security by investing national resources in order to reduce dependence on external financing (African Union Roadmap, 2012).

The country is not yet on track in making substantial domestic contributions to reduce dependence on external funding. Government's contribution to the HIV and AIDS response declined by 50% from 22 Billion Tshs (PER 2006/7) to 11 Billion Tshs (PER 2011/12).

1.3.2 Global Commitments

International agreements, declarations, treaties and conventions on HIV and AIDS to which the Government of Tanzania is signatory include:

- The UN Millennium Development Goals (MDGs),
- The United Nations General Assembly Special Session on HIV and AIDS (UNGASS), and
- The Political Declaration on HIV AIDS of June, 2011, which identified 10 global targets to achieve by 2015.

The Millennium Development Goal commitments, to which the Government of Tanzania is a party, ends in 2015. The available statistics indicate that the country is on track towards achieving MDG 4 and 6 related to Child and Infant mortality and combating HIV/AIDS, Malaria and other diseases by 2015. However challenges remain in achieving MDG 5 of reducing Maternal Mortality by 75%

Other International agreements, declarations, treaties and conventions on HIV and AIDS include:-

- UNAIDS agenda for Accelerated Country Actions for Women, Girls and Gender Equality and HIV (2010-2014) (Operational plan , 2010).

- Global Plan towards elimination of new HIV infections among children and keeping their mothers alive (2011-2015).
- Global commitments made by development partners in support of HIV and AIDS need to be honoured.

Translation of these regional and global commitments into domestic policies and resources as demonstrated in political leadership and fiscal investments in the national response will ensure the achievement of sustainable results. In effect, this will speed up the realization of results proposed in the NMSF III as well as the national long and medium term development frameworks. This Strategic Framework will be complemented by a costed two years action plan and other tools for its implementation and monitoring.

1.4 CONTEXT AND RATIONALE OF THE NMSF III

The last ten years have witnessed significant progress in the delivery of efficacious HIV prevention, care, treatment, and programme strengthening interventions, leading to the decline in new HIV infections in much of Sub Saharan Africa. During the same period, treatment programmes were scaled up, saving millions of lives. Consequently, HIV prevalence is stabilizing and life expectancy is increasing as many people living with HIV (PLHIV) are kept alive through efficacious treatment. All this was made possible by the establishment of innovative global health financing mechanisms like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GF), the United Nations Innovative Financing Mechanism (UNITAID), and the United States President's Emergency Plan for AIDS Relief (PEPFAR). Over this period, the face of the epidemic changed from an emergency condition that required vertical approaches into a broader, long-term response that focused on overall development.

However, since the advent of the global macro-economic crisis in 2008, funding for HIV and AIDS has steadily declined and funding mechanisms have begun to change their approaches to adapt to the new economic environment. The Global Fund cancelled its call for Round 11 proposals and initiated the New Funding Model at the same time, global health and funding institutions reasserted performance-based funding and value for money approaches, for investing the scarce resources on appropriately targeted, evidence-informed, cost-effective interventions. The NMSF III has taken these changes into account with the ambition of investing for results. The following approaches have been adopted under NMSF III:-

1. Evidence-informed planning using selected priority interventions with high impact and targeting them to the locations and populations where they will make the most impact.
2. Focusing on results which contribute to the attainment of desired national outcomes and investing in systems to monitor and evaluate achievements.
3. Assessing the efficacy and feasibility of interventions, focusing on the capacity and systems required for cost-effective, programme implementation and evaluation.
4. Addressing the structural and behavioural aspects of the epidemic, situating evidenced-informed interventions in their proper context, while addressing key populations.
5. Ensuring the sustainability of interventions, including financial, material and human resources, community ownership, organizational development, services availability, coverage and accountability.

The above approaches link with other key national strategies including:

1. Tanzania Development Vision 2025, which identifies Tanzania's national aspirations.
2. The National Strategy for Growth and Reduction of Poverty (NSGRP) targeting the elimination of HIV in Tanzania.
3. The Health Sector Strategic Plan III (2009-15) which focuses on achieving the Millennium Development Goals, in which HIV is a cross-cutting target disease; and
4. HIV Health Sector Strategic Plan II (2013-17), designed to support universal access to preventative, care, treatment and support services.

1.5 PRINCIPLES OF THE NMSF III

1.1.1. Integration

The national response to HIV and AIDS extends beyond the scope of TACAIDS and NACP, encompassing other health sector programmes such as TB, nutrition, and reproductive and child health services, as well as other social and economic sector responses, including anti-poverty programmes. The NMSF III promotes fostering, fortifying, and reviewing sectoral contributions to the National Response, documenting and evaluating all contributions as part of the mid-term and end-term reviews. The NMSF III leverages the resources and structures existing among key state and non-state actors to ensure a common agenda towards the global and national goals of zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination.

1.1.2. Demand Creation

Creating demand for HIV-associated services begins with quality improvement. With high-quality, life-saving and life-enhancing services in place, accessibility becomes the next priority. Leveraging the interventions of the Mpango wa Maendeleo ya Afya ya Msingi (MMAM), the Primary Health Care Development Plan (2007-2017), itself designed to ensure the equitable access to integrated HIV and public health services, the NMSF III also promotes efforts to strengthen Tanzania's network of health facilities, promoting client satisfaction and encouraging appropriate demand for facility and community based services. Strong political and government commitment and leadership will also be needed to increase demand among Tanzania's underserved and key populations at higher risk for HIV. Active participation of community leadership, cultural and religious leadership, the formal and informal segments of the private sector, and PLHIV leadership will also be needed to supplement the efforts of the public sector. Demand for HIV-associated services will also be enhanced through promotion of mutual accountability and responsibility, as a part of the collective national response.

1.1.3. Human Rights

The NMSF III safeguards human rights through promoting the gender-HIV strategy by removal of all barriers to HIV-associated services. This includes review and improvement of the legal, policy, and social environment that encourages access for under-served and key populations. The human

rights of people living with HIV will also be protected through their meaningful engagement in implementing the NMSF III, including their active leadership and feedback in an environment free of stigma and discrimination.

1.1.4. Gender

Recognizing the existing structural inequalities that exist because of gender discrimination and gender-based violence, the NMSF III promotes comprehensive sexuality and gender education at all levels to supplement the biomedical HIV curricula in use. This includes alignment with the “Medical Management Guidelines of Gender – Gender Based Violence (GBV) and Child Abuse.” However, recognizing that a small percentage of women and girls currently access formal GBV services, the NMSF III promotes a broader, multi-sector response to the widespread ignorance around issues of sexuality and gender that lead to stigma, discrimination and violence.

CHAPTER TWO

2. Country Context and Situational Analysis

2.1 Geographic and Demographic Characteristics

The United Republic of Tanzania covers approximately 945,300 square kilometres and sharing borders with eight (8) countries. For administrative purposes, Mainland Tanzania is divided into 25 regions, which are further subdivided into 156 district, municipal and town councils. According to 2012 population census, the population of Mainland Tanzania is approximately 43.6 million people and it has been growing at an annual rate of 2.7%. Nearly half of the population (48%) is below 15 years of age; 49% are aged 15-64 years and 4% are over 65 years. Furthermore statistics indicate that 73% of population live in rural areas and 27% live in urban areas. The sex ratio stands at 95 males per 100 females. The life expectancy at birth is 56 years for females and 53 years for males. Infant mortality has dropped from 58 per 1,000 live births in 2007/08 to 51 per 1,000 live births in 2009/10, while under-5 mortality has declined from 91 per 1 000 live births to 81 per 1 000 live births during the same period. Underlying these successes has been the continued implementation of the Reproductive and Child Health Strategic Plan, the Strategic Plan to Accelerate the Reduction of Maternal, Newborn, and Child Deaths, and the Expanded Programme for Immunization (EPI). Progress achieved through these strategic interventions in maternal health has provided a platform for further integration and strengthening of programmes in HIV prevention, including PMTCT, counselling and testing, bio-medical interventions in care and treatment, and community service delivery.

2.1.1 Economic Characteristics

Tanzania is among the poorest countries in the world with a per capita Gross National Income of US \$ 550. Tanzania is ranked at position 152 out of 187 countries on the Human Development Index (UNDP 2011). The economy depends heavily on agriculture, which accounts for more than one-quarter of GDP, provides 85% of exports, and employs about 80% of the work force. The population is concentrated in the Lake Zone along Lake Victoria in the north, around Dar es Salaam, the main business and trading centres along the coast, and in the southern highlands around Mbeya. Large areas of the country are sparsely populated.

Macro-economic performance in Tanzania has been resilient to shocks with an estimated real GDP growth of 6.4% in 2012. Furthermore, GDP is projected to remain buoyant, increasing to 6.9% in 2013 and projected to 7% in 2014, creating opportunities for financing key social sectors, such as health, including HIV, TB, and malaria programmes (Tanzania Country Notes, 2013). The economy is largely based on service provision, agriculture, industry, mining and construction.

Despite the impressive GDP growth, poverty remains persistent and has been at the centre of the development debate. It was against this background that the new national development agenda, MKUKUTA II, was designed with a greater focus on making growth more broad based and pro-poor.

Key goals under the strategy include:

- Reducing poverty by promoting inclusive, sustainable and employment-enhancing growth.
- Creation and sustenance of productive and decent employment, especially for women, youth and people with disabilities.
- Food and nutrition security through increased agricultural productivity.

Specifically for the national response to HIV and AIDS, MKUKUTA II set the following operational targets:

- HIV infection rate reduced.
- National HIV prevalence in 15-24 years age group reduced from 2.4% in 2010 to 1.2% by 2015.
- Access to ARV and food supplement for PLHAs increased; and
- Number of orphaned and vulnerable children aged 0-17 whose households receive external support increased from 586,170 in 2009 to 1,318,187 by 2015.

Under the food and nutrition security anti-poverty strategy, the government rolled out the “Kilimo Kwanza” or “Agriculture First” initiative, designed to reduce poverty through increased productivity in agriculture, which has been an integral part of the overall development strategy. This strategy targets poverty reduction from the 2012/2013 level of 34% to 24% by 2015 – still higher than the MDG target of 19.3%. Priorities include clean water provision and irrigation, financial and insurance services, value addition, trade and exports development. Unemployment also remains a concern with nearly 2.4 million people unemployed as of 2011. Most of the unemployed are young and urban-based, representing 10.7% of the population. A lack of sufficient employment opportunities for young women, in particular, exposes them to risky behaviour with incumbent dangers of HIV infection.

Recognizing the challenges posed by Tanzania’s economic climate, and the social and economic vulnerability of a significant part of the national population, the NMSF III will promote synergy with the National Social Protection Framework (2011), which provides guidelines for improved co-ordination, implementation and enforcement of social protection interventions that ensure livelihoods for the poorest and most vulnerable groups. The national response to HIV and AIDS should therefore also promote scaling up social protection interventions such as pensions (including income transfers) and insurance schemes, as well as strengthening and implementing laws related to social protection.

2.1.2 Social and Cultural Characteristics

2.1.2.1 The Situation of Women and Children

Existing gender imbalances have hindered women’s meaningful participation and decision-making in development programmes. Regardless of their socio-economic or educational status, approximately 40% of women do not have the final say in decisions regarding their own health, their children’s health or their own daily household expenditure. Women’s access to mass media

is significantly lower than that of men, and this, compounded by lower literacy and more limited education, undermines the contribution that women are able to make towards social and economic development. Female household populations still have high numbers with no formal education, 11.5% in urban areas and 30.2% in rural areas (2013, p. 27). Yet, women remain the primary labour force for household food production in the nation.

According to a 2007 study, approximately one million children in Tanzania had been orphaned, 12% of the vulnerable children had been separated from their siblings, and up to 240,000 children below the age of 15 were living with HIV and AIDS (Social Protection in Tanzania, 2007). More recently, orphaned children were estimated at 11.2% in urban areas and 9.2% in rural areas in Mainland Tanzania. Regarding food scarcity, 9% of urban and 17% of rural households reported often having problems satisfying their food needs. Access to improved sources of drinking water is also unavailable for more than 11.4% of urban dwellers and 53.2% of rural dwellers. While almost all youths aged 15-24 years have heard about HIV and AIDS, less than half have enough knowledge to protect themselves against infection.

2.1.2.2 Gender Based Violence (GBV)

Gender inequality and gender based violence have been cited in various reports to contribute to HIV infection. Unequal power relations between men and women limits decision making for women and girls in negotiating for safe sex and condom use, and increases the extent of violation of women's and girls' rights. The most common forms of GBV are physical, sexual, psychological, and economic, including financial deprivation and exploitation. The Tanzania Demographic and Health Survey (2010) reveals that 39% of women in the age 15-49 years have experienced physical violence at least once in their lives, with 33% of such violence occurring within the 12 months preceding the survey. There are notable zonal variations in GBV ranging from 61% of women in the Central zone to 22% in the Northern zone having experienced GBV, irrespective of woman's education or economic status (Ibid., p.270). Overall 10% of women in the age 15-49 years had a forced first sexual intercourse (Ibid., p.271).

Results from the National Survey on "Violence against Children" in 2012 by UNICEF in Tanzania show that girls are particularly vulnerable to sexual violence. Nearly one out of three females and one out of seven males have experienced some form of sexual violence prior to the age of eighteen. Few children disclose, fewer children seek services, and even fewer receive them when they are brave enough to report. Overall, the National Survey showed that about 48% of girls and 68% of boys had never disclosed the sexual violence that they had experienced in childhood prior to the survey. Only about 20% of girls and 10% of boys who had experienced sexual violence sought services after the experience, but not all respondents who sought services received them. Approximately 13.0% of females and 3.7% of males who experienced sexual violence reported that they actually received services after seeking them. Girls who received services said they received counselling, clinic, or hospital services, or help from an elder or community leader. Tanzanian children experiencing sexual abuse and violence are more likely to be exposed to sexual exploitation, including transactional sex, less likely to have a HIV test or use condoms, and more

likely to have multiple sexual partners as they grow older (Violence Against Children Report, 2011). The result from “Child Sex Abuse “in 2012 revealed that young children are not safe. The problem of child and sexual abuse in the society is growing. The need for concerted public education on the nature of this violence and its consequences is imperative.

2.1.2.3 Risky Traditional Practices

Although Tanzania has positive traditional practices which help to mitigate the impact of HIV and AIDS, such as strong extended family support structures and social sanctions, there are also some risky traditional practices that hinder the effectiveness of the national response. These include wife inheritance by a male relative of the deceased husband, female genital mutilation, early or child marriages, and limited property rights for widows. HIV Prevalence among widows aged 15 and 49 years is estimated at 24.7%. A comparison of TDHS 2004 data and that of the TDHS 2010 shows that the proportion of married young women aged 15-19 years fell by 20% while, pregnancy and childbirth among young women of this age dropped by more than 12%. Nevertheless, despite the gains, one in six young women aged 15-19 is married. In addition, young women and girls face a significantly higher risk of death from pregnancy and delivery-related complications, which is further compounded by the high frequency of births which occur at home without skilled attendants.

2.1.2.4 Policy and Legal Environment

Tanzania developed its first National Policy for HIV and AIDS in 2001, subsequently implemented through two strategic frameworks which were completed in 2012. In 2008, Tanzania enacted the HIV Prevention and Control Act (HAPCA). Part VIII of the Act provides for PLHIV rights and obligations. Section 33(1) (a) and (b) provide for rights to access quality medical services and treatment for opportunistic diseases. Section 33(2) (a) and (b) provide for obligation of protection to others from re-introducing infections into the population. According to Section 28-32 of this law, discrimination is a punishable offence. In 2010, regulations for HIV Counselling and Testing, use of ARVs, and disclosure were developed and gazetted. The regulations provide for protection against forced testing and mandatory disclosure.

The National HIV and AIDS Policy (2012) further emphasize the importance of respect for the human rights of PLHIV, as stipulated in the Constitution of the United Republic of Tanzania. Specifically the policy commits to enhancing measures that ensure all civil, legal and human rights for men, women, boys and girls living with HIV and AIDS, in accordance with the URT Constitution and other International Conventions. Against a backdrop of protective policies and laws, the Law of Marriage Act (1971), which provides for early marriage (15 years for females by statute, or 14 years with consideration of “special circumstances”) thus increasing the risk of HIV infection to young women and girls, and other similar laws need to be revised.

Other opportunities for reform and improvement under the current policy and legal framework also deserve consideration. For example, the shortages in human resources for the national response to HIV and AIDS, together with the need to scale up service provision, require examination of the policies surrounding task sharing for interventions such as HIV testing, PMTCT, and HIV treatment.

As described in “Analysis of Policy, Legal, and Regulatory Frameworks for Task Shifting in Tanzania,” the Minister of Health and Social Welfare has the power to permit other health professionals, broadly defined, to dispense prescription drugs such as ARVs and to expand the prescribed tasks that can be performed by nurses and other clinical staff, such as initiating or managing ART (Health Policy Initiative, Tanzania, 2013). Task sharing also involves increased community mobilization for the benefit of all sectors in the national response to HIV and AIDS.

2.2 THE HEALTH SYSTEM IN TANZANIA MAINLAND

The health system in Mainland Tanzania operates with technical coordination and in-service training of health care workers from the Ministry of Health and Social Welfare (MoHSW); administration and supervision of facilities by the Prime Minister’s Office – Regional and Local Government (PMO-RALG); and using human resources provided with pre-service training under the authority of the Ministry of Education and Vocational Training (MoEVT). In addition, the health system is facilitated by ministries, departments and agencies which provide different services that support health, ranging from actors in the legal framework that support justice and gender rights to those responsible for agricultural improvements and increased access to water. There are many actors that play a role in the health system. The public health sector is also augmented by services from non-state actors including faith-based organizations (FBOs), Community Service Organizations (CSOs), and other private sector actors, both formal and informal.

The health sector has been implementing the Health Sector Strategic Plan III (2009-2015), which is currently under review in preparation for HSSP IV. Under HSSP III, eleven strategies are enumerated in conjunction with two major programmes, the Primary Health Services Development Programme (PHSDP or MMAM) previously mentioned and the Human Resources for Health Strategic Plan. These programmes are designed to scale up health facility service coverage and human resources for health respectively, which support the overall health sector response to HIV and AIDS.

2.2.1 Human Resources for Health (HRH)

Human resources for health in Tanzania are produced by 135 pre-service institutions, including 62 government, 47 FBO, 5 private and 10 university programmes (2012, p. 32). From the 2006 – 2011, the total number of health care workers has increased from 47,000 to 56,000. However, much work remains to be done (Ibid., p.24). The current Human Resource for Health Strategic Plan (2008-13) has been focusing on strategies for improved training, recruitment, and retention of health care workers (2008, p. 23).

2.2.2 Health Facilities

The health system has a total of 6,342 health facilities which include facilities owned by private, faith-based organizations and Parastatal institutions. In terms of distance to a health facility, 96% of urban households and 70% of rural households in Mainland Tanzania live within 5 kilometres of a health facility (2013, p. 18). In addition, only 55% of health workers are serving a rural population, which represents 75% of the total population. Moreover, there are fewer specialized cadres of health care workers available in the rural areas (2012, p. 30). As of December 2012, there were

4,914 health facilities providing PMTCT services, of which 1,404 provided full ART services. To reach the NMSF III treatment targets, in line with PMTCT Option B+, all facilities providing PMTCT will need to be upgraded to provide ART.

2.2.3 The Health Sector Response to HIV and AIDS

The MoHSW provides HIV health services through the coordination of the National AIDS Control Programme (NACP) as well as TB, nutrition, and reproductive and child health services. These services include surveillance of HIV infections and other STIs, HIV care and treatment, Prevention of Mother to Child Transmission, HIV Counselling and Testing, home based care, and monitoring and reporting of the health sector response to HIV and AIDS. NACP's strategic role in the national response to HIV and AIDS is further detailed in the Health Sector HIV and AIDS Strategic Plan (HSHSP, 2013-2017), a subset of both the Health Sector Strategic Plan III and the National Multi-sector Strategic Plan III.

From the 6,342 health facilities mentioned above, a total of 1,078,018 PLHIV were enrolled in care and treatment clinics all over the country and 660,723 PLHIV initiated on ART as of December 2012.

The NMSF III will leverage the health sector's comparative strength by working closely with the MoHSW and other key departments to deepen the implementation of the Primary Health Services Development Plan 2007-2017 (PHSDP).

However, there are challenges facing the health sector response to HIV and AIDS. These include coping with the rapidly expanding programmes, inadequate and unpredictable financing, weak procurement and supply chain management, shortage of skilled human resources for health, and poor infrastructure to provide HIV and AIDS services, resulting in inadequate coverage of services. These challenges are being addressed in the on-going implementation of the PHSDP. MOHSW is also implementing the Human Resources Strategic Plan 2008/2013 (HRHSP) that guides the health sector in proper planning, development, management and effective utilization of human resources (2008, p. 1). However, according to the Public Expenditure Review of Human Resources for Health, it is unlikely that the health sector will achieve its target of having a work force of 214,753 in public and private sectors by 2017, due to the limited capacity of the training institutions in the country (PER - HRH, 2011). Collaboration and partnership between the public and private sectors should therefore be strengthened to achieve the best results.

CHAPTER THREE

3 Overview of HIV and AIDS in Tanzania

3.1 HIV Prevalence on the General Population

Since the first three AIDS cases were reported in Tanzania in 1983, infections have spread rapidly, leading to a generalized epidemic, with pockets of a concentrated epidemic, and a devastating impact on social and economic development. The predominant mode of HIV transmission is heterosexual contact between HIV-infected and uninfected individuals, with sexual transmission accounting for approximately 80% of infections. Vertical infections from mothers to newborns account for about 18% of infections and medical transmission through unsafe blood for approximately 1.8%. By the end of 2012, Tanzania had an estimated 1.5 million people living with HIV and approximately 86,000 new HIV infections (Spectrum, 2013). This can be attributed in part to widespread risky behaviours, inconsistent and incorrect condom use, inadequate numbers of eligible individuals on antiretroviral therapy, increased gender-based vulnerability, and some risky, traditional cultural practices.

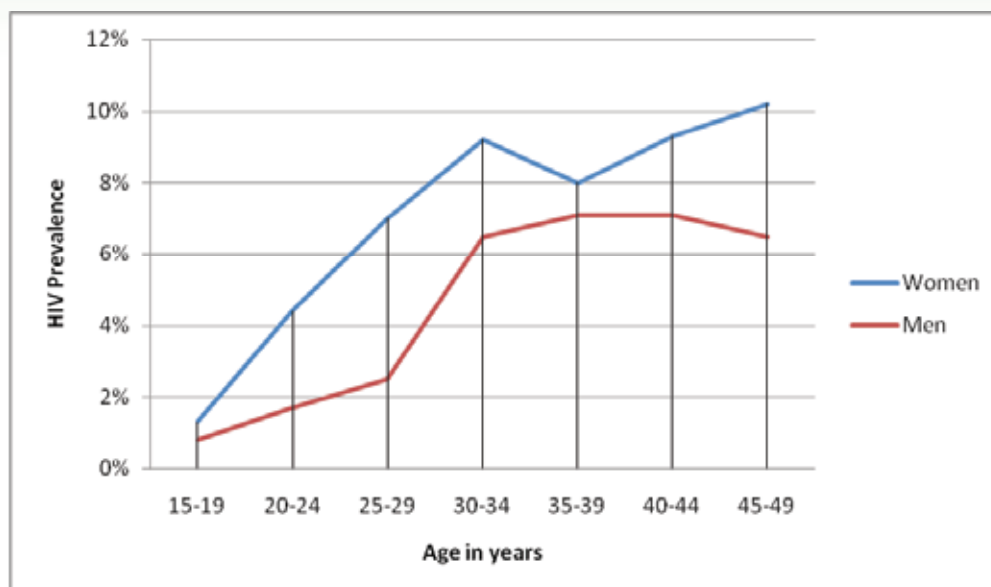
3.1.1 HIV Prevalence

Although HIV prevalence in Mainland Tanzania has declined from 7.0% to 5.3% during the period from 2003/04 to 2011/12 (2011-12) among all adults aged 15-49, and from 6.3% to 3.9% among men in the same age group, there has not been a statistically significant decrease among women. Regional variation throughout Mainland Tanzania ranges from 1.5% in Manyara to 14.8% in Njombe.

3.1.2 HIV Prevalence by Age and Sex

There exist age and sex differentials in HIV prevalence in Tanzania as indicated in figure 2 below. Among both men and women, HIV prevalence increases with age generally and women invariably have higher prevalence rates in all age groups compared to men. However, prevalence among young women aged 25 – 29 is 3 times higher compared to young men in the same age group.

Figure 1: HIV Prevalence (%) by age and sex

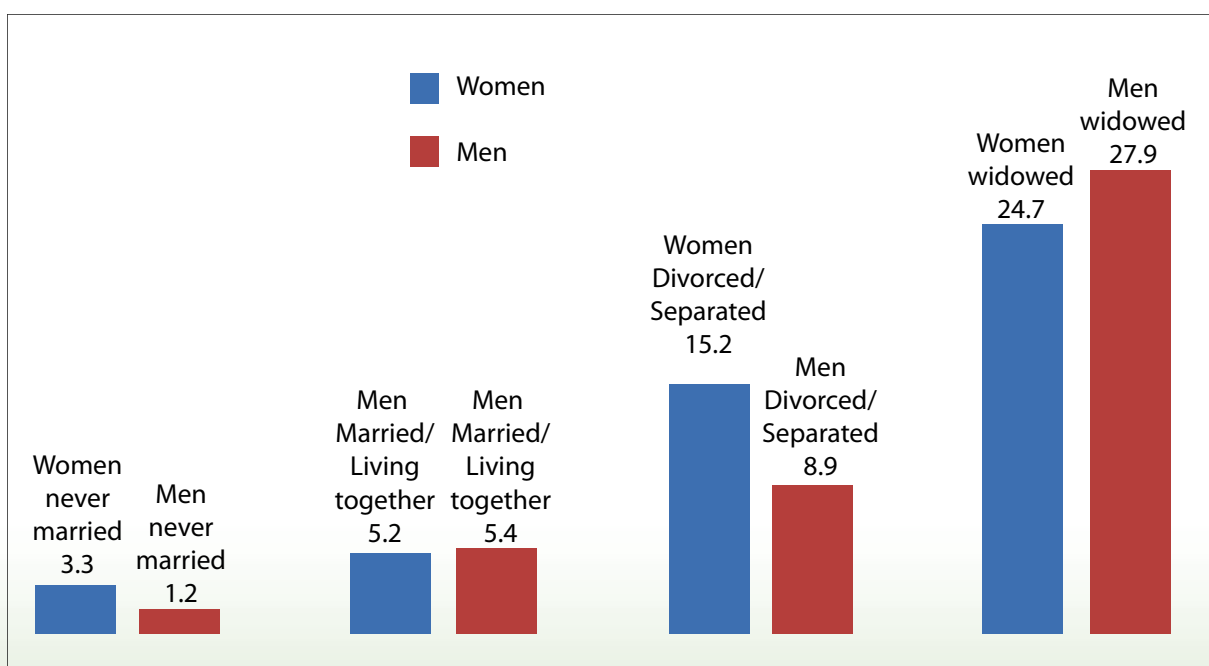


Source: THMIS 2011/12

3.1.3 HIV Prevalence by Marital Status

HIV prevalence is significantly associated with marital status and highest among those widowed and divorced/separated. Prevalence is higher for women compared to men among the never married and divorced/separated.

Figure 2: HIV Prevalence by Marital Status 2012

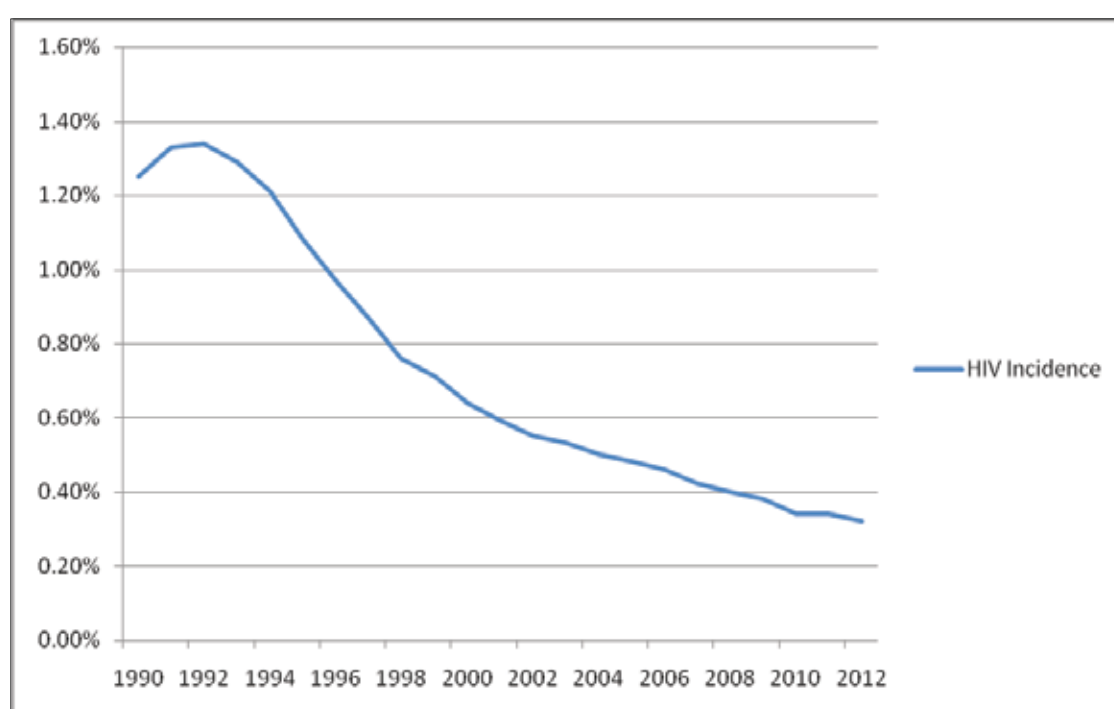


Source: THMIS 2011/12

3.1.4 Trends in HIV Incidence and Prevalence

Data from four rounds of antenatal clinic attendees and two national population surveys and projections indicate that HIV incidence and prevalence have declined and stabilized. The incidence of HIV infection in the age group 15-49 years peaked at 1.34% in 1992, declined rapidly down to 0.64% in 2000, and steadily declined further to 0.32% in 2012. Similarly, HIV prevalence increased to a peak of 8.4% in 1996, declined to 5.7% in 2008, and declined further to 5.3% by 2012. However, a wide variation exists between regions and within regions across social and age groups (THIS 2004, THMIS 2008 & 2012).

Figure 3: HIV incidence in Tanzania (age 15-49)

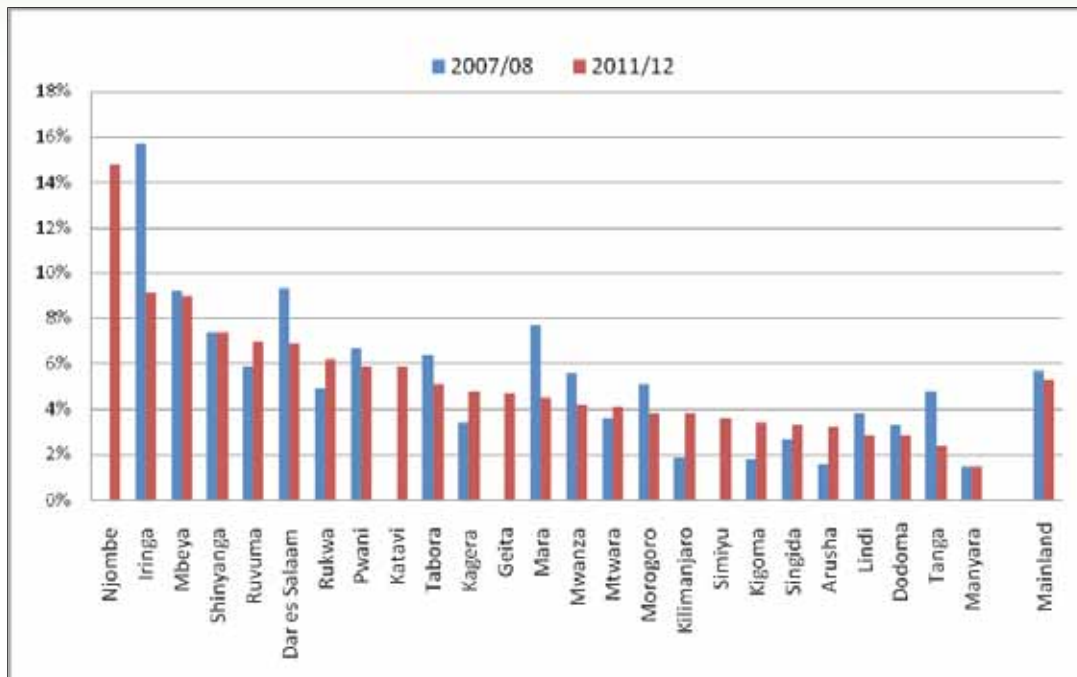


Source: Spectrum estimates (UNAIDS, 2013)

3.1.5 Trends of HIV Prevalence by Regions in Tanzania

While there was an overall decline in HIV prevalence in Tanzania in the period 2008 and 2012, the change was not statistically significant. There are 8 regions that witnessed an increase in prevalence levels; these include Ruvuma, Rukwa, Kagera, Mtwara, Kilimanjaro, Kigoma, Singida and Arusha. The increase in HIV prevalence in these regions could be a factor of successful care and treatment programmes or an actual rise in HIV infection within the regions or both. Other possible factors, such as HIV test refusal rates, should also be explored to explain the change in prevalence over this short time period.

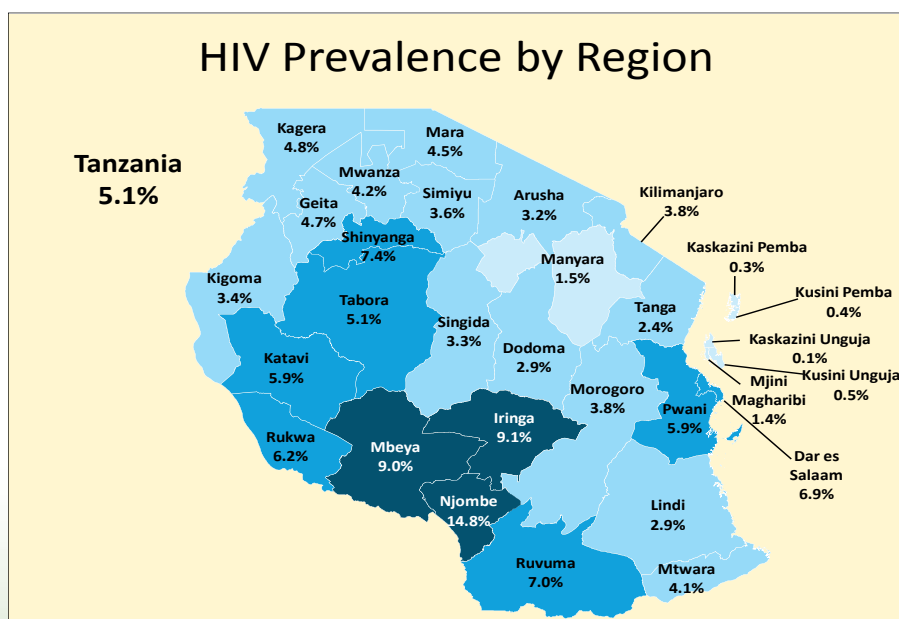
Figure 4: HIV Prevalence by Region between 2008 and 2012



Source: THMIS 2007/08 and THMIS 2011/ 2012

Six regions in the Southern Highland Zone (Njombe, Iringa, Mbeya, Ruvuma, Rukwa and Katavi), two regions in the Coastal (Pwani and Dar es Salaam) zone and one in the Lake zone (Shinyanga) had HIV prevalence rates above the national average. These variations call for a strategic focus in this NMSF III to control and scale down new HIV infections in regions with high prevalence and understand and address the factors behind rising trends in prevalence in the regions.

Figure 5: HIV Prevalence by region, 2011/2012

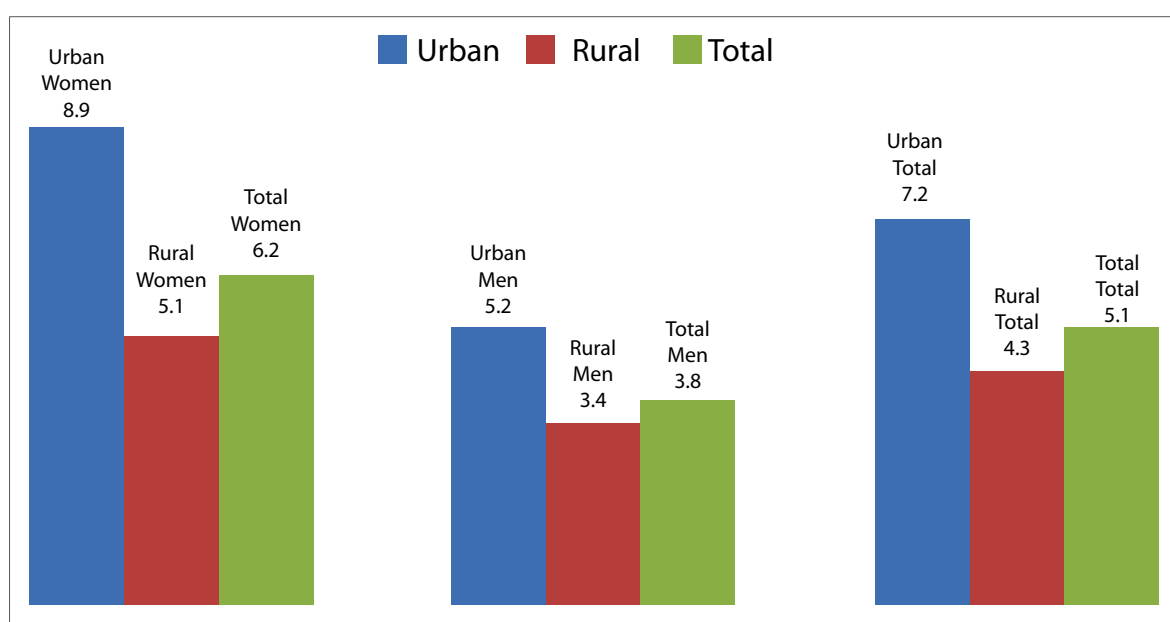


Source: THMIS 2011/12

3.1.6 HIV Prevalence in Urban and Rural Areas by Sex

Tanzania has marked rural-urban and sex differences in HIV Prevalence. For both males and females, urban residents (7.2%) have higher levels of HIV infection than rural (4.3%) residents.

Figure 6: Tanzania HIV Prevalence by sex and residence



Source: THMIS 2011/12

3.1.7 HIV Prevalence among Key Population Groups

Tanzania follows the international standard definition of Key Populations, a term referring to populations at high risk for exposure to HIV or for transmitting HIV (Terminology Guidelines, 2011). In the Tanzanian context, these key populations include all PLHIV, as well as serodiscordant couples, sex workers and their clients, men who have sex with men, women who have anal sex, and people who inject drugs. Other vulnerable groups who may also be among those at higher risk for HIV exposure or transmission include women and girls, youth, people in conflict and post-conflict situations, refugees and internally displaced persons, migrant labourers, and people working in mining and fishing industry and their surrounding communities. Recent studies conducted in various regions in Tanzania showed varying degrees of HIV prevalence among key population groups, with the prevalence of MSM, FSW, and PWID all significantly above the national average (Country Progress Reporting, Part A: Tanzania Mainland, 2012). This variation is alarming and therefore calls for effective strategic HIV prevention interventions. In the Tanzanian context, other population groups that deserve special consideration in HIV programming include prisoners, long-distance track drivers, disabled (in all forms), fishing communities, and people in mining, women and children.

3.1.8 People Who Inject Drugs (PWID)

A small sample survey of 430 respondents undertaken in Temeke Municipality, Dar es Salaam region revealed an HIV seroprevalence of 26% (34.8 % among IDUs and 11.7 % Non IDUs). Among the newly diagnosed IDUs, women had higher HIV prevalence and there was also a high proportion of Hepatitis C co-infection. Gender also played a significant role in the risk profile of injecting and non injecting drug using participants. Males and females did not report significantly different injecting risk behaviours, but females were more likely to have sold sex and have a higher number of sex partners thus increasing their vulnerability to HIV infection. Among People Who Inject Drugs (PWID) with non-injecting partners, 89% of males and 75% of females reported inconsistent condom use with their regular partner (Risk Practices among PWID in Temeke, 2011). Stigma and discrimination against PWID remains high, posing a significant challenge to outreach and delivery of friendly health services. This highlights the need to prioritize the recommended package of comprehensive intervention for HIV prevention and care among PWID. Furthermore, the importance of PWID not sharing needles should remain a key component of the comprehensive harm reduction package in Tanzania, together with education about the risks of sexual transmission and the need for protection through consistent and correct use of condoms.

3.1.9 Sex Workers

A BROAD Definition of a sex worker includes anyone who exchanges sexual services for money or goods, whether regularly as a full-time activity, temporarily as a short-term measure, or sporadically as an occasional though longer-term activity. Sex workers include men and women, young and old. Prevention, care, treatment, and support programmes for sex workers and their clients are being implemented in Tanzania, but need significant expansion and support.

In a study conducted with 537 female sex workers in Dar es Salaam, one-third of respondents were reported to be divorced or separated, while over half were never married. In the study, 69.7% reported that sex work constituted their main source of income; 31.4% tested HIV sero-positive; 69.3% reported always using a condom with regular clients though only 31.6% reported always using a condom with their steady partner in the previous 30 days. A high prevalence of sexual and physical abuse (51.7%) was also reported in the previous 12 months (HIV BBSS Among Female Sex Workers, DSM, 2012).

According to the Violence Against Children Survey (VAC) results, 4% of Tanzanian girls received money or goods in exchange for sex at least once in their lifetime. Of the girls, 82% who reported receiving money or goods for sex also reported childhood sexual violence; 90% who received money or goods for sex reported childhood physical violence by a relative, and 50% who received money or goods for sex reported childhood emotional violence (Violence Against Children Report, 2011). A study conducted in Mwanza region on cross-generational and transactional sexual relations revealed that the main reason for having sexual relationship was to receive presents or money. The study involved male and female respondents aged 12 years and above from primary 52% and secondary schools 10% (Luke & Kurtz, 2002). Stigma and discrimination against sex workers remains high, posing a significant challenge to outreach and delivery of friendly health services.

Overall, these data call for an urgent need to address the different contexts in which sex work occurs. The high HIV prevalence among sex workers requires addressing the factors that inhibit condom use in both transactional and intimate partner contexts. In addition, the correlation of childhood sexual violence and engaging in transactional sex emphasizes the need to educate, empower, and equip girls and young women to avoid exposure to non-consensual, forced sex and sexual violence.

3.1.10 Men Who Have Sex with Men (MSM)

In a research study of 271 MSM with a mean age of 26 years, 41% were reported to have tested HIV seropositive; 63.1% had also been married or cohabited with a woman at least once in their life. Those reporting no condom use with their last casual sex partner was 43.2%, while 49.1% used condoms with their last regular sex partner. About 30% of all respondents were reported to be engaged in commercial sex work (Condom Use in MSM, 2013). Stigma and discrimination against MSM remains high, posing a significant challenge to outreach and delivery of friendly health services. Given the criminalization of consensual adult homosexual intercourse, the multi-sectoral national response requires significant cooperation from all key stakeholders to ensure that MSM are reached with HIV and AIDS services.

3.2 KEY FACTORS IN HIV TRANSMISSION

A number of key factors in HIV transmission have been identified, including individual behavioural, socio-cultural and biomedical factors. These factors are important, as they become critical strategy considerations in combating the epidemic. Addressing these issues effectively will contribute to overall prevention goals.

3.2.1 Individual Behavioural Factors

Individual behavioural factors refer primarily to the inter-personal contexts in which sexual behaviour and sexual HIV transmission occur.

3.2.1.1 Multiple Unprotected Sexual Relations

Multiple sexual relations in the form of concurrent or serial, extramarital, premarital, trans-generational, transactional, casual or a combination of these are common in Tanzania. Sex with more than one partner in the year prior to the survey was reported by 21% of men and 4% of women (THMIS 2011/12). There is a direct relationship between HIV prevalence and the number of lifetime sexual partners, rising from 2.9% among women with one life time partner to 18.9% among those with 10 or more lifetime partners, and 0.9% to 7.5% among men respectively (Ibid., p.115). Multiple concurrent partnerships (MCP) are driven by socio-cultural gender-based factors including poverty, frequent travel, working away from home and peer pressure. The underpinning transmission factor is unprotected sexual intercourse.

3.2.1.2 Inter or Cross-Generational Sexual Relations

Inter- or cross-generational sex, involving high-risk intercourse, between young women and older men was estimated at 7.6% among women aged 15-19 in mainland Tanzania in 2010. There was a notable difference between urban and rural populations, with 10.4% of Mainland urban young

women at risk and 6.7% of Mainland rural young women. Urban Dar es Salaam, however, performed better than the national trend with only 4.8% of young women reporting such high-risk behaviour (TDHS, 2011). Anecdotal evidence indicates that male youth also practice sex with older women, motivated by money, gifts or a social standing aspiration.

3.2.1.3 Early Sexual Debut

Early sexual debut and adolescent sexual networking without protection exposes young people, especially girls, to HIV and STI infection. In Mainland Tanzania, 9.7% of young women and 10.2% of young men aged 15-24 had sexual intercourse before age 15, while 51.6% of young women and 43.9% of young men aged 18-24 had sexual intercourse before 18 (THMIS 2011-2012). Out of those who have never married (15-24), only 57.9% of women and 59% of men used condom during their last sexual intercourse (Ibid. p.99).

3.2.1.4 Alcohol Abuse

Alcohol abuse is associated with the risk of contracting sexually transmitted infections, including HIV. In reviewing the literature on alcohol use and sexual risk in southern Africa, including Tanzania, studies show consistent links between the quantities of alcohol that people drink and sexual risks for contracting HIV. In addition, clear gender differences emerge in the various studies: men's drinking is associated with increased risks; while women's risks are primarily associated with their male partner's drinking. In one study of a mining community in Tanzania, testing HIV positive was independently associated with greater alcohol use (HIV and STI prevalences in goldmine communities, 2003). Others studies from Tanzania correlate increased sexual risk taking with increased levels of drinking (Alcohol Use and Sexual Risks, 2007).

3.2.1.5 Infrequent and Inconsistent Use of Condoms

The dual protection provided by condoms is subject to their consistent and correct use. Infrequent and inconsistent use of condoms often lower protection among individuals in long standing relationships including married and cohabiting individuals. The challenge to condom usage in Tanzania revolves around four critical factors:

1. Accessibility, including the potentially high cost of condoms, demand creation, unavailability and stock outs, poor marketing and distribution outlets (distribution and cost), and gaps in integrating condom usage in reproductive health programming.
2. Lack of correct knowledge of usage, efficacy, and stigma related to condom usage.
3. Attitudes including persistent risky behaviour choices and religious beliefs.
4. Inadequate capacity for women and girls to negotiate condom use due to traditional and cultural factors which perpetuate gender inequality.

3.2.1.6 Unprotected Penetrative Heterosexual Anal Intercourse

Penile-anal intercourse is typically associated with male homosexual relationships, with relatively little attention given to the issues related to anal intercourse in heterosexual relationships. Anal intercourse is thought to be associated with considerable risk of HIV-1 transmission, studies,

however, have shown that women's risk of contracting HIV through heterosexual anal sex (HAS) is also significantly higher than from vaginal intercourse. The pooled risk of male-to-female HIV-1 transmission for unprotected receptive anal sex is much higher ranging from 1.4% to 1.7% per sex act, with no significant differences between per sex act risks of unprotected receptive anal intercourse for heterosexual couples.

In 2012/2013 Mwanza Intervention Trial Unit (MITU) in collaboration with Ifakara Health Institute and MUHAS carried out formative study to determine the dynamics of heterosexual anal sexual intercourse in Mwanza, Tanga, Dar es Salaam, and Morogoro regions, and demonstrate that, the practices do happen among couples in Tanzania. To understand the magnitude a follow up study is required.

Comprehensive sexual education including targeted information about the risk of HIV transmission through anal intercourse, together with increased access to condoms should be considered in developing strategies to address these groups.

3..2.2 Socio-Cultural Factors

Socio-cultural factors refer to the broader population-level contexts in which HIV transmission occur. These include factors such as stigma, discrimination, mobility, migration, gender based violence, gender inequalities and wealth disparity.

3.2.2.1 Stigma and Discrimination against PLHIV

Stigma is highly prevalent in Tanzania at various levels and settings, as data from the 2012 Stigma Index show. There is breaching of confidentiality through health delivery systems. While 15% of the PLHIV felt that health care providers did not keep their information confidential, another 5.4% had their serostatus disclosed without their consent. Further, the study revealed discrimination by health care providers. For example, 13% of PLHIV were told not have children, 44% were denied access to reproductive health information, 14% were coerced in accepting particular infant feeding options, and about 9% were coerced in their use of family planning methods. Few (19%) eligible pregnant women living with HIV received ART for PMTCT. Others were coerced into sterilization and pregnancy termination by health service providers due to their HIV positive status (People Living with HIV Stigma Index, 2012).

The study also reveals high levels of self-stigma. Most PLHIV reported a sense of shame (44%), self-blame (63.4%), feelings of worthlessness (85%), feelings that PLHIV deserves to be punished (10%), and self-isolation because of their HIV positive serostatus. Self-Stigma drives many PLHIV who are sexually active not to bear children (38%) or get married (16%) because of their HIV positive serostatus. PLHIV also remove themselves from places where they would be potentially stigmatized, including work places, for fear of gossip (45%), being verbally insulted, harassed, and threatened (30%). Furthermore, the study showed that fewer PLHIV know where to seek assistance once their human rights are violated. A majority of PLHIV are not aware of their rights,

the national HIV and AIDS Policy, legal information, and global commitments on HIV and AIDS. In addition, community acceptance towards PLHIV is very low. As the stigma index reports, 25% of women and 40% of men in Tanzania do accept interacting with PLHIV. The situation is critical in rural areas where only 21% of women and 35% of men have positive attitudes toward PLHIV, as compared to 36% of women and 54% of men in the urban areas.

3.2.2.2 Mobility and Migration

Mobile population groups such as seasonal labourers in plantations, road construction sites, mobile markets, truck drivers, fishermen and miners are vulnerable to HIV infection because they often practice higher risk sex with non-marital or co-habiting partners. Studies have found samples of long-distance truck drivers with high HIV prevalence. These results are consistent with the findings in the THMIS 2007/08 and 2011/12, which found that individuals who travel away from home frequently are more likely to be HIV seropositive than those who do not. Among women in the THMIS 2011/12, those who had slept away from home five or more times in the past 12 months were twice as likely to be HIV seropositive (11%) as those who did not travel away from home (5%).

3.2.2.3 Gender Inequalities

Women and girls are more vulnerable to HIV infection than their male counterparts in Tanzania due to biological, socio-cultural and economic factors. According to UNAIDS, up to 80% of HIV seropositive women in long term relationship acquired the virus from their partners. This inequality sometimes results in gender based violence, such as rape, sexual assault and battery. Other factors such as multiple sexual partnership, polygamy, violence, alcohol, and substance abuse also play an exacerbating role in reinforcing gender inequalities.

3.2.2.4 Income Inequality and Poverty

There is emerging evidence that income inequality and poverty also play a role in the context of HIV transmission, as the following points illustrate.

1. HIV prevalence is higher among those employed (6%) than those not employed (3%).
2. Anecdotal evidence indicates that wealthy men and women are engaged in cross-generational transactional sex with younger or poorer vulnerable groups of either sex who in turn need money or material benefits. In addition, poverty has been reported to push young girls and boys into commercial sex work.
3. Inability to afford condoms has in several studies been reported as a barrier to condom usage or negotiated safe sex.
4. Women who are not sex workers engage in risky sex for purposes of providing food for their children and survival.
5. Poverty increases vulnerability to fast progression to AIDS, as many poor people get infections which lower their immunity.

The National HIV and AIDS Policy 2013 also notes that poverty aggravates the intensity of the impact that HIV and AIDS may have on women, orphans and the disabled.

3.2.3 Biomedical Factors

Biomedical factors affecting HIV transmission include low levels of male circumcision in some regions, low coverage of quality assured blood transfusions, non-sterile medical injections, high prevalence of STIs including Human Papilloma Virus (HPV), high levels of HIV couple discordance, transmission of infection from parent to child and low levels of self-knowledge about HIV serostatus.

3.2.3.1 Low levels of Voluntary Medical Male Circumcision (VMMC)

Male circumcision has been associated with a decreased risk of HIV infection by men, presumably because of physiological differences that reduce the susceptibility to HIV infection among HIV-negative, circumcised men. In Mainland Tanzania, HIV prevalence among circumcised men was 3.5%, compared with 5.2% of uncircumcised men (2013, p. 119). Currently, there is substantial demographic and regional variation in the prevalence of circumcision. Overall, 70.9% of men have been circumcised, though the level of male circumcision is substantially higher among urban men than rural men, 94.2% to 64.2% respectively. More than half of the regions have levels of circumcision of 50% or more. Male circumcision coverage is lowest in Rukwa (28%), Simiyu (30%), and Shinyanga (32%) (Ibid., p.87); while the corresponding HIV prevalence in the same region is 6%, 3.6%, and 7.4% respectively.

3.2.3.2 Low Coverage of Quality Assured Blood Transfusions

Transfusing blood that has not been screened against HIV virus infection puts the recipient at an increased risk of being infected. Tanzania has not yet achieved universal (100%) screening of donated blood for HIV infection; mechanisms to ensure quality and continuity in screening are still inadequate, particularly at the lower levels of the health system. So far, only 35.7% of the donated blood in the country is screened for HIV in a quality assured process (Tanzania Country Progress Report, 2010). The total requirements for Mainland Tanzania are estimated at 436,253 units of blood in 2012, or 1% of the total population, as per WHO recommendations.

3.2.3.3 Unsafe Medical Injection

WHO estimates globally that at least 5% of new HIV infections are attributed to unsafe, injection practices. About 2% of women and 3% of men in Tanzania received unsterile medical injections (2013, p. 90). It had been revealed that only 5% of facilities in the country had all the basic requirements for infection prevention such as soap, water, gloves and disposable boxes for sharps (used needles and lancets). About one third of the health units had facilities for adequate disposal of sharps and bio-hazards materials while only 15% had guidelines for infection prevention control.

3.2.3.4 Prevalence of Sexual Transmitted Infection (STI)

It has been established that STIs such as gonorrhoea and syphilis increase an individual's chances of becoming infected with HIV during unprotected sex. A survey in Mainland Tanzania revealed that 3.1% of women and 6.9% of men reported having an STI, an abnormal discharge, or a genital

sore. Similarly elsewhere, evidence has been established between the increased vulnerability of PLHIV to Human Papilloma Virus (HPV), which causes cervical cancer. Tanzania is a country with high prevalence of cervical cancer; yet, women's knowledge of HPV screening and cervical cancer varies greatly by education (52% of women with no education compared to 75% with secondary education) and wealth (53% of the lowest quintile compared to 82% of the highest quintile) (Ibid., p.92).

3.2.3.5 Mother to Child Transmission of HIV Infection

TDHS (2010) reported that Mother to Child Transmission (MTCT) is the second most common cause of HIV transmission within the Country. There are two notable gaps; these include low levels of attendance of ante-natal clinics (out of the 4 recommended visits) and lack of full integration of Prevention of Mother to Child Transmission (PMTCT) services in Maternal and Child Health services. Approximately, 24% of HIV positive pregnant women that attended antenatal clinics were not reached by PMTCT services and 43% of HIV exposed infants who needed ARVs to prevent MTCT did not receive it due to limited access to treatment, stock outs of commodities, or attrition from the programme (TDHS, 2011).

3.2.3.6 High Levels of Discordance and Low Level of Knowledge of HIV Serostatus

Partners that are engaged in unprotected sex while not knowing their serostatus are at an increased risk of acquiring HIV. A recent survey has established that among the general population, 6% of couples are discordant with 3.5% of couples indicating the man is infected and 2.8% showing that the woman is infected. Discordance is more common among urban than rural couples (THMIS 2011-2012).

3.3 ASSESSMENT OF THE NATIONAL RESPONSE

3.3.1 Organization of National Response to HIV and AIDS in Tanzania

TACAIDS has a responsibility of providing multi-sectoral policy guidance and oversight of the National HIV and AIDS response. Specifically, TACAIDS coordinates the National Multi-sectoral HIV and AIDS Strategic Framework with the key functions of policy development, resource mobilization, advocacy, monitoring and evaluation.

The advocacy, monitoring and evaluation of the AIDS response is decentralized to the local government authorities (LGAs). Planning, implementation and monitoring of the national response resides with the sectors, which are also decentralized to the LGA levels. The Public Sector has a defined administrative structure that stretches from the community (village or Mtaa) level, up to National or Central level. The roles and responsibilities of each of these levels in the National Response to HIV and AIDS are well defined.

3.3.2 Implementation of the National Response

Elimination of HIV in Tanzania demands active and meaningful participation of the entire community, individually and collectively. This NMSF III provides guidance to all public and non-public sectors to review and implement well focused, cost effective and results-informed HIV interventions that target the individual person and the entire sector according to the epidemiology and the comparative advantages of each sector in order to achieve the three zeros. The process of developing and

implementing the sectors' strategic plans will be undertaken under the leadership of the chief executive officers who will also be responsible and accountable for the results. The sectors will closely monitor and submit performance reports to the Prime Minister's Office through TACAIDS.

3.3.3 Achievements of the National Response

Overall, the HIV prevalence of Mainland Tanzania declined between national surveys undertaken in 2004 (7%) and 2012 (5.3 %). There was no statistical significant decline between the two most recent surveys in 2008 (5.7%) and 2012 (5.3 %). HIV Counselling and Testing sites increased from 1,035 in 2009 to 2,168 by the end of December 2012. Provider Initiated Testing and Counselling (PITC) was available in all hospitals and 50% of health centres. The total number of new clients pre-test counselled and tested increased from 998,887 reported in 2009 to 1,009,691 by end of 2010.

3.4 GAPS AND CHALLENGES OF THE NATIONAL RESPONSE

3.4.1 Gaps and Challenges in HIV Prevention

3.4.1.1 Knowledge of HIV and AIDS

There is a huge difference between awareness of the epidemic and specific knowledge of how to prevent transmission and acquisition. There are notable differences among different age groups in comprehensive knowledge of HIV prevention. Although there is no clear relationship between older age and better knowledge, youths aged 15-19 appear to have lower knowledge than those in older age groups. Knowledge of HIV prevention methods is lowest among those who have never had sex. Levels of knowledge of preventive methods are higher in urban than in rural areas.

3.4.1.2 Prevention of Mother to Child Transmission (PMTCT)

Many HIV positive women and HIV exposed infants still do not access Prevention of Mother to Child Transmission (PMTCT) services. About 30% of all HIV positive pregnant women in need of ARV therapy to reduce the risk of MTCT did not access eMTCT services at all in 2011; 44% of all children at risk of HIV infection from their mothers did not access ARV for PMTCT. This could partly be explained by the RCH service utilization pattern by pregnant women. The TDHS (2010) shows that while 96% of women have had at least one ANC visit, only 43% had attained the recommended minimum of 4 ANC visits. This trend coincides with higher HIV testing that is done at first visit and very low ARV prophylaxis uptake for mothers and their infants later in the postpartum period.

Inadequate community and male partner involvement are the main challenges to attain eMTCT; 70% of health facilities did not provide Early Infant Diagnosis (EID) services and 43% of HIV exposed infants did not receive any prophylaxis to prevent MTCT. Even facilities with EID services experience long delays in specimen transport, testing and provision of results that threaten the health of infants with HIV infection at the time when they are most likely to die from this infection. Promotion of Option B+ to enrol all HIV seropositive women into lifelong ART is being used to address some of the existing service gaps but in itself will be inadequate to reach all HIV positive women and exposed infants with sustained, quality life-saving interventions.

3.4.1.3 HIV Testing and Counselling (HTC)

The challenges in the implementation of HTC services include low utilization of the VCT services especially in rural areas due to long distances; inadequate human resources; stigma and discrimination, gender inequalities and gender based violence; limited couple testing; and low disclosure of HIV test results to partners preventing efforts to make informed health decisions such as use of condoms.

Programmatic gaps arising as a result of the above challenges include: 47% of men and 62% of women aged 15-49 were tested and received results leading to a gap of 53% for men and 38% for women that needs HTC services. PITC services had not been rolled out in 50% of health centres and in all dispensaries considering that health centres and dispensaries serve over 80% of the country's population.

3.4.1.4 Blood Transfusion

As previously mentioned, only 35.7% of Tanzania blood supply is quality assured as per WHO standards.

3.4.1.5 Scaling up Male Circumcision

The National Strategy on Voluntary Medical Male Circumcision had targeted to circumcise 2, 800,000 adult males in 12 priority regions by 2015. However, the programme managed to circumcise only 415, 398 (15 %) up to December, 2012. This intervention will now aim at targeting sexually active men in the non-circumcising and high HIV prevalence regions for short term impact and targeting younger males for long term impact. The regions targeted are Rukwa, Mbeya, Iringa, Kagera, Mwanza, Tabora, Shinyanga, Njombe, Geita, Simiyu, Katavi and Rorya district in Mara region.

3.4.1.6 Key Populations (KPs)

Access to services and interventions for key population groups is limited by stigma, criminalization and risky behaviour practices towards cross-infection among key population groups and the general population is high. The main challenges include limited data on key populations beyond Dar es Salaam, limited coordination of implementers working with key populations, and lack of national standards or strategies for interventions targeting KPs.

Programmatic gaps identified include: countrywide KPs magnitude and dynamics is still unknown; inadequate user friendly services for KPs; the gap in terms of comprehensive package of services and effective interventions, resulting in insufficient coverage and utilization of HIV treatment and prevention services by KPs (NMSF II Evaluation Report, 2012).

3.4.1.7 Mainstreaming HIV and AIDS interventions

While the private sector, Civil Society Organizations (CSOs) and Faith Based Organizations (FBOs) have been actively mainstreaming HIV interventions in their workplaces, workplace interventions outside the public sector has been limited; furthermore, both private and public sector external mainstreaming has also been weak. The expanding private sector highly justifies increasing information and strengthening service interventions at workplaces. Existing anecdotal evidence suggests that stigma and discrimination against health workers and school teachers living with HIV

and AIDS is high. In other sectors, demand for information about rights, duties and care of public servants is high but there are limited services and sexual harassment and abuse of power is a perceived risk factor for HIV transmission.

3.4.2 Gaps and Challenges in Care, Treatment and Support

3.4.2.1 Enrolment in Care and Treatment

By June 2012, one-third (34%) of PLHIV had not been enrolled for care: only 54% of all children and adults enrolled in care and treatment were ever enrolled on ARVs as of March 2012 and these constituted 41% of the estimated total of PLHIV. Thus, both the overall target of enrolling 90% of PLHIV on ART and 18% of all enrolled PLHIV on ART as children has not been met. There is significantly low (35%) enrolment of males in care and treatment and have shown to report late for treatment (MoHSW, 2011). Nevertheless, the number of people estimated to be infected with HIV has held steady because of ongoing new infections, population growth, and the availability of life-sustaining treatment for those infected. The cumulative number of clients on antiretroviral treatment (ART) as of June 2012 was 626,444, surpassing the "3 by 5" target of 440,000 by 2011.

The country however, has reported the following challenges:

- (i) Existence of a weak referral and networking system; inadequate supervision and support to counsellors; non adherence to national HTC guidelines; as well as existence of poor infrastructure which compromise privacy and confidentiality.
- (ii) Failure to adhere on treatment (on and off) due to various reasons; over advertisement of alternative medicine such as kikombe cha Babu.
- (iii) Lack of mechanism to track the clients who receive treatment at another facility leading into Loss to Follow-up (LTF).
- (iv) Poor integration of HIV care and treatment with other general services TB/RCH/Immunization.
- (v) Lack of collaboration /coordination between facility and community activities and poor linkage of HBC and care and treatment facility.
- (vi) Critical shortage of skilled Health Care Providers and those currently trained for ART care are not evenly distributed.
- (vii) Inadequate infrastructure of the health system in general to cope with increasing number of patients who are on lifelong treatment.
- (viii) Scarcity of resources for ARV and other HIV commodities example-CD4 testing is inadequate, erratic and not accessible to some facilities.

3.4.2.2 HIV and AIDS Trained Human Resources for Health

The system faces daunting challenges with regard to staffing. An estimated 40% of the staff positions in health facilities are unfilled and the burden of HIV and AIDS is stressing the already overburdened system (TACAIDS, 2012).

3.4.2.3 Facilities, Equipment and System Delivery

There are 6,342 registered health facilities in Tanzania of which 1,403 (22%) are providing ART services. Equipment, planning and distribution of services and a tracking mechanism of clients on treatment also leaves critical gaps. Resources to support Home Based Care are low and community mobilization remains inadequate. Majority of care giving is undertaken by women and girls and interventions that promote and support equal sharing of responsibilities between men and women in families and communities remain limited. There is no up-to-date record of the number of service providers trained per category, appropriately deployed or exiting ART care and treatment.

3.4.2.4 HIV/TB Collaboration

In HIV and TB collaboration, currently services are not sufficiently linked with the efficiency of the surveillance system especially the comprehensiveness of the database on co-infected patients is weak due lack of TB/HIV health education in all sectors, together with existing buildings being not in compliance with TB infection control. Challenges include:

- (i) Increase case finding and diagnosis of TB in people living with HIV
- (ii) Slow initiation of Isoniazid Preventative Therapy among PLHIV
- (iii) Poor implementation of TB Infection Control measures in health facilities and inadequate integration on TB and HIV treatment.

3.4.3 Gaps and Challenges in Social and Economic Impact Mitigation

3.4.3.1 PLHIV/OVC and their Households

Poverty and lack of well-developed national and community supporting systems have impeded PLHIV and OVC access to quality care and support services. Studies indicate that community based care programs increase access to important interventions for people living with HIV and those affected by HIV and AIDS. Community programs support mobilization on harmful behavioural awareness creation, provision of community and home-based care services, facilitate linkage and referral to health facilities for facility-based services. However, community programs are not well recognized, supported and funded despite the fact that they play critical catalytic role in ensuring healthy living of the people affected and living with HIV and AIDS. In HIV and AIDS programming, the community interventions support delivery of care and support services and promote retention in HIV care. Furthermore, some community-based models serve to bridge the gap of distance and service provision between health facilities and households as they provide some clinical care services in the community, such as mobile care services, ARV refills, OI distribution and other services.

Additional gaps in addressing the PLHIV were reported in the NMSF II Evaluation Report (2012) as:

- (i) Limited universal access to adequate and quality care and treatment services for PLHIV, Reproductive Health, TB/HIV, Sexually Transmitted Infections (STI) and Opportunistic Infections (OI).

- (ii) Mapping and setting priorities to address the needs of affected families and PWHIV and monitoring the changes in the priorities and capacities of care giving families and adjusting programmes accordingly.

Gaps in services for orphans and other most vulnerable children are:

- (i) Capacity building of CSOs and community structures to facilitate the work of caregivers of different ages and gender groups.
- (ii) Inadequate allocation of resources and poor coordination of activities undertaken by different stakeholders at regional and district levels.
- (iii) Lack of coordination among stakeholders with common interest of working with elderly living with HIV or those taking care of relatives living with HIV.
- (iv) Low rate of reporting through TOMSHA to 60%
- (v) Inadequate reproductive Health, TB/HIV, Sexually Transmitted Infections (STI) and Opportunistic Infections (OI) treatment services.

Gaps related to involvement of PLHIV and their networks include:

- (i) Inadequate involvement of PLHIV in joint planning, reporting and monitoring forum at district level,
- (ii) Inadequate Joint efforts and collaboration between District clusters and PLHIV Networks inadequate collaboration between networks of PLHIV.
- (iii) Inadequate capacity of network members to manage and implement interventions.

As indicated in the NMSF II Evaluation Report (2012), 28% of identified MVCs did not receive core services including health care, psychosocial support, food and nutrition, and education support. Nearly one-third of the councils have not undertaken MVC identification processes. The magnitude of need and level of support even in districts that have undertaken the identification of MVC is yet to be verified calling for the mapping of MVC, service providers and regularly updated database and the strengthening of the follow-up system. Other gaps include:

- (i) Inadequate capacity of Village MVC and CMA and Committees to handle MVCs interventions and allocation of resources leading to low coverage of services provided.
- (ii) Inadequate coordination of activities undertaken by different stakeholders at regional and district levels. Include disabled and elderly in relation to HIV services.

3.4.3.2 Informal Sector HIV Response

The informal sector is a key contributor to the national economy; however, its contribution to the HIV national response is not well coordinated and documented. Policy makers and advocates will have to make evidence-informed decisions to mainstream HIV and AIDS in their social and economic services. The informal sector has untapped potential for financing its own response.

3.4.4 Gaps and Challenges in Monitoring, Evaluation and Research

The National HIV and AIDS Evaluation and Research Agenda (NHAREA) has been completed and already disseminated at the national level. In addition, the NHAREA was developed at the time when the new national priorities for the elimination of HIV were not yet adopted. With the development of NMSF III, there is need to review the Research Agenda to address the new priorities, gaps and challenges taking into consideration existing national capacities and challenges for responding to the epidemic.

Gaps in M&E and Research can be grouped into the following categories:

- (i) Human Resources, including technically qualified M&E, in data collection, processing and utilization. At regional level, where personnel responsible for M&E functions have been appointed, there are often no specific M&E units.
- (ii) Advocacy for HIV Strategy does not sufficiently reflect M&E issues. There is a lack of a multi-sectoral operational plan development and implementation.
- (iii) M&E Standards, harmonization and coordination among Tanzania multiple partners and reporting requirements.
- (iv) Insufficient research for addressing qualitative and quantitative aspects of the determinants of the epidemic.

3.4.5 Financing of the National Response

Successful implementation of the national response depends a lot on the availability of adequate financial resources. The organization of funding the national response is the responsibility of the government of Tanzania. The government recognizes the importance of fulfilling global and regional commitments to HIV and AIDS financing and in this regard will continue to increase the level of funding, establish an HIV and AIDS Trust Fund and develop mechanisms to coordinate contributions from the private sector, CSOs informal sector and development partners.

The NMSF II (2008 -2012) was costed in order to provide indication of financial resources required for the HIV and AIDS response in the country. The costed Strategy estimated total requirements of Tshs. 1 trillion shillings per year for Tanzania response. HIV and AIDS services especially treatment, prevention, enabling environment and impact mitigation are still in high need of resources. Treatment programme has only achieved about 60% of the requirements, WHO treatment guidelines by the country has revised its care and treatment guidelines to reflect the recommendations of WHO and has agreed to go for option B+ eliminate mother to child transmission (eMTCT). These two changes will demand more funds and approximately 118 billion Tshs. for five years. There is a need to scale up PMTCT which is still below the targets.

3.4.5.1 The Government of Tanzania

The Government of Tanzania's contribution to HIV and AIDS has been more than 20 million USD per year from the central government, including Ministries, Departments and Agencies (MDAs) contribution budgeted under respective Medium-Term Expenditure Frameworks (MTEFs). It is estimated that every MDA uses up to 5% of the allocated budget for HIV and AIDS activities. Most of the activities carried out are related to workplace programs. However Tanzania needs to make a transition from the conventional workplace programs to designing multi-sectoral responses to the epidemic e.g. the agricultural sector planning for and implementing programs that will ascertain food security for PLWHA.

Local Government Authorities play important role in response to HIV by providing its collected 5% of public revenue (from various fees, charges, levies and taxes set locally. Examples of the taxes are property taxes, charcoal and wood fees, forest products fees, livestock auction fee, produce cess, service levy, land rent and others) 20% is to be spent on HIV and AIDS. In the financial year 2012/13 expenditure of this collected public revenue has increased to 25%. More advocacy is required to raise the amount of LGA own sources allocated to HIV and AIDS response.

Total of 21 billion Tanzania shillings (US\$ 13 million) is budgeted and spent on HIV and AIDS at the LGAs level every year. There are total of 17 different sources of funding for HIV and AIDS at the LGAs level – including block grants, multilateral, bilateral, NGOs and own sources.

Own source local revenue accounted for 10% of LGAs resources (prior to rationalization), which has now reduced to about 5%. These are collections by the LGAs from various fees, charges, levies and taxes set locally. Examples of the taxes are property taxes, charcoal and wood fees, forest products fees, livestock auction fee, produce cess, service levy, land rent and others. Experience has shown that these sources have been financing HIV and AIDS up to about 2% of the collected own sources.

3.4.5.2 Development Partners

There has been a declining trend of HIV and AIDS financial resource over the last four years. Changes of financing mechanisms for some of the Development Partners (bilateral and multilateral and the World economic recession affecting most of these countries are some of the reasons contributing to this trend. Tanzania has been fortunate to attract donors and their contribution is almost 71% of the HIV and AIDS resources to our national response.

3.4.5.3 Global Fund

Tanzania is the beneficiary of the Global Fund and implements various grants under Global Fund. Global Fund Round 4 Rolling Continuation Channel aims to make availability of affordable condoms at the community and private sectors. Global Fund Round 6 focused on HIV/TB co-infection with HIV prevention and treatment components designed to cover 31 districts. The programme ended in 2012 and subsequently TB programme has been supported through a two year transitional funding mechanism. Global Fund Round 8 phase I and II focus on procurement of HIV and AIDS commodities for the period of 2008-2015. Global Fund Round 9 focuses on the Health System

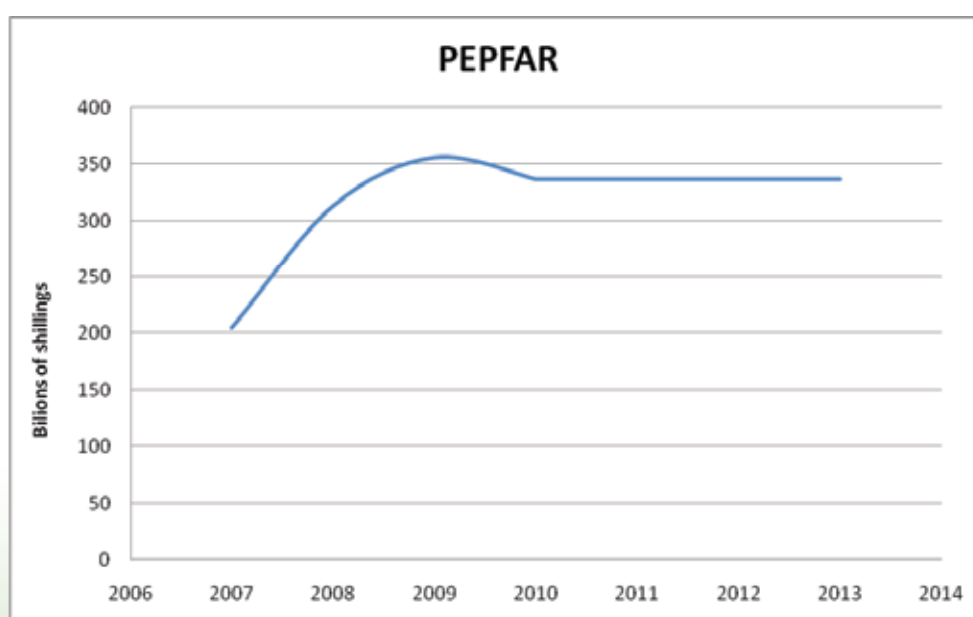
Strengthening (HSS) and the negotiation of phase II is going on with Global Fund. The Global financing mechanism has changed from round based project application to new funding model, which requires countries to apply on yearly basis. The new funding model will rely on countries HIV and AIDS strategic plan requirements as well as counterpart funding.

3.4.5.4 PEPFAR Partnership Framework

President’s Emergency Plan for AIDS Relief (PEPFAR) started being implemented in Tanzania in 2004. The program areas of support include Home-Based Care and Support, Antiretroviral Therapy Program, Voluntary Counselling and Testing, improvement of infrastructure of HIV care and treatment centres, Prevention of Mother to Child Transmission on HIV, prevention of HIV transmission through blood transfusion and contaminated instruments, orphans vulnerable children and community outreach HIV and AIDS prevention programs that promote abstinence and/or being faithful. PEPFAR program contributes about USD 361 million a year, which is about 71% of the total donor support for HIV and AIDS programme in Tanzania. The first phase of the programme covered five years from 2004 to 2008.

PEPFAR partnership framework is in the second phase (2009 to 2013). The programme sets for a paradigm shift from a ‘donor-recipient’ relationship to one partnership embodied by both governments. It outlines (mutual, non-binding) commitments and responsibilities for the USG and GOT. It also sets forth expected progress over time of USG support, GOT investment and policy change. This phase focuses on the sustainability through strengthening local organizations (public and CSO) to lead, manage, and implement various HIV and AIDS programs. One of the focuses includes Global Fund Implementation in the country and close collaboration with Global Fund. PEPFAR new program will be implemented for another five years (2013-2017).

Figure 7: PEPFAR HIV Funding Trend



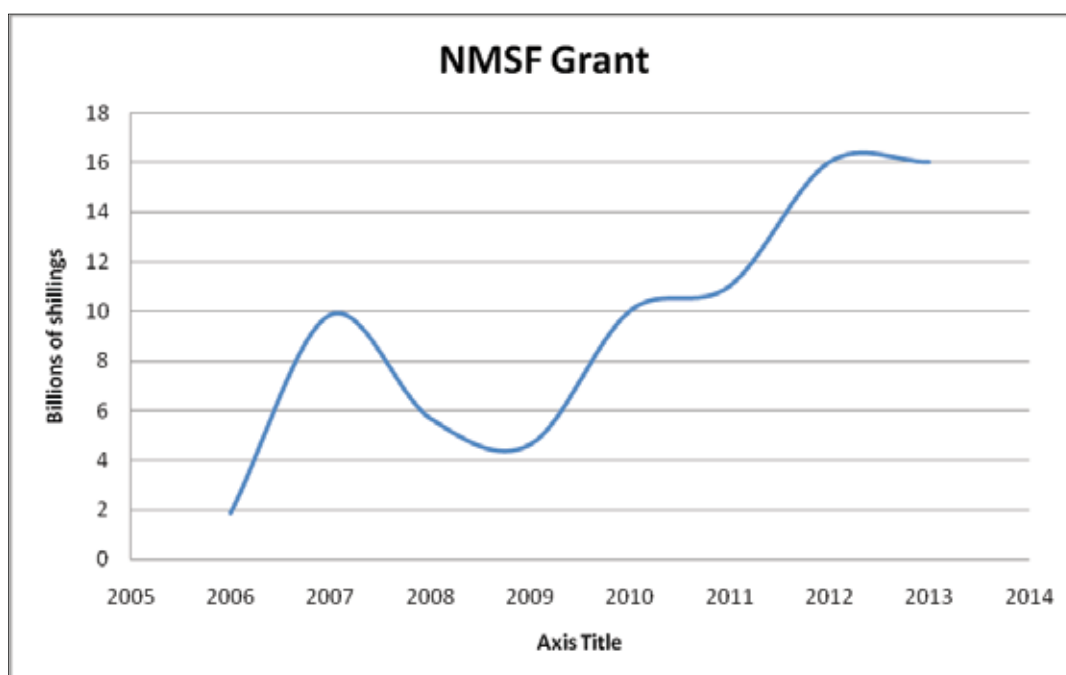
Source: PEPFAR funding report 2006 – 2014.

3.4.5.5 NMSF Grant

NMSF Grant supports implementation of HIV and AIDS interventions at the districts and Local Government Authorities (LGAs) levels up to the wards and village levels. The grant allocates resources to LGAs for implementation and to the Regional Secretariats (RS) for supportive supervision and monitoring and evaluation of the implementation of the NMSF. TACAIDS and Prime Minister’s Office – Regional Administration and Local Government (PMO-RALG) are supported to oversee and coordinate the program. This programme is supported by the Governments of Canada and Denmark.

The funds are shared among districts according to a mutually agreed and transparent allocation formula in which; population accounts for 70%, number of residents who are below national poverty line 10%, district medical vehicle route 10% and HIV prevalence of the region 10%. Support of NMSF Grant is of increasing trend as indicated in figure 8. Disbursements to Local Government Authorities have been 100% of the planned activities in the last two years.

Figure 8: Trend in NMSF Grant Funding



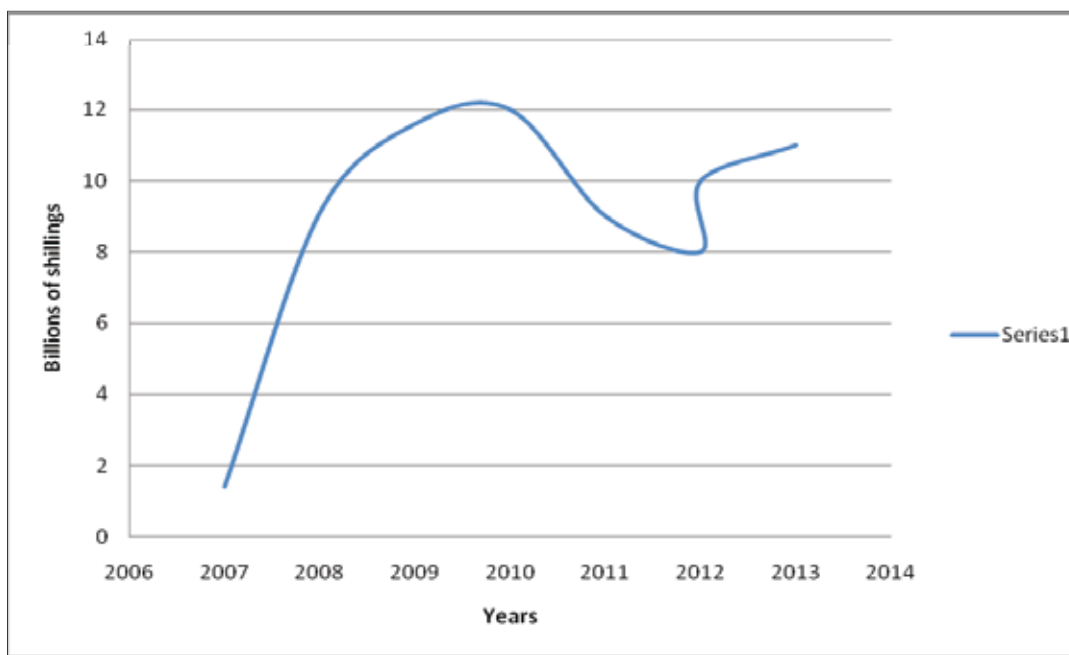
Source: TACAIDS financial reports (2006 – 2013)

3.4.5.6 United Nations Development Assistance Plan (UNDAP)

HIV and AIDS activities have been mainstreamed into the sectoral activities implemented in the government ministries through UN Agencies focussing on strengthening the country systems, policies and processes. This enables the country to build national capacity to deliver basic services while increasing coverage and quality. The UN programme is financed through UN agencies’ own resources and additional funding provided by donors. Some of UN agencies implementing this programme are UNDP, UNAIDS, UNFPA, UNICEF, WHO, WFP, ILO, UNESC, UNODC and UNIFEM. The mentioned above UN agencies are dealing with education, labour and employment, gender,

children, development, agriculture, food security and health. The UN agencies use their mandates to bring in changes into the Tanzania national response to HIV and AIDS. Implementation of this program is being overseen by the National Steering Committee.

Figure 9: UNDAF HIV and AIDS Financial Trend



Source: TACAIDS reports (2009 -2013)

3.4.5.7 The Private Sector

Tanzania estimates to have about 400 formal companies. The private sector and CSOs play an important role in the HIV and AIDS response in the country contributing about 2% of the funding used for the HIV national response per year (PER 2012). The services supported include HIV prevention, care and support, impact mitigation and advocacy.

Private companies fund their HIV and AIDS workplace programs largely from own sources, while services provided by Civil Society Organizations CSOs are funded by various sources which include Rapid Funding Envelope (RFE), Foundation for Civil Society, the Global Fund through Africa Medical Research Foundation (AMREF), President’s Emergency Plan for AIDS Relief (PEPFAR), Christian Social Services Commission (CSSC) and other direct donor assistance.

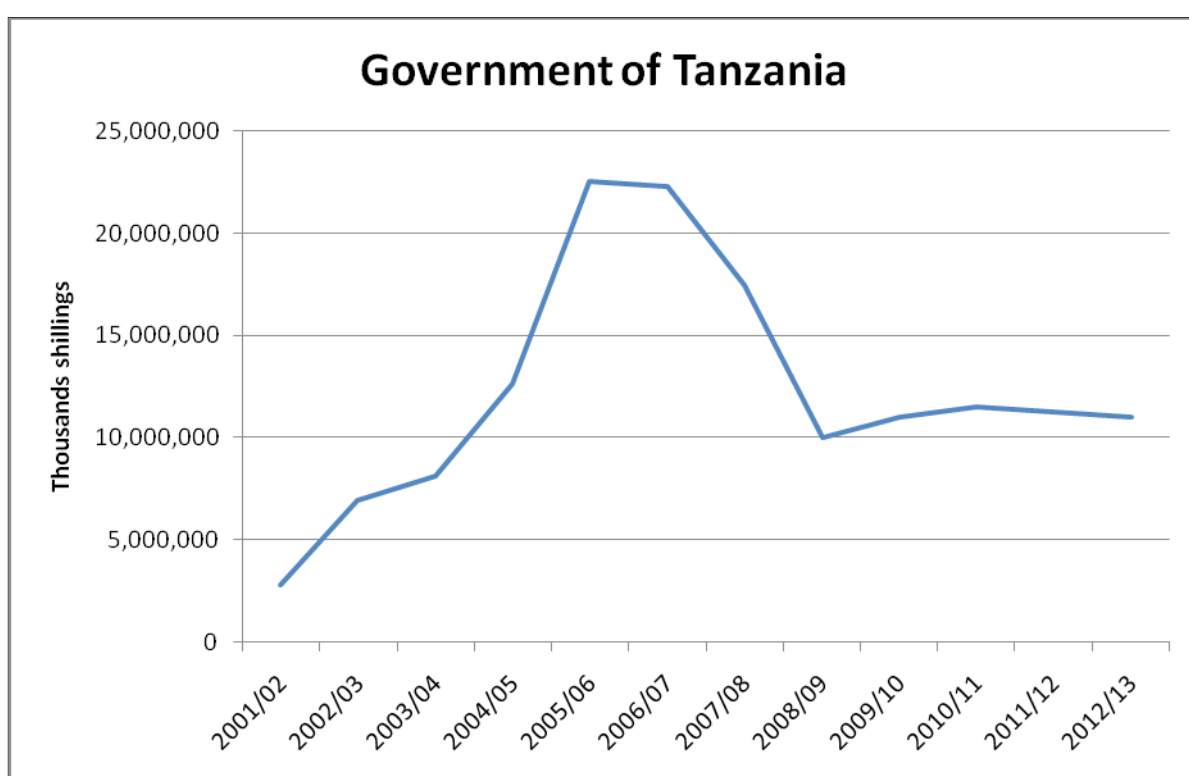
Establishment of AIDSTrust Fund for Tanzania will facilitate a mechanism and an enabling environment for the private sector to contribute more to the HIV national response. The Public Expenditure Review (2012) indicated that 15% of the companies are willing to support and contribute to AIDS Trust Fund. More advocacy for private sector response to HIV and AIDS is required and the country should ensure private sector HIV and AIDS interventions are coordinated and in synchrony with the NMSF III. Greater emphasis must also be placed on their Corporate Social Responsibility (CSR) in line with the priorities of the nation.

3.4.6 Gap in Resource Mobilization, Allocation and Accountability

Government's contribution to the HIV and AIDS response declined by 22% from 14 Billion (Year 2008/9) to 11 Billion (2011/12). Government contribution to the national response accounts for 10%. However, the government contributions do not include structures, human resources and their remunerations.

The total requirement for NMSF II (2008 -2012) was TShs 1 trillion per year; however, only 50% was available.

Figure 10: Government of Tanzania HIV and AIDS Financing Trend



Source: Ministry of Finance reports (2001 – 2013)

The recent study on the private sector financing HIV and AIDS in Tanzania observed that private sector finances HIV and AIDS by 2%. National Health Insurance Fund finances HIV and AIDS treatment by 1%. This is mainly for public servants and their supported families who access the health services.

The accountability of audit tracking of expenditures has shown weaknesses in the lower level HIV and AIDS accountability structures such as absence of system of oversight mechanisms for their performance, non-equitable allocation geographically and non-alignment of resource allocation with priorities, especially in the prevention area which was given only an average of 23%. The 2011/12 Controller and Auditor General's Report and an independent study of 10 councils, noted the need for improving governance for HIV and AIDS funding in LGAs.

3.4.7 Gaps and challenges in the Enabling Environment

The HIV and AIDS response has for the last three decades undergone changes in focus. From HIV and AIDS as a strictly health issue, to addressing AIDS as a multi-sectoral challenge that calls for all actors to respond. With the developments and scaling up of interventions in prevention, care and treatment, there is now a global and national call for the elimination of new infections, end of AIDS related deaths and end of stigma and discrimination. The new priorities demand structural changes, transformative conceptualization, and strengthening of sector strategy planning, namely:

- Governance, oversight and coordination of the national response to HIV and AIDS require strong government, civil society, and PLHIV engagement.
- NMSF structures have been established for state and non-state actors at all levels. However, their performance has been low due to the following gaps: Lack of understanding of roles of different actors at sub-national levels; inadequate planning capacity within sub-national structures; lack of coordination of sectoral AIDS structures; and inadequate capacity of secretariat and leadership of structures.

CHAPTER FOUR

4 Strategic Results Framework

The commitment to eliminating HIV in Tanzania requires a strategic process guided by NMSF III through 2018. This chapter describes the process through which the long term impacts of Zero New HIV Infections, Zero AIDS-Related Deaths, and Zero Stigma and Discrimination will be tracked and achieved. Quantitatively tracking these desired impacts remains a challenge; however, targeted outcomes of the strategic areas of investment will inform overall progress. Effective implementation of the five strategic areas of primary investments, six supportive areas of secondary investments, and five cross-cutting programmatic principles will therefore be monitored and evaluated with specific, measureable, achievable, realistic and time-bound (SMART) indicators and targets. Under NMSF III the following overarching impact-level results will be achieved by 2017/18 namely;

1. The incidence of HIV in the general population is halved by 2018.
2. A significant reduction in AIDS-related deaths among people living with HIV and AIDS.
3. Reduced stigma and discrimination among PLHIV.

Table: Indicators for measuring impact of the NMSF III with respective baselines and targets

Impact	Indicator	Baseline	Target 2017/18
1	HIV incidence rate in the general population	0.32% (2012)	0.16%
2	% of PLHIV on ART are alive after 12 months	74 (2011)	80%
3	% of people expressing or accepting attitudes towards people living with HIV and AIDS	31.9% (2012)	40%

To achieve the above results the following outcomes are expected:

- Proportion of eligible PLHIV on care and treatment increased and sustained.
- Increased access and quality of HIV Testing and Counselling.
- Elimination of Mother to Child Transmission.
- Increased male and female condom use by men and women during risky sex
- Elimination of blood borne transmission of HIV.
- Reduced risky behaviour of sexual intercourse among the general, infected, most-at-risk and vulnerable populations.
- Increased prevalence of Voluntary Medical Male Circumcision (VMMC).
- Increased access and quality of treatment of (STIs).
- Community Based Care and Support Interventions response to HIV within their local context.
- HIV mainstreamed in sector-specific policies and strategies.
- Reduction of all HIV and AIDS related stigma and discrimination.

The NMSF III will achieve these outcomes through the following strategic investment areas:-

4.1 STRATEGIC AREAS OF PRIMARY INVESTMENT

1. Comprehensive Antiretroviral Therapy (ART) service delivery is the single most important investment in the NMSF III. Scaling up and sustaining access to and retention in treatment, care and support interventions, along with investments in infrastructure, procurement and supply chain management, require exceptional programme management to ensure the continuous availability of ART for all HIV-positive Tanzanians.
2. HIV Counselling and Testing with effective linkages to facility- and community-based services that respects human rights, informed consent, focuses on high disease burden areas, as well as mobile, hard-to-reach, and key populations (including discordant couples, sex workers, men who have sex with men, women who have anal sex, people who inject drugs, and others at highest risk).
3. Elimination of Mother to Child Transmission includes the adoption and implementation of PMTCT option B+ throughout the country, providing testing and counselling to all prospective mothers and placing all HIV positive mothers on life saving ART.
4. Comprehensive Sexuality, Gender, and Health Education and Services includes all necessary investments in curricula and training for the provision of facility and community based interventions that deliver a comprehensive package of education and services relating to sexuality, gender, and health for the HIV national response.
5. Condom Provision and Programming employs targeted and innovative strategies to increase the availability and access to male and female condoms and water-based lubricants, through both the private and public sectors.

4.2 SUPPORTING AREAS OF SECONDARY INVESTMENT

1. Voluntary Medical Male Circumcision (VMMC) is being expanded into geographic areas with low circumcision rates.
2. Provision of Safe Blood requires the quality assurance and effective screening of voluntary non-remunerated blood donors for 100% of the country's blood needs.
3. Treatment of Sexually Transmitted Infections (STIs) is being improved through the integration of STI services with other health services, with special attention given to stigma-free services for key populations.
4. Targeted Behaviour Change Communication (BCC) across the strategic programmes is designed to increase the demand for services, enhance knowledge, and lead to positive changes in risky behaviours at personal, community and national levels.

5. Community Based Care and Support Interventions are designed to improve referrals and linkages to services (such as health, social welfare, and economic support) as well as address the stigmatization of PLHIV and key populations in communities. These interventions will both reduce the numbers of lost-to-follow-up (LTFU) clients and improve the overall social environment for PLHIV.
6. Mainstreaming of HIV and AIDS interventions in the routine activities of all sectors will ensure that demand is created for HIV and AIDS services, the public is informed about the realities of the disease and its effective treatment, and that stigma and discrimination against PLHIV and key populations are addressed across all segments of society. This includes workplace interventions in both the public and private sectors.

4.3 CROSS-CUTTING PROGRAMMATIC PRINCIPLES

1. **Integration** ensures that segregation of duties and duplication of efforts will be avoided whenever possible. Integration of ART, PMTCT, and RCH clinics is one example. Consolidation of trainings, supervision budgets, and human resources are other examples.
2. **Demand Creation** means that all programme components must be complemented by civil society efforts, the public, private, and informal sectors, to create demand for high quality services within the targeted communities.
3. **Human Rights** as a principle means that laws, policies, and education programmes will always safeguard the rights to health services, informed consent, and protection under the law, particularly for PLHIV and key populations.
4. **Gender** as a principle means that all programme activities need to address the disparities that result from gender discrimination and gender-based violence.
5. **Programme Strengthening** builds the service platforms in the country by which HIV prevention, care, treatment, and multi-sectoral support services are performed.

4.4 RESULTS TOWARDS THREE ZEROS

4.4.1 Towards Zero New HIV Infections

Testing for recent seroconversions in nationally and regionally representative samples using recommended and approved tests will provide the highest level of assurance that the numbers of new infection are, in fact, steadily decreasing. While promoting this quality of data collection for the future, the NMSF III shall use modelling from prevalence data to set incidence targets for the time being. In setting both incidence and antiretroviral treatment targets, the NMSF III specifies that the ratio of new infections to persons newly initiated on Antiretroviral Therapy (ART) should not exceed 1.0. This ratio should remain below 1.0 throughout the implementation period of the NMSF III, as a result of the aggressive ART targets, through both the existing and planned modifications of treatment guidelines, including implementation of PMTCT Option B+. Outcome

indicators from each of the eleven (11) strategic investment areas will track progress towards this long-term impact. The impact result will be an HIV incidence rate (either directly measured or modelled) of less than 0.16% by 2017 (from a baseline of 0.32% in 2012).

4.4.2 Towards Zero AIDS-Related Deaths

Ongoing scale-up of ART will definitively save lives, reducing AIDS-related deaths. Clinical assessments of all deaths with comprehensive HIV co-morbidity records and any other approved approaches would be necessary to validate the evidence of elimination of AIDS-related deaths in Tanzania. While promoting improvements in vital registration and verbal autopsies of community and facility deaths as soon as possible in order to establish a baseline, the NMSF III employs both the HIV patient monitoring system (CTC database) and prevalence surveys (THMIS) for setting outcome targets related to provision of effective care and treatment with antiretroviral therapy. Outcome indicators relating to the performance of three areas of primary investment (Comprehensive Services, HTC, and ART) will track progress in identifying PLHIV, serving them in their communities, and ensuring their access to life saving treatment. The impact result will be significant reductions in AIDS related deaths by 2017.

4.4.3 Towards Zero Stigma and Discrimination

Robust and nationally representative participation from all segments of PLHIV, including underserved and key populations, is essential to verifying that no one living with HIV is subjected to stigma and discrimination. While promoting and coordinating the expansion and effectiveness of related stakeholder organizations, the NMSF III uses nationally and regionally representative surveys (THMIS) to set targets for proxy indicators. Outcome indicators from all strategic areas inform the social and epidemiological context in which stigma and discrimination occur; while the primary investment areas of comprehensive sexuality, gender, and health education and services, and the supporting investment area of behaviour change communication are targeting Zero Stigma and Discrimination. The impact result will be reduced stigma and discrimination among PLHIV (including KP).

4.5 RESULTS FRAMEWORK AND PRIORITY STRATEGIES BY INVESTMENT AREA

4.5.1 Antiretroviral Therapy (ART)

Category	Result	Data Source/s
General Population	1. By 2017, 95% of ART eligible adults (15+) and 80% of ART eligible children (<15) receiving ART 2. HIV incidence is no more than 0.16% by 2017	CTC Database Spectrum
Pregnant Women	3. 100% of all estimated HIV-infected pregnant women receiving ART by 2018	THMIS Census Projections HMIS CTC Data base
TB co-infected	4. 100% of estimated HIV-positive incident TB cases receive treatment for both TB and HIV by 2017	CTC Database HMIS WHO TB Statistics

Strategies;

- (i) Promote an effective continuum of diagnosis and linkage and retention in care and treatment in the context of ARVs, ART should be integrated into HIV testing, PMTCT, care, treatment, and prevention activities, as it is relevant and consistent with the new WHO framework for The Use of Antiretroviral Drugs for Treating and Preventing HIV Infection.
- (ii) Improve the supply chain management through facility management capacity building and improvement of the supply delivery system. This should include monitoring of facilities for threatened stock outs of ARVs and lab testing materials, including test kits and properly functioning CD4 machines and reagents.
- (iii) Strengthen the M&E system to identify and trace lost patients.
- (iv) Strengthen the client counselling and referral systems at all levels.
- (v) Improving active follow up of HIV exposed children through Early Infant Diagnosis (EID) and early treatment of HIV positive children.
- (vi) Increase the availability and distribution of drugs to communities.
- (vii) Increase the availability and coverage of ART at health facility level.
- (viii) Promotion of the current national policy for all HIV patients with CD4 \leq 350 to be placed on ART and preparation for the new guidelines for initiation with CD4 \leq 500.
- (ix) Strengthen ARV pharmaco-vigilance monitoring and prevention of the emergence of HIV drug resistance in individuals enrolled on antiretroviral therapy.

- (x) Promotion of ART regimen simplification, using fixed dose combinations whenever possible.
- (xi) Establish and enforce a national quality standard.
- (xii) Preparation for adoption of Point of Care (POC) viral load testing for disease monitoring and.
- (xiii) Promote the involvement of the community health workers (CHW) to improve retention, follow-up and adherence of ART patients.

4.5.2 HIV Testing and Counselling

Category	Result	Data Source/s
General Adult Population (15-49)	1. By 2018, at least 38.7% of women (15-49) and 33.8% of men (15-49) report having been tested for HIV and received their result within the last 12 months (increase from 2012 rates of 30.5% for women and 26.7% for men)	THMIS
Pregnant Women	2. 80% of all women attending at least one ANC visit are tested for HIV and receive their result (55% TDHS 2010)	TDHS
Service Provision	3. 5,469,026 tested annually by 2018	Programme M&E

Strategies;

In order to promote an effective continuum of diagnosis and linkage and retention in care and treatment in the context of ARVs, the following strategies should be applied:

- (i) Ensure high quality, routine, internal, quality assurance and external proficiency testing for all lab- and non-lab-based HIV rapid testing personnel.
- (ii) Promote couple HIV Counselling and Testing, through integrating RCH clinics and CTCs.
- (iii) Strengthen linkages, referral systems and networks for those who test HIV positive to access other services, especially treatment, which will also contribute to prevention of HIV transmission.
- (iv) Expand HTC services to couples, adolescents, and youth with a focus on high prevalence regions.
- (v) Train, support, and monitor school-based HIV and AIDS peer counsellors.
- (vi) Support to scale up innovative approaches for mobile HTC.
- (vii) Include HIV testing and counselling training in pre-service curricula for all cadres.
- (viii) Identify, train, support and monitor community and faith leaders as promoters of HIV counselling and testing including couple testing and premarital testing.

- (ix) Promote task shifting in lower level health facilities i.e. use of non-medical workers to facilitate HTC and PLHIV assist with community mobilization.

4.5.3 Elimination of Mother to Child Transmission (emtct)

Category	Result	Data Source/s
Pregnant Women	1. By 2018, 100% of all HIV positive, pregnant women receive ARVs to prevent transmission (up from 77% in 2012).	Cross reference ART indicator for pregnant women above
Infants and Children	1. Percentage of infants born to HIV -positive women receiving a virological test for HIV within 2 months of birth. 2. 90% of all HIV exposed children are tested for HIV by the age of two months (4-8 weeks old) and receive their results within 4 weeks, by 2017.	CTC Database (HEI card) HMIS THMIS

Strategies:

- (i) Provision of ARV combination therapy to all HIV positive pregnant women under the guidelines of PMTCT Option B+. Integration and coordination of key activities for putting patients on HIV care, including coordination and communication of CTC/PMTCT sites with testing and counselling providers and community health care workers.
- (ii) Develop institutional capacity, systems and human resource capacity in comprehensive eMTCT and paediatric HIV care and Treatment.
- (iii) Strengthen systems for Monitoring and evaluation of eMTCT and paediatric HIV care and treatment services at all levels.
- (iv) Strengthen health logistics to include comprehensive management of PMTCT commodities.
- (v) Adoption of Task Sharing policy to allow nurses to initiate and dispense standard Option B+ lifelong ART to all pregnant women.
- (vi) Strengthen follow up of HIV infants by linking HBC to health facilities.

4.5.4 Comprehensive Sexuality, Gender, and Health Education and Service

Category	Result	Data Source/s
CSE (Comprehensive Sexuality Education)	1. Percentage of schools that provided life skills-based HIV and sexuality education within the previous academic year.	EMIS, BEST
PLHIV	1. 80% of adults, youth and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy by 2018. 2. 80% of estimated PLHIV enrolled in care and treatment by 2018 (36% in 2012). 3. By 2018, at least 80 % of PLHIV on ART are alive after 12 months (74% for 2011 cohort).	THMIS CTC Database
Care and Treatment Clinics (CTC)	1. All health centres provide CTC services by 2018. 2. At least 30% of dispensaries provide CTC services by 2018. 3. At least 20% of private health facilities provide CTC services by 2018.	HRHIS HMIS
Gender Based Violence (GBV)	1. Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months reduced to 20% by 2018 (from 40.7% in 2007/08).	TDHS
Key Populations	1. Key populations (sex workers, MSM, PWIDs) identified and reached for prevention education, HTC, and ART services.	Programme M&E

Strategies;

- (i) Strengthen the capacity of communities, NGOs, CBOS, private and informal sectors and CSOs involved in prevention of HIV transmission, and to actively advocate for enforcement of laws (especially the Law of the Child Act and its Child Prevention Regulations), to help protect girls and key populations .
- (ii) Empower and build capacity of political organizations and networks of PLHIV, religious and faith leaders to promote mutual fidelity and address harmful cultural practices.
- (iii) Deliver quality comprehensive sexuality and life skills education at primary, secondary and tertiary levels through core curriculum and provide effective programs to reach out of school youth.

- (iv) Scale up quality adolescent reproductive health services in line with national standards for adolescent friendly reproductive health services.
- (v) Strengthen community based services for HBC, GBV, and OVC
- (vi) Support the roll out of the National Costed Plan of Action for Most Vulnerable Children (NCPA 2013-2017).
- (vii) Strengthen the government lead coordinated response to MVC support across all ministries and sectors to reduce fragmented and duplicative programming.
- (viii) Support the National Social Welfare Workforce Strengthening Strategy to ensure access to quality social services. Ensure that the special needs of children of different age groups, elderly and disabled citizens are considered in the provision of services.
- (ix) Strengthen the capacity of households and communities to protect, care and support OVC and PLHIV.
- (x) Strengthen the coordination and leadership, policy and service delivery environment for the OVC and PLHIV.
- (xi) Strengthen linkages and referral between the community based and facility services along the continuum of care.
- (xii) Ensure national institutionalization and harmonization of the community health care cadre roles and responsibilities.
- (xiii) Roll out Positive Health Dignity and Prevention (PHDP) package of services in the community and facility level.
- (xiv) Strengthen linkages with MCGDC VAC prevention and response plan and other sectoral commitments.
- (xv) Ensure that the special needs of elderly and disabled citizens are considered in the provision of services.
- (xvi) Promote and support entrepreneurship education, livelihood, savings and financial literacy, income-generation for support groups, including PLHIV and care-takers).
- (xvii) Strengthen the capacity of political leaders to address and advocate for behavioural factors contributing to intergenerational sex, incest and child abuse.
- (xviii) Assess capacity building needs of for CSOs working with key population.
- (xix) Strengthen capacity building of CSOs working with key population.
- (xx) Strengthen capacity building for infected and affected people with HIV.
- (xxi) Develop of entrepreneurship among people infected and affected by HIV.

- (xxii) Improve food production for PLHA
- (xxiii) Raise awareness of good nutritional practices among PLHIV.
- (xxiv) Review the existing laws to ensure the rights of PLHIV and
- (xxv) Advocate for adoption and enforcement of laws to protect the rights of PLHIV

4.5.5 Condom Provision and Programming

Category	Result	Data Source/s
General Adult Population (15-49)	1. By 2018, 55% of both men and women, rural and urban, who are engaged in multiple sexual partnerships, report condom use at last sexual intercourse (increase from 2012 rates of 34% for women and 40.4% for men).	THMIS
Youth (15-24)	2. By 2018, 70% of young men and women (15-24) report condom use at last sexual intercourse (increase from 2012 rates of 57.9% for women and 59% for men).	THMIS
Key Populations	3. By 2018, 80% of high risk groups (SW, MSM, PWID) report condom use at last sexual intercourse. 4. By 2018, reported access to water-based lubricant among MSM and SW. 5. PWID, MSM and SW tracked with unique identifiers for services in 7 regions.	THMIS Programme M&E

Strategies:

- (i) Develop a costed, comprehensive, integrated national male and female condom strategy which includes guidelines for condom distribution, management, monitoring and reporting. Using strategic information to determine the best mix of public sector and private sector interventions to ensure maximum availability, use, and value for money. This will include expanded access to public sector condoms outside health facilities without undercutting the private sector.
- (ii) Promote the role of the youth clients in distributing condoms in their groups and communities for themselves and.
- (iii) Promote and provide condoms to key populations engaging in higher risk sexual practices utilizing their social networks.

4.5.6 Voluntary Medical Male Circumcision (VMMC)

Category	Result	Data Source/s
Adult Men (15-49)	1. 80% of men (15-49) in 12 prioritized regions with high HIV prevalence and low VMMC rates have access to VMMC services.	THMIS

Strategies;

- (i) Expand VMMC for HIV prevention using existing facilities and outreach services.
- (ii) Conduct operational research to strengthen the effectiveness of voluntary medical male circumcision services.
- (iii) Develop demand creation strategies to increase the number of older men accessing VMMC services.

4.5.7 Provision of Safe Blood

Category	Result	Data Source/s
TNBTS and its national blood supply networks	<ol style="list-style-type: none"> 1. 100% of all donated blood is effectively screened for HIV, hepatitis B, hepatitis C, and syphilis as per WHO quality assurance procedures. 2. At least 80% of national blood is received from voluntary, non-remunerated blood donors. The total requirements for Mainland Tanzania are estimated at 436,253 units of blood in 2012, or 1% of the total population, as per WHO recommendations. A more precise needs assessment for national blood requirements is under way. 	TNBTS

Strategies:

- (i) Ensure all blood collected and distributed by TNBTS and its network is effectively screened for HIV and other transfusion-transmissible infections, i.e., hepatitis B and C viruses, and syphilis as per WHO guidelines, including for regional referral hospitals.
- (ii) Expand the existing blood transfusion services at district and regional levels to have adequate storage and distribution.
- (iii) Mobilize communities to support the NBTS in the recruitment and retention of HIV negative voluntary blood donors.
- (iv) Promote the linkages between blood donation services to HTC services, by referring the HIV negative individuals as potential volunteers including linking collection of blood to national campaigns for Counselling and Testing in schools and VMMC.

- (v) Mobilize private sector to support donor recruitment by sponsoring non-remunerated blood donation.

4.5.8 Sexually Transmitted Infections (STIs)

Category	Result	Data Source/s
General Adult Population (15-49)	<ol style="list-style-type: none"> 1. STI infection rate reduced by 50% (from 7% to 3.5% of men and women) by 2018. 2. At least 75% of men and women (15-49) are accessing STI services. 	NACP STI Surveillance Report Service Provision Assessment Survey
Women (15-49)	<ol style="list-style-type: none"> 3. Syphilis prevalence reduced from 4.3% (2012) to 1.2% among women attending Antenatal Care clinics in 2018. 	ANC Surveillance
Health Facilities	<ol style="list-style-type: none"> 4. All Regional Referral Hospitals and 10% of District Hospitals providing HPV screening services by 2018. 	HMIS

Strategies;

- (i) Expand coverage and quality of STI services in public and private facilities to cover all health facilities including dispensaries.
- (ii) Promote facility based STI and targeted outreach services that are user friendly for youth and key population groups.
- (iii) Empower community, civil, religious and cultural leaders to undertake STI/HIV education and counselling, and education programmes that address risky behaviours and practices in their communities.
- (iv) Coordinate with other health programmes such as MNCH services, RCH for the national strategy on cervical cancer prevention and treatment, Life Skills Education (LSE) and nutrition to ensure effective dissemination of STI information. Risks of co-infection with HIV, prevention of STI infection and necessity of early proper diagnosis and treatment are also significant.
- (v) Promote use of vaginal and oral interventions (microbicide) to control the epidemic, STIs and undesired pregnancies and
- (vi) Train health care workers and equip them to be able to diagnose and provide appropriate treatment for anal STDs.

4.5.9 Behaviour Change Communication (BCC)

Category	Result	Data Source/s
General Adult Population (15-49)	<ol style="list-style-type: none"> 1. Percentage of adults (15-49) with comprehensive HIV knowledge increased to 64% for women and 72% for men by 2018 (2012 rates were 42.2% for women and 50.3% for men). 2. Percentage of adults (15-49) who report non-stigmatizing responses increased from 24.7% (2012) of women to 50% (2018) and from 39.9% of men (2012) to 65% (2018). 	THMIS
Youth (15-24)	<ol style="list-style-type: none"> 1. Youth comprehensive knowledge about aids and source of condoms at 60% for women and 67% for men by 2018 (up from women 40.3%, men 47.3% 2012). 	THMIS TDHS
Gender Based Violence (GBV)	<ol style="list-style-type: none"> 1. Decrease in percentage of men and women (aged 15-49) who agree that a husband is justified hitting or beating his wife for specific reasons, from 38% and 54% respectively (TDHS 2010) to 30% and 46% respectively. by 2018 	TDHS
Demand Creation	<ol style="list-style-type: none"> 1. Service targets for HTC and ART met by 2017 	Cross reference HTC and ART indicators
Key Populations	<ol style="list-style-type: none"> 1. Stigma against key populations reduced. 	PLHIV Stigma Index

Strategies;

- (i) Focus all communication efforts on creating demand for HIV services and education.
- (ii) Scale up evidence-informed interventions targeting younger adolescents, with a focus on younger girls to mitigate their risks against contracting HIV, unintended pregnancies, and falling victim to sexual violence.
- (iii) Promote violence prevention and safer sexual behaviours to decrease HIV transmission with a focus on reducing unprotected multiple, concurrent partnerships, transactional unprotected sex, and unprotected cross-generational sex.
- (iv) Increase comprehensive knowledge on HIV through personal/couples communication and other different channels, e.g., influential people, work place programs (including the informal sector) and religious leaders.
- (v) Increase access to targeted messages by using local media outlets (radio/TV) in the reduction of risky behaviours and access to effective HIV services.

- (vi) Coordinate behaviour change communication through popular media community mobilization and outreach, including entertainment approaches.
- (vii) Empower and engage the communities, parents and guardians to actively advocate for and undertake measures that address sexual exploitation of children and youths, and intergenerational sex. Support community members' role to identify and help youths who are at risk of engaging in risky sexual behaviour.
- (viii) Support youth-friendly communication programs which include the parents and guardians and other adults.
- (ix) Support BCC interventions that address the gender roles, norms and inequalities that increase women's vulnerability to HIV and compromise men's and women's health.
- (x) Address the position of women in society, particularly their economic standing.
- (xi) Develop BCC strategy with targeted information, education and communication for PWID, MSM, sex workers and their clients.

4.5.10 Community Based Care and Support Interventions

Category	Result	Data Source/s
ART	1. 80% of adults, youth and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy by 2017.	Cross reference ART indicator for PLHIV above
Home Based Care	2. The ART client loss to follow-up rate is less than 10% by 2018 (26% for 2011 cohort). 3. At least 80% of councils budget their own funds to cover 30% of the budget requirements for HBC services.	CTC Database NACP Appointment Tracking System CCHP Annual Report

Strategies;

- (i) Empower community based organizations to link with health facilities for patient follow-up.
- (ii) Empower government and civil society organizations to advocate for increased resources for HBC at the council level.
- (iii) Promoting mapping of community service providers by programme and locality, identify and pre-qualify service providers by priority area, grant management and service demand creation.
- (iv) Increase and sustain community outreach programmes targeting MARPs and vulnerable groups.
- (v) Increase the CSOs supported to deliver HIV services at community level responsive to local context™.
- (vi) Strengthen linkages between community owned and managed structures and health system.

4.5.11 Mainstreaming Of HIV and AIDS Interventions

The NSGRP/MKUKUTA II calls on a variety of sectors to address issues of HIV and AIDS, including all Ministries, Agencies and Departments such as agriculture, tourism, mining, education, transport, infrastructure, employment/job creation, social sectors private and informal economy. The NMSF III further calls on these sectors to develop and promote research that forges concrete linkages with the five areas of primary investment and supporting areas of secondary investment. Under mainstreaming the following outcome indicator will track the performance.

Category	Result	Data Source/s
MDAs and LGAs and Private Sector	Percentage of public and private enterprise with work place policies and programmes 80% public and 60% private.	Work place survey

Strategies;

- (i) Implement and increase coverage of workplace interventions to cover informal economy and private business sector.
 - (ii) Develop policy guideline for workplace intervention by various sector based on their environment.
 - (iii) Develop strategies targeting interventions for workplace.
-
- (i) Enhance institutional capacity, systems and human resource capacity in coordinating private and public HIV and health national response at workplaces.
 - (i) Develop and implement national strategy for promoting HIV interventions at workplaces in cooperation with tripartite plus forum on HIV and AIDS at workplace.
 - (i) Develop minimum standards of practice for comprehensive HIV&AIDS workplace programmes for both public and private, including informal sectors.
 - (i) Foster integration of workplace HIV programmes into occupational, health and safety systems where possible within workplace setting for sustainability.
 - (i) Strengthen a pool of workplace trainers/focal points/coordinators to support public and private entities in implementing HIV workplace programmes.
 - (i) Expand HIV and AIDS workplace programme to more comprehensive health workplace programme in key sectors like agriculture, mining, transport, construction and fisheries.
 - (i) Improve monitoring, documentation and reporting on existing and new workplace programmes in public and private sector including informal work setting.

4.6 PROGRAMME ENABLERS

Eliminating HIV in Tanzania is a developmental imperative enshrined in the strategic objective of the LTPP (2011/2012-26/26). During the implementation of the NMSF III the following programme enablers will be deepened and /or strengthened in order to ensure the intended results are attained. The results will contribute to the strategic objectives of the LTPP (2011/2012-26/26).

Table: Results Framework for Programmatic Critical Enablers

Table 4:4 Results Framework for Programmatic Critical Enablers

Priority Area/ Group	Impact results
1. Response Coordination, Governance and Management	
Coordination structures and implementation arrangements	<ul style="list-style-type: none"> Functional coordinating structures that are aligned to National Vision 2025, Sector Governance Structures, Sector and NMSF III in place by 2018
Gender and human rights	<ul style="list-style-type: none"> Increased equity and access to services and the reduction in gender inequalities.
Individual and community centered HIV response.	<ul style="list-style-type: none"> Increased personal and community accountability towards HIV and AIDS risk perception by 2018
Regional and global coordination	<ul style="list-style-type: none"> National response is harmonized with regional and global protocols by 2018.
Donor and Government funding and spending is aligned to meet the demand	<ul style="list-style-type: none"> Geographical resource mapping is done and in place by 2015.
2. Resource Mobilization and tracking	
Increase domestic funding for HIV and AIDS national response.	<ul style="list-style-type: none"> AIDS Trust Fund operating by July 2015 Domestic resource mapping and mobilization plan for the national response in place by November 2014 At least 50% of LGA allocating funds for HIV and AIDS response from own source by November 2015 National Health Accounts and National AIDS Spending Assessment institutionalized.

Strengthen good governance and accountability.	<ul style="list-style-type: none"> • HIV mainstreamed in the sector core business strategies. • Management and Coordination Strategy Developed, Costed and aligned to NMSF III by December 2013 • Sectors and key partners are accountable on the biannual plans developed. • National and decentralized committees discuss HIV and AIDS resources. • At least 30% of LGAs conduct value for money audits.
Sufficient non-financial resources for the national response is available by 2017	<ul style="list-style-type: none"> • Each LGA have developed a resource centre for HIV and AIDS. • Each region produces culturally-relevant HIV and AIDS materials.
3. A functional and effective HIV M&E system that guide the planning coordination and implementation of the HIV response.	
Strengthening the capacity of institutions to carry out monitoring evaluation and research.	<ul style="list-style-type: none"> • An efficient HIV M&E system that guarantees continuous information/data generation, sharing, use and learning.
Harmonizing and linking the monitoring and evaluation systems.	<ul style="list-style-type: none"> • A functional and effective national multi-sectoral HIV and AIDS M&E system in place by 2017.
Generating accurate and relevant data and ensuring timely dissemination.	<ul style="list-style-type: none"> • Accurate, quality assured, and independently verified HIV data generated and disseminated by 2017.
Strengthening the capacity of stakeholders to use HIV M&E data for planning, decision making and programming.	<ul style="list-style-type: none"> • Increased access and utilization of HIV and AIDS data/information by policy makers and programme planners at all levels by 2017.
Supporting HIV research and evaluation priorities and use research findings for HIV programming and decision making.	<ul style="list-style-type: none"> • The national HIV and AIDS researches and evaluations provide indicator values of the NMSF III result framework by 2017.

4.7 IMPLEMENTATION ARRANGEMENTS

The governance, leadership and management of the HIV response lies with the Government of Tanzania as outlined in the HIV and AIDS Policy (2013). This framework highlights the necessary organizational arrangements, management structures and institutional coordination arrangements to ensure attainment of the key priorities outlined in Chapters 4. Priority areas for Governance Management and Coordination will entail: (1) Coordination structures and implementation arrangements (2) Gender and human rights (3) Individual centred HIV response (4) Stigma, denial, discrimination and regional and global coordination and mobilization of resources both financial and physical. Strategies for each priority area is as detailed below:

4.7.1 Priority Area 1: Align functional coordinating structures to NMSF III

Priority strategies:

- (i) Develop TACAIDS institutional milestones for multi-sectoral HIV and AIDS coordination;
- (ii) Review and strengthen coordination and reporting mechanisms at national, regional and LGA levels.
- (iii) Build infrastructural and technical capacity of secretariats of non-state actors to best coordinate (plan, mobilize, monitor implementation and reporting) their constituencies;
- (iv) Develop financing mechanisms to ensure non-state coordinating entities are functional;
- (v) Support self-coordinating entities to develop consolidated work plans that address NMSF III results;
- (vi) Hold annual reviews of work plans and report to TACAIDS on the progress towards set goals of non-state organizations;
- (vii) Support ministries, departments, and agencies (MDAs) in costing their NMSF III aligned work plans; and
- (viii) Build capacity of LGAs and community HIV and AIDS response.

4.7.2 Priority Area 2: Reduction of Gender Inequalities and Gender Based Violence

The priority strategy is to ensure that all sectors implement the Gender Operational Plan for HIV (GOPH) Response in Tanzania Mainland (GOP, 2010).

Strategies;

- (i) Manage strategic information flow to determine the connection between the GBV and HIV and AIDS in Tanzania.
- (ii) Promote public participation in the ownership of the results of the three (3) zeros
- (iii) Build leadership capacity among women, men, PLHIV and other key populations to engage in national HIV and AIDS response towards attaining national priorities

- (iv) Ensure active participation of women and men at all levels of the implementation of the NMSF III. Support roll out and implementation of the Multisectoral Plan of Action to Prevent and Respond to Violence against Children (VAC Plan of Action 2013-2016)

Strengthen government-led and community-driven responses which will facilitate OVC accessing adequate care, support and protection services through increasingly integrated and sustainable approaches.

4.7.3 Priority Area 3: Individual and House Hold Centred HIV and AIDS Response

To better prevent new HIV infections, ensure more uptake of enrolment and adherence to treatment and effectively addresses stigmatizing attitudes. The framework emphasizes individual perception of risk to infection, understanding of the danger of failure to attain optimum care and sustenance of treatment, and the cost of stigma and discrimination towards the overall results of the response. NMSF III emphasizes on the following strategies:

Strategies:

- (i) To work with political and civil leadership to explain individual HIV risk perception, responsibility towards prevention of new HIV infections; promoting access of the population to care and treatment; and mitigation of the impact of the epidemic on PLHIV and their households.
- (ii) Develop consolidated sectoral plans for promotion of personal HIV risk perception and personal protection.
- (iii) Enforce developed policies and by-laws to protect the rights of PLHIV.
- (iv) Promote media (local and national) in promoting personal risk and responsibility to HIV prevention.
- (v) Ensure rights and responsibilities of people living with HIV and/or those affected by HIV.
- (vi) Develop programs that support enhancing self-esteem of PLHIV such as task sharing at CTC, PMTCT, home based care, VCT etc.
- (vii) Develop and utilize communication and motivation tools for PLHIV to know their rights and responsibilities.

4.7.4 Priority Area 4: National Response is harmonized with Regional and Global Protocols

Strategies;

- (i) Advocate for the use of the NMSF III in negotiating future regional and global protocols.
- (ii) Advocate for the implementation of cross-border initiatives especially those related to prevention, care and treatment.
- (iii) Ensure timely collection, processing and reporting on all major indicators in line with national commitments in the regional and global agenda.

- (iv) Enhance cross learning between other areas of health, development and HIV programming, and development of AIDS programmes based on country context and priorities.

4.7.5 Priority Area 5: Resources Mobilization, Disbursement and Management

The government's contribution to the HIV and AIDS response declined by 50% from 22 Billion (Year 2006/7) to 11 Billion (2010/11) or 33% of the actual value of 2006 if inflation is factored in. Around 95 % of all HIV funds come from international donors, whereas 5.0 % came from government. The government's contribution does not factor in in-kind or indirect costs such as infrastructure, human resources, transport and health system at large. This caused the calls for government to undertake the study to determine government contribution. The heavy reliance on external sources presents challenges in terms of sustainability. At the same time, stability in the level of external funding is a compromise to ensure the medium term continuity of service provision.

4.7.5.1 Government Contribution

Although government expenditure in the national response has been extremely low ie 5% of the total budget, government commitment was noted in creating a strategic objective on HIV and AIDS within the Medium Term Expenditure Framework (MTEF). Continued resource mobilization from both internal and external sources and its sustainability, especially for the prevention and treatment and care of PLHIV, is crucial and will continue to be an important element of the National Response. TACAIDS during the life of NMSF III will enhance efforts towards securing increased funding from the government, in addition to tapping existing devolved funds operating at the District /council levels, among others in an effort to mitigate this risk.

4.7.5.2 Key Partners/Funders

Currently, Development Partners provide the bulk of the funding for HIV interventions in Tanzania. According to PER 2012 the main international donors are the U.S., President's Emergency Plan for AIDS Relief PEPFAR (71%) and Global Fund (20%). Other major Development Partners (10%) include DANIDA (Denmark), GIZ (Germany), Canada and UN agencies. The major donors for the NMSF III period are anticipated to be PEPFAR and Global Fund. PEPFAR support has remained steady from approximately US\$350 million annually. As far as Global Fund is concerned, on-going projects (Round 8) will run until 2015 while Tanzania will be eligible to apply via the new funding model in 2014. In response to the observed HIV financing trend, the Government of Tanzania is increasing the budget allocation for health and HIV and AIDS and by establishing the AIDS Trust Fund (ATF).

4.7.5.3 Funding Priority Strategies

- Advocate for a National Public-Private Partnership for HIV and AIDS Framework.
- Develop and operationalize the national resource mobilization strategy.
- Develop a costed-plan of action for the NMSF III based on funding only appropriately targeted evidence-informed interventions and strategies for attaining national results.

- Scrutinize the use of all donor funds to ensure that they are budgeted in costed work plans at both the partner and donor level.
- Strengthening good governance and accountability of HIV and AIDS resources at all levels.
- Advocate for Health financing strategy.
- Advocate for fast tracking for the implementation of the Tanzania AIDS Trust Fund.
- Institute a regular resource tracking mechanism of HIV and AIDS resources.
- Develop mechanism for Regional Secretariat, LGAs and Community, Private and informal sector to contribute to HIV and AIDS resources.
- Undertake a study to cost GOT non – monetary forms of contributions to HIV and AIDS.
- Advocate for HIV Resource Mobilisation from internal and external funding sources.
- Strengthen financing and disbursement mechanisms including pooling of funds.

4.7.5.4 Resource Allocation

There should be equitable distribution of resources in urban and rural settings depending on the magnitude of the epidemic and the size of the targeted population. The NMSF III advocates for proper allocation of funds to different implementers and community groups. Adequate amount OF funds will be channelled to civil society and private sector organisations that are targeting marginalized groups that are often not reached by regular public services oriented towards the general population. Refinement of THMIS to capture adult and paediatric HIV prevalence data at the district level and improvement in planning and monitoring mechanisms will enable central coordinating bodies to ensure correction of this disproportionate resource allocation.

4.8 FINANCIAL AUDITS

Financial Audits will be performed regularly (on a yearly basis) to verify that spending mechanisms follow national and international regulations. The internal and external audits within MDAs will perform the task to ensure that procurement and tender regulations are strictly followed for all purchases and management of activities according to the yearly work plan and to government's requirements.

To track HIV-related expenditure in a calendar year, the Public Expenditure Review, National AIDS Spending Assessment (NASA), National Health Account and the HIV/AIDS Audit at the level of MDAs, LGAs and any implementers who access funds in audit period financial audits will be performed. This approach aims to inform a multi-sectoral HIV perspective.

4.9 HUMAN RESOURCES AND TECHNICAL NEEDS

Human resources are critical for scaling up and maintaining the National response to HIV. Considerable progress has been made under NMSF II in relation to addressing the problem of human resources related to the provision of prevention, care support, treatment and, to a limited extent, for impact mitigation activities. Despite the increased demand for care and treatment to support PLHIV there was a sharp decline in the numbers of health staff and other workers. Specifically, the health workers have declined by 20% from 67,000 between 1994 and 1995 to 54,245 in 2002, and a further decline of 48,800 is projected by 2015.

The Ministry of Health and Social Welfare introduced emergency plan for recruitment of health workers in order to address the human resources constraints. These problems were also addressed by key partners including the Clinton Foundation, the Benjamin Mkapa HIV and AIDS Fellows Programme. While considerable emphasis is placed on front line workers to deliver services, there is an increased need to deal with the issues of support staff and their activities as well.

CHAPTER FIVE

5 Governance and Institutional Arrangement

The governance, leadership and management of the HIV response lies with the Government of Tanzania as outlined in the HIV and AIDS Policy (2001) currently under review. This Chapter highlights the necessary organizational arrangements, management structures and institutional coordination arrangements that ensure attainment of the results outlined in Chapter 4.

This chapter lists the relevant governance, oversight and coordination structures that are relevant to the NMSF III and the roles and responsibilities of HIV and AIDS stakeholders, both state and non-state. The issue of monitoring and evaluation, which requires synthesis from a number of different systems into a single high-level dashboard, is described in the next chapter.

5.1 Governance, Oversight and Coordination Structures

In the United Republic of Tanzania, governance, oversight, and coordination structures represent central and local government authorities in the performance of executive, legislative and judicial functions. The implementation of the NMSF III will work in line with the hierarchy of responsibilities from national to grass root level. A highlight of responsibilities of different stakeholders is presented below.

5.1.1 Parliament

The Standing Parliamentary Committee responsible for HIV/AIDS and Drug Abuse and other sector-specific committees such as Economic Affairs, Industries, and Trade, Social Services, Community Development, and Agriculture, Livestock and Water will govern and oversee the implementation of strategies that impact on the NMSF III. In addition, the Parliament has three oversight committees which monitor the whole of the public sector: the Public Accounts Committee for the central government, the Local Government Accounts Committee for the LGAs, and the Parastatal Organization Accounts Committee for parastatal public authorities. These committees provide financial accountability for all State and Parastatal institutions that collaborate in the NMSF III.

5.1.2 Cabinet

The Cabinet, which is the highest decision making body in the Executive arm of the government, is chaired by the President and comprised of the government ministers. Supporting the Cabinet, the Inter-Ministerial Technical Committee (IMTC), chaired by the Prime Minister, governs and oversees all ministries, departments, and agencies with respect to their internal and external collaborative efforts. Multi-sectoral coordination for all initiatives therefore falls under the jurisdiction of this Committee, including efforts related to HIV/AIDS.

5.1.3 Prime Minister

The Office is responsible for coordination, oversight and control of the government business. The Prime Minister's Office handles all sectoral collaboration efforts including the national response to HIV and AIDS and chairs the Tanzania Global Fund Coordinating Mechanism (TNCM) which also addresses other multisectoral related diseases.

5.1.4 Tanzania Commission for AIDS (TACAIDS)

TACAIDS derives its governance, oversight, and coordination functions from the Act of Parliament No. 22 of 2001, and is under the jurisdiction of the Prime Minister's Office. The Commission operates under the jurisdiction of the Prime Minister's Office; it directs the national response to HIV and AIDS and oversees the multi-sectoral coordination necessary for integrated action among state and non-state actors. The Commission is also responsible for strategic leadership, coordination in the implementation of the NMSF III, advocating, mobilizing and distribution of funds. Furthermore, the Commission is also responsible for harmonizing information systems to produce high-level dashboard of the NMSF III indicators, and directing technical working groups to ensure communication between stakeholders and accountability for results. The implementation of the NMSF III will follow the Three Ones," namely one Coordinating Body which is TACAIDS, one National Strategy – NMSF and one Monitoring and Evaluation Framework .

5.1.5 Joint Technical Working Group for HIV and AIDS (JTWG)

The Joint Technical Working Group is the legal dialogue structure for the MKUKUTA Cluster II, the platform for HIV and AIDS priority setting, and the reference point for implementation of the NMSF III. The JTWG is chaired by the Prime Minister's Office and oversees the technical working groups described in the NMSF III below.

5.1.6 Tanzania National Coordinating Mechanism (TNCM)

The Tanzania National Coordinating Mechanism, a multi-sectoral body currently chaired by the Prime Minister's Office, was established to govern, oversee, and coordinate resources received from the Global Fund to Fight AIDS, tuberculosis and malaria. .

5.1.7 Technical Working Committees (TWCs)

The NMSF III Technical Working Committees (TWCs) are designed to oversee all investments in the NMSF III Results Framework, receive technical reports from sector-specific TWGs that contribute to the national response to HIV and AIDS, and produce technical reports for use by state and non-state institutions. The six (6) TWCs: - Prevention, Care and treatment and support, Impact mitigation, Enabling Environment, Monitoring and Evaluation and Research, Finance and Audit

These Working Committees will be self-coordinating entities, made up of different constituencies from government, CSOs, and Development Partners. Each group will coordinate the implementation of priority strategies in their result areas. These Working Committees will report to the Joint Thematic Working Group (JTWG) which is designed to oversee all investments in the NMSF III result areas. There will be HIV and AIDS biennial review to track progress in achieving results; this forum will also provide policy guidance to TACAIDS on future directions in the national response. Initiatives to reach the three zeros, reducing HIV incidence, AIDS-related deaths, identifying and combating stigma and discrimination are cross-cutting for all TWCs.

5.1.8 Ministries Departments and Agencies (MDAs)

MDAs have roles and responsibilities related to the national response to HIV and AIDS. These include:-

- (i) Identifying factors relevant to the spread of HIV and AIDS in their sector.
- (ii) Identifying sectoral strengths, weaknesses and comparative advantages in the national response to HIV and AIDS.
- (iii) Developing sector-specific HIV and AIDS plans, strategies and budgets in line with the NMSF III.
- (iv) Mobilizing resources for sector-specific HIV and AIDS intervention and
- (v) Monitoring, Evaluation and research in their sectors.

Despite of the functions and roles of MDAs, the following MDAs have specific roles and responsibilities in the National Response to the HIV epidemic.

5.1.9 Health and Social Welfare Services

Sectors responsible for health and social welfare will contribute to the Health Sector HIV Strategic Plan, which forms a crucial component of the NMSF III and represents the largest monetary investment in the national response to HIV and AIDS. Health facilities, health care workers, and social welfare officers receive technical direction from the ministry responsible for health and social welfare and administrative direction from the Prime Minister's Office – responsible for Regional and Local Government (PMO-RALG) through the management of the Regional and District AIDS Coordinators. Health and social welfare includes HIV and AIDS care, treatment and prevention, as well as support for orphans and vulnerable children (OVC), including children with disabilities.

5.1.10 Education and Community Development

The MDAs responsible for education contribute to the national response to HIV/AIDS through the provision of basic education, life skills and specialized technical training. Comprehensive sexuality, gender, and health education at primary, secondary, and tertiary levels, as well as outside of school settings, is the primary investment for empowering people living with HIV (PLHIV) to live without fear of stigma and discrimination. The MDAs responsible for community development also contribute to this investment area, focusing on the existing social and cultural contexts in Tanzanian society that make people vulnerable to HIV infection and PLHIV vulnerable to economic and health deprivations.

5.1.11 Labour and Employment

The MDAs responsible for labour and employment are responsible for ensuring that work places have supportive policies for PLHIV that are effectively implemented. These include collaborative efforts with public and private employers as well as institutions safeguarding social security and disability coverage for PLHIV.

5.1.12 Finance

The MDAs responsible for managing the financing of the national response to HIV and AIDS liaise with both foreign and domestic funding sources and are charged with raising the allocations and disbursements of HIV/AIDS funds to the responsible institutions implementing the NMSF III.

5.1.13 President's Office Planning Commission

The Commission is responsible for Strategic Thinking of the National Economy, providing advice to the government on medium and long-term strategies for socio-economic development focusing on the big picture. The Commission mainly focuses on strategic policy analysis on issues and problems of great public importance such as HIV and AIDS with a view to proposing appropriate solution.

5.1.14 Local Government Authorities (LGAs)

Consistent with the government policy on decentralization by devolution, the NMSF III places increased responsibilities and expectations for the strengthening of the national response to HIV and AIDS through better planning, implementation, monitoring and evaluation at the LGA level. These LGA's structures include; Village Multi-sectoral AIDS Committees (VMACs), Ward Multi-sectoral AIDS Committees (WMACs), Council Multi-sectoral AIDS Committees (CMACs), Council HIV and AIDS Coordinators (CHACs), District AIDS Coordinators (DACs); council and district commissioners and district consultative committees are also important mechanisms for planning and implementing HIV programmes. Implementation of the NMSF III requires active communication and involvement at each of these levels to ensure that results have been achieved and documented. The regional secretariat has the responsibility of providing policy guidance, technical assistance, monitoring and evaluation of Local Government Authority HIV and AIDS interventions. Regional TACAIDS Coordinators will be responsible for providing coordination role to all multisectoral HIV and AIDS implementers in the region.

5.1.15 Research and Higher Learning Institutions

Research and Higher Learning Institutions play an important role in the national response to HIV and AIDS, through technical guidance, research and training of future professionals. Integrating knowledge about HIV and AIDS, into the wide range of academic programmes should, thus, be encouraged.

5.1.16 Formal Private Sector

The formal private sector in Tanzania is coordinated through the Association of Tanzania Employees (ATE) in collaboration with Tanzania Private sector Foundation (TPSF). Trade Union Congress of Tanzania (TUCTA) together with Ministry of Labour formed an umbrella organization creating a public-private partnership. ATE comprises over 800 companies (small, medium and large enterprises). With its significant workforce, the private sector should develop interventions and

tailor their policies to best care for, and provide prevention services for their staff in relation to HIV and AIDS. In some instances, the nature of an industry increases vulnerabilities to HIV and AIDS either to their staff, neighbouring communities or the general community. It is therefore of paramount importance for the private sector to effectively contribute to coordination of the national response.

5.1.17 The Informal Private Sector

The informal private sector permeates all levels of society and cuts across people from all walks of life. The informal private sector, therefore, can play a valuable role in the national response to HIV and AIDS. The Tanzania Informal Economy Networks on AIDS Initiative (TIENAI) collaborates with the informal private sector in all regions in Tanzania and is tasked with developing a strategic plan in line with the NMSF III.

5.1.18 Non-governmental Organizations (NGOs)

NGOs play multiple roles in the national response to HIV. The roles of these NGOs should include advocacy, complementing the public sector in delivering community-based services, and playing the role of a “watchdog” to ensure social accountability and responsibility. They are coordinated through the National Steering Committee (NSC), with technical assistance in capacity building being provided by TACAIDS. The NSC oversees networks which include NACOPHA, TAF, SHIVYAWATA, NACONGO, TACOSODE, TANGO, FemACT, Policy Forum, Youth Coalition and LESEHA.

5.1.19 Faith-Based Organizations (FBOs)

The Faith-Based Organizations (FBOs) in the country are important stakeholders in the national response. FBOs have also been instrumental in providing spiritual and material support to PLHIV and those affected by HIV and AIDS, including orphans and widows. They also support a significant percentage of health care services and contribute extensively to the development of the health sector. FBOs can mobilize resources and conduct community-based care interventions in a cost-effective way. Being rooted in community structures, they are favourably positioned to reach out with the right messages, in line with their moral and ethical commitments; thus, they should engage significantly with the national response to HIV and AIDS. The coordination of these FBOs is through the Tanzania AIDS Interfaith forum (TAIFO), representing Christian and Muslim constituencies.

5.1.20 National Council of People Living with HIV and AIDS (NACOPHA)

PLHIV are the key actors of the national response. They are expected to organize themselves in associations that can help in the fight against HIV in Tanzania. The NMSF III advocates that PLHIV groups focus on:

- (i) Protecting the rights of their members.
- (ii) Educating the public at large through sharing their life experiences.
- (iii) Promoting and participating in the provision of compassionate care to PLHIV.
- (iv) Fighting stigma and discrimination at all levels.
- (v) Advocating for responsible behaviour among their members.
- (vi) Advocating for access to ART.
- (vii) Promoting policies and legislation in the interests of their constituencies, particularly their most vulnerable, least represented members
- (viii) Promoting positive prevention.

5.1.21 Development Partners

Development Partners and UN agencies are instrumental players in the national response to HIV and AIDS through providing the necessary financial resources, technical expertise and material supplies for addressing the epidemic at all levels. Development partners and UN agencies will work in close collaboration with government. Key roles and responsibilities include:

- Continually forging partnerships to address emerging or unattended priorities.
- Supporting the modalities of the national response that government partners see as core challenges facing insufficient resources.
- Coordinating their assistance through a single Development Partner Group for HIV and AIDS interventions in the country to avoid duplication and ensuring sustainability of services.
- Support the implementation of NMSF III

The roles and responsibilities of each stakeholder will deliberately be aligned and harmonised to national and inter-sectoral planning budgeting systems and programme reporting cycles. TACAIDS will ensure that all stakeholders are coordinated and operate within a nationally owned strategy and aligned results framework, grounded in mutual accountability, gender, equality and human rights. Significant investments will therefore be made to improve the capacity of stakeholders involved, both in terms of systems and infrastructure development as well as in the improvement of skills of their skills.

5.2 Governance and coordination

The implementation arrangement will be guided by this NMSF III with a dichotomy of interventions between medical and non-medical responses. Medical related responses referred to as Health sector responses will be coordinated by the National AIDS Control Program of the Ministry of Health and Social Welfare; while TACAIDS will play two key roles namely (1) Overall coordination of the multi-sectoral response as stipulated in the Tanzania Commission for AIDS Act (2001) and (2) Coordinate non-medical interventions. TACAIDS will ensure that all responses are linked and informed by both the medical and non-medical interventions. All stakeholders are obliged to report to TACAIDS on the agreed reporting requirements (national HIV and AIDS M & E framework). TACAIDS will produce and disseminate annual response reports. Administration, accountability and openness will be guided by standard procedures of good governance.

CHAPTER SIX

6 Monitoring, Evaluation and Research

6.1 Monitoring, Evaluation and Research within the NMSF III

This chapter deals with Monitoring and Evaluation of the implementation of interventions measures the performance of the NMSF based on set indicators. It details systems through which the effectiveness of coordination will be measured, results tracked and how research will be designed to inform the ongoing strategy for achieving the three zeros. SMART indicators and targets must be complemented by complete, timely and verified data. Achieving the necessary quality of monitoring, evaluation and research for producing these data will require improvements, strategic coordination and additions to the existing information systems. Program components in the NMSF III monitoring, evaluation and research should be designed and adapted with the principles of the NMSF III that is integration, demand creation, protection of human rights, gender disparities and system strengthening.

6.1.1 Monitoring and Evaluation for the National Multi-sectoral Response to HIV and AIDS

Monitoring and evaluation of the national multi-sectoral response to HIV and AIDS relies on a variety of systems and data sources routine and periodic, supported and maintained by many stakeholders. During the course of implementing the NMSF III, these M&E systems will require ongoing improvement which will include programme monitoring tools, disease surveillance, household surveys, epidemiological studies and operational research tools. Some M and E systems will need to be developed, some systems will need to be strengthened, and others will need to be maintained and integrated for improved inter-operability and fostering linkages between interventions. All M&E systems will need to produce reliable data that are widely shared among stakeholders and which translate into improved decision-making.

6.1.2 Research to Inform the National Multi-sectoral Response to HIV and AIDS

During the course of implementing the NMSF III, support for research will be prioritized to enhance the primary and secondary areas of investment as elaborated in Chapter 4. All sectors should be challenged to develop, enhance, implement and disseminate research efforts that link to the NMSF III areas of investment in new and innovative ways.

6.1.3 Health Sector Information Systems

A number of health sector information systems have been developed to support the national response to HIV and AIDS and progress towards the three zeros. The list is intended to be necessary but not sufficient, highlighting the key systems already in place.

6.1.4 Health Management Information System (HMIS)

The Health Management Information System (HMIS) has been in use in Tanzania since 1993 and is designed to cover all health programmes at all health facilities (government, private, NGO, and parastatal). During the course of NMSF III implementation, strengthening of the HMIS will focus on revisions of new registers, training of users and reporting compliance. Strengthening the linkages between HIV services and other health facility services will rely on the quality and effectiveness of the HMIS.

6.1.5 Care and Treatment Centre (CTC) Databases

The Care and Treatment Centre (CTC) databases are part of the HIV Patient Monitoring System used by Ministry of Health and Social Welfare to track longitudinal patient data and aggregate information for the national programme. Paper-based patient records are stored at all CTC facilities. Electronic database records, known as the CTC 2 database, summarize these paper tools, operate in approximately 40% of all CTCs, and capture around 80% of enrolled patients. There is also a CTC 3 macro database used by the sector to produce national level reports. The NMSF III promotes expansion of care and treatment data base system to capture more enrolled patients, as well as greater linkages between these databases DHIS and other sector systems.

6.1.6 Pharmacy Module

The Pharmacy Module is a computer based access database for ARV and Opportunistic Infection (OI) drug inventory recording, reconciliation between inventories and dispensing and ledger records. Furthermore, it reminds about unreconciled inventories and batches approaching expiry. It also calculates and prints the Integrated Logistics System's Report and Request form, individual patient records and analysis of dispensing records, matches requests with deliveries, reports drug trends over time. It runs as a stand-alone system or can be linked with the CTC 2 database. The NMSF III promotes rollout of this module to improve facilities ability to reduce ARV and OI drugs stock-outs and expiry for multi-sector approaches.

6.1.7 Integrated Logistics System (ILS)

The Integrated Logistics System (ILS) is used for reporting use of drugs and related medical supplies, as well as for requesting, re-supply and replacing the vertical supply systems that previously existed. In order for the NMSF III to fulfil its strategy of reducing stock-outs and expiry and ensuring patient access to HIV medicines and commodities, health facilities will be encouraged to adopt and use the ILS.

6.1.8 Electronic Logistics Management Information Software (eLMIS)

The Electronic Logistics Management Information Software is an integrated data warehouse with a data entry module for all R&R forms, routine logistics data, as well as an analytical and customary reporting tool to monitor the flow of products from the Medical Stores Department (MSD) central warehouse, through the zonal warehouses and ultimately to the health service delivery points. It is designed to help programme managers determine which facilities are under-stocked or over-stocked, review trends in consumption on a product-by-product basis, estimate procurement requirements for all products, identify facilities with potential inventory management problems and plan deliveries to facilities. The NMSF III supports the rollout of the eLMIS to improve MSD's ability to reduce the stock-out and expiry of HIV medicines and commodities.

6.1.9 Multi-sectoral Information Systems

Multi-sectoral information systems that support the national response to HIV and AIDS include programmatic and financial management tools, demographic surveys, population surveys, operational research tools and output data collection systems. These multi-sectoral information systems will also be used to track the indicators and targets in the NMSF III results framework and verify overall progress towards the three zeros. The list of available systems is intended to be necessary but not sufficient as additional systems may be developed to target existing information gaps.

6.1.10 Tanzania Output Monitoring System for HIV and AIDS (TOMSHA)

Tanzania Output Monitoring System for HIV and AIDS (TOMSHA) was launched in 2004. The system is designed to capture information on all non-medical HIV and AIDS services that have been provided by CSOs, MDAs, LGAs and private sectors. The information is reported on quarterly basis by HIV and AIDS implementers. Financial resources spent on HIV and AIDS interventions by non medical HIV and AIDS implementers are reported through TOMSHA on annual basis. HIV and AIDS Prevention Services (e.g., condoms, life skills), HIV Impact Mitigation Services (e.g., nutrition, school fees, and health commodities), HIV and AIDS training, and HIV and AIDS programme management are included in the quarterly reports. TOMSHA is one of the routine data sources that feed into the National Multisectoral M&E System for HIV and AIDS. Strengthening of TOMSHA during the implementation of NMSF III will focus on increased training of users, supportive supervision, data quality improvement and reporting compliance among all state and non-state actors. District cluster survey will be advocated for throughout NMSF III.

6.1.11 Nationally and Regionally Representative Surveys

Periodic, nationally and regionally representative surveys, such as the Tanzania HIV and AIDS and Malaria Indicator Survey and the Tanzania Demographic Health Survey, condom availability survey, HIV Public Expenditure Review will continue to be used by the NMSF III to track multi-

sectoral indicators related to the national response to HIV and AIDS. The NMSF III directs other sectors, such as agriculture, tourism, mining, transport infrastructure, employment/job creation, and education to evaluate their HIV and AIDS interventions according to objectives outlined in the nationally and regionally representative surveys.

6.1.12 Spectrum

Spectrum is a statistical modelling software application developed by UNAIDS to support decision-making for multi-sectoral programming and policy. The software includes a number of program area and health system modules. Spectrum estimates in the NMSF III employed the Demographic, AIDS, and TB/HIV modules. Data sources that fed the Spectrum estimates include the NACP programme data on ART and PMTCT, TB programme data, THMIS prevalence data and 2002 Census Population data. The NMSF III will use Spectrum to determine and set incidence targets.

6.1.13 EPICOR

EPICOR is the accountancy software used in Tanzania's Integrated Financial Management System (IFMS) and the Enterprise Resource Planning (ERP) software used by MSD. The NMSF III supports the rollout of EPICOR to all councils to strengthen the ability of the councils to budget and effect funds to support the national response to HIV and AIDS.

6.1.14 PlanRep 3

PlanRep 3 is a computer based Access database used by LGAs. It is used to incorporate the Strategic Plan Medium-Term Expenditure Framework (MTEF), revenue projections, funds received and to track expenditures and implementation. This system imports to and exports from the EPICOR accounting software and is designed for district aggregations at the regional and national level for use by PMO-RALG and the Ministry of Finance. The NMSFIII supports the use of Plan Rep3 to track the planning, expenditure and implementation of multi-sectoral HIV interventions at the national and LGA levels.

6.1.15 Local Government Monitoring Database (LGMD)

The LGMD collects information on social services delivered by the Local Government Authorities. It is currently being upgraded to cope with technological advancements. LGMD offers a platform for integration of HIV and AIDS systems such as TOMSHA. The NMSF III encourages integration with other M&E systems for improved sustainability and ownership of the information systems at local government level.

6.1.16 Education Management Information System (EMIS)

EMIS is a system that collects and manages information on the education sector activities. The system also captures information on training on HIV and AIDS life skills based education. Life skills education is provided in primary, secondary schools and teachers training colleges. It also provides information on school attendance among orphans and non orphans.

6.2 Information system gaps

In order to fully track progress towards the three zeros, as enumerated in the indicators in Chapter 4, some current gaps in the available information systems will need to be bridged. In particular, there are deficits of information in three major areas: numbers of AIDS-related deaths, numbers of new HIV infections in adults and in children, and monitoring systems of uniquely identified Key Populations. Data that is available is not powered to represent geographical areas smaller than regions, such as districts or wards. This seriously limits efforts to target resources appropriately. In the dissemination of information, there is still a weakness in the systematic dissemination of M&E information at all levels, including facilities, programs, districts, regions and national bodies. Routine, systematic and meaningful data use for decision making must be strengthened.

6.2.1 Numbers of New HIV Infections

Tanzania Mainland has been experiencing a generalized mature epidemic for the past three decades. However, evidence point towards the existence of concentrated sub epidemics within some Key Populations. In the light of the scale up of coverage for ART among general and key populations, monitoring of effectiveness of the HIV and AIDS programs using prevalence measurements is less valuable than using incidence. The NMSF III will promote the adoption of incidence based measurement towards assessment of incidence beyond the commonly used modelling approaches.

6.2.2 Numbers of AIDS-Related Deaths

Clinical assessments of all deaths with comprehensive HIV co-morbidity records are necessary to validate the total numbers of AIDS-related deaths in Tanzania. Given the current resource limitations, practical methods for comprehensive community and facility-based death estimations are required. The NMSF III encourages research and support in this area of research so as to track the success of interventions, to measure and reduce the numbers of AIDS-related deaths.

6.2.3 Key Populations

There have been some scattered studies of Key Populations that provide information of the magnitude of infection among the key population groups; however, these studies were done on irregular intervals and at small scale. A Respondent Driven Sampling (RDS) method was the commonly employed approach in performing Integrated Biomedical Behavioural Surveillance (IBBS). Planned, comprehensive and representative approaches to identify the magnitude and track trends of HIV infection among all key population groups in all relevant areas are needed.

6.3 MID AND END TERM REVIEW

Using the NMSF III indicators, both mid- and end-term reviews will be conducted to assess progress and make course corrections for the future. Low performing/low impact strategic interventions will be revised; high performing/high impact strategies will be strengthened and expanded. A full and independent end term evaluation will be undertaken to ascertain the achievements of set objectives and the targets. The results will form the basis for the formulation of the fourth generation NMSF.

Definitive progress made towards achieving zero new infections, zero AIDS related deaths, and zero stigma and discrimination will itself promote the economic and social development that will invigorate the national response to HIV and AIDS and result in an AIDS free generation in Tanzania.

6.4 Strengthening the M&E System And Research

The key role of the M&E system is to track performance of NMSF III, in order for NMSF III to fulfil its functions, system strengthening measures are necessary. Priority strategies for strengthening M&E systems include:

- (i) Strengthening the capacity of institutions to carry out monitoring, evaluation, and research including generation and timely dissemination of accurate data and information for planning, decision making and programming for the HIV and AIDS priority response at all levels.
- (ii) Harmonization and linkage of the monitoring and evaluation systems and creating mechanism for enforcement of reporting compliance by all implementers of HIV and AIDS interventions at all levels.
- (iii) Strengthening capacity for planned and systematic data collection, analysis and reporting for Key Populations and vulnerable groups.
- (iv) Strengthen consistent data quality assurance through internal and external validation of results through periodic data auditing.
- (v) Plan for incidence studies to complement the current HIV prevalence surveys and surveillance.
- (vi) Advocate for sustained adequate budgetary provision and timely release of funds for the M&E system.
- (vii) Build and strengthen capacity for and promote sustainable use of ICT.
- (viii) Undertake HIV and AIDS gender auditing of key policies and programmes.
- (ix) Ensure databases used for the national HIV and AIDS response are updated and maintained.
- (x) Facilitate operationalization of the national HIV and AIDS research agenda
- (xi) Adopt new innovations on Research and Monitoring for evidence-informed planning and decision making to include innovation for treatment and prevention.i

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