

UNITED REPUBLIC OF TANZANIA



MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Health Sector HIV and AIDS Strategic Plan 2017–2022 (HSHSP IV)

NATIONAL AIDS CONTROL PROGRAMME



July 2017

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Abbreviations

AA	Acetic Acid
AfSBT	African Society for Blood Transfusion
AGYM	Adolescent Girls and Young Women
ANC	Antenatal care
ART	Antiretroviral treatment
ASR	Age-standardized incidence rate
ATF	AIDS Trust Fund
BMF	Benjamin William Mkapa Foundation
BMGF	Bill and Melinda Gates Foundation
BRN	Big Results Now
BTS	Blood Transfusion Safety
CBD	Community-based Distribution
CBHP	Community Based Health Program
CBHS	Community Based HIV and AIDS services
CBO	Community Based Organization
CCP	Comprehensive Condom Programming
CHAI	Clinton Health Access Initiative
CHF	Community Health Fund
CHMT	Council Health Management Team
CITC	Client Initiated HIV Testing and Counselling
COPE	Client Oriented Provider Efficient
CP	Combination Prevention
CSO	Civil Society Organisation
DFF	Direct Facility Financing
DHIS	District Health Information System
DPG-AIDS	Development Partners Group for AIDS
DPG-Health	Development Partners Group for Health
DPs	Development Partners
DQA	Data Quality Assessment
DSDM	Differentiated Services Delivery Model
EID	Early infant diagnosis
EIMC	Early Infant Male Circumcision
eLMIS	Electronic Logistics Management System

eMTCT	Elimination of mother-to-child HIV transmission
EQA	External Quality Assurance
ETR	End-of-Term Review
FANC	Focused Antenatal Care
FBO	Faith Based Organization
FPs	Focal Persons
FSW	Female sex workers
GBV	Gender Based Violence
GDP	Gross Domestic Product
GoT	Government of Tanzania
HBF	Health Basket Fund
HCT	HIV Counselling and Testing
HCW	Health care worker
HFS	Health Financing Strategy
HLIs	Higher Learning Institutions
HMIS	Health Management Information System
HPV	Human Papilloma virus
HRH	Human Resources for Health
HRHSP	Human Resources for Health Strategic Plan
HSHP IV	Fourth Health Sector HIV/AIDS Strategic Plan
HSIQAS	Health Services Inspectorate and Quality Assurance section
HTS	HIV testing services
HVL	HIV Viral Load
IBBS	Integrated Biological and Behavioral Surveillance
ICT	Information Communication Technologies
IP	Infection Prevention
IPT	Isoniazid preventive therapy
JAHSR	Joint Annual Health Sector Review
JTWG	Joint Thematic Working Group
LARS	LLAPLa Assessment and Response System
LEA	Legal Environment Assessment
LEEP	Loop Electro-surgical Excision Procedure
LIS	Laboratory Information System
LMU	Logistic management Unit
LTFU	Lost to follow up

M&E	Monitoring and Evaluation
MAT	Medication Assisted Therapy
MDG	Millennium Development Goal
MERT	Monitoring, Evaluation and Research
MOF	Ministry of Finance
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MoHSW	Ministry of Health and Social Welfare
MOT	Modes of HIV Transmission
MSD	Medical Supplies Department
MSM	Men who have sex with men
MTCT	Mother-to-child transmission
MTEF	Medium Term Expenditure Frameworks
MTR	Mid-term Review
NACCT	National Advisory Committee for Care and Treatment
NACP	National AIDS Control Programme
NACS	Nutrition Assessment Counseling and Support
NBTS	National Blood Transfusion Services
NCTP	National Care and Treatment Plan
NEHSHIP	National Essential Health Sector HIV and AIDS Intervention Package
NGOs	Non-governmental organisations
NHACC	National HIV/AIDS Coordination Committee
NHIF	National Health Insurance Fund
NHP	National Health Policy
NMSF	National Multisectoral Framework
NPAP	National Pharmaceutical Action Plan
NTA	National Technical Award
NTA	National Technical Award
NTD	Neglected Tropical Disease
OI	Opportunistic Infection
OJT	On-Job-Training
ORCI	Ocean Road Cancer Institute
OVC	Orphans Vulnerable Children
PCR	Polymerase Chain Reaction
PEPFAR	The United States President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated Testing and Counselling

PLHIV	People living with HIV
PLSU	Pharmaceutical and Laboratory Services Unit
PMTCT	Prevention of mother-to-child HIV transmission
POC	Point of Care
PPM	Planned Preventive Maintenance
PPP	Public Private Partnership
PrEP	Pre-exposure prophylaxis
PSCM	Procurement and supply chain management
PSS	Pharmaceutical Services Section
PSSN	Productive Social Safety Net
PT	Proficiency Testing
PWID	People who inject drugs
PWUD	People who use drugs
QI	Quality Improvement
RCC	Regional Consultative Committee
RCH	Reproductive and Child Health
RHMT	Regional Health Management Team
RHP	Regional Health Plan
RMNCAH	Reproductive Maternal Neonatal Child and Adolescent Health
RTQII	Rapid Testing Quality Improvement Initiative
RUM	Rational Use of Medicines
RUTF	Ready to Use Therapeutic Food
SAM	Severe and Acute Malnutrition
SBBC	Social and behaviour change communication
SBMR	Standard Based Management and Recognition
SDG	Sustainable Development Goal
SI	Strategic Information
SLMTA	Strengthening of Laboratory Management Towards Accreditation
SRH	Sexual and reproductive health
STI	Sexual transmitted infections
STP	Short Term Plan
SW	Sex Workers
TACAIDS	Tanzania Commission for AIDS
TASAF	Tanzania Social Action Fund
TB	Tuberculosis

TFDA	Tanzania Food and Drug Authority
THIA	Tanzania HIV Impact Assessment
THMIS	Tanzania HIV and Malaria Indicator Survey
TI-CoT	Tanzania Initiative for Accelerating Children on Treatment
ToT	Trainers of Trainers
TTI	Transfusion Transmissible Infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session on HIV & AIDS
UNICEF	United Nations Children's Fund
URC	University Research Council LLC
USG	United States Government
VAC	Violence Against Children
VAPN	Voluntary Assisted Partner Notification
VCT	Voluntary counselling and testing
VEO	Village Executive Officer
VIA	Visual Inspection with Acetic Acid
VMMC	Voluntary Medical Male Circumcision
WCF	Workers Compensation Fund
WHO	World Health Organization
XDR-TB	Extensively drug-resistant Tuberculosis

Executive summary

The Premise

The fourth Health Sector HIV/AIDS Strategic Plan (HSHSP IV) 2017-2022 was developed at the same time that the review of the Third National Multisectoral Framework (NMSF III) and the Global Fund application for 2018-2020 processes were underway so the three processes complemented each other.

The Strategy is further informed by various global scenarios that assure low-income countries of the availability of additional resources to build programs for the sustainable control of the HIV epidemic. These include; The UNAIDS Fast-Track Strategy (90-90-90: 90 per cent of people with HIV diagnosed, 90 per cent of them on ART and 90 per cent of them virally suppressed by 2020); The WHO Global Health Strategy for HIV, viral hepatitis, STIs, 2016-2021; PEPFAR 3.0 (a data-driven approach that strategically targets geographic areas and populations where investments can realize the highest impact); The GFATM which aims at investing to end the Malaria, AIDS and TB epidemics and the Tanzania Investment Case which applied epidemiological synthesis and programmatic and economic analyses to develop scenarios for moving Tanzania towards the global goals. Tanzania has chosen the “Maximum Coverage Technical Efficiencies” scenario which matches the country’s epidemiology and current funding landscape.

However, the most dominant source of reference for developing the HSHSP IV was findings from the review of the HSHSP III which identified what worked well, what needs to be improved and what needs to be dropped.

Factors that informed the development of the Strategic Plan

Heterogeneity of HIV prevalence: According to various studies, HIV prevalence in Tanzania is characterized by significant heterogeneity across age, gender, social-economic status and geographical location, suggesting different risks of HIV transmission. HIV prevalence is higher in urban areas than in rural areas; 7.5% versus 4.5% respectively. However, there are high prevalence districts and hotspots within regions that formerly had relatively low HIV prevalence.

Higher infection rates among women and growing numbers of new infections among young people despite the steady decline of new HIV infections. In 2015 UNAIDS estimated the number of PLHIV in Tanzania to be 1,385,779, of which 120,000 are children aged below 15 years and 750,000 are women aged 15 years and above. The THMIS 2012 shows that HIV prevalence is higher among women than men, standing at 6.3 % and 3.9% respectively. The prevalence of HIV is less than 2% among 15-19 years for both males and females and then increases with age for both sexes. The age disparities in new HIV infections suggest an increase in numbers of new infections among younger populations.

Varied sources of new infection and higher risk of infection among KVP: In Tanzania Mainland, stable and casual heterosexual relationships are the main source of new infections, standing at 38.8% and 28.9% respectively as per the 2014 study on Modes of HIV Transmission (MOT) in Tanzania. However, key and vulnerable populations are at higher risk of HIV infection given other factors including stigma and discrimination when they access services. The main key populations include; sex workers (SW), men who have sex with men (MSM), people who use and/or inject drugs (PWUD/PWID) and vulnerable groups including orphans and vulnerable children (OVC), adolescent girls and young women (AGYW), mobile populations (long distance truck drivers, people in mining and construction industries, fisher folks and fishing communities, plantation workers, displaced persons), people in closed settings (e.g. prisoners), and people with disabilities. An Integrated Biological and Behavioral Surveillance (IBBS) survey conducted between 2010 and 2014 revealed that the highest HIV prevalence is among PWID 36% (N=30,000), FSW 26% (N=155,450), MSM 25% (N= 49,000), and PWUD 22% (n=300,000).

Higher infection rates among young girls: Available data suggest that HIV infection rates begin to rise much earlier in girls than boys, and these differences persist until much later in adulthood. Given the epidemiologic evidence of their early and heightened vulnerability, addressing sexual health services and age-tailored HIV prevention for adolescent girls is a priority.

These factors were taken into consideration when developing interventions for the HSHSP IV to ensure compliance with a differentiated approach to HIV prevention, care and treatment.

Existing Gaps, Challenges and Opportunities

Despite significant progress made towards achieving the triple 90 goals during HSHSP III, there are a number of gaps and persistent challenges that need to be addressed and opportunities that can be tapped into to strategically can turn things around in all thematic areas. The following are key:

- HIV testing services (HTS) which are a key component in the prevention strategy need to be more efficient and ambitious to meet the 90-90-90 targets through more targeted testing approaches with linkage to care.
- ART services are critical for epidemic control in Tanzania so they need to be more ambitious if we are to meet the Fast-Track's 90-90-90 targets. This can best be done through increased enrolment based on the new "Treat All" approach while paying attention to monitoring, adherence and retention in care and viral suppression.
- The eMTCT services need to consolidate gains made so far by reducing LTFU, promoting male involvement, and addressing the unmet need for family planning.

- Condom provision and programming requires innovative approaches for distribution and improved monitoring mechanisms to increase access and targeted condom promotion and provision to high-risk groups during the implementation of HSHSP IV.
- KVP are at high risk of HIV transmission and require an aggressive scale up of targeted services tailored to the unique requirements of these groups. These services should as much as possible be integrated into the health service delivery system – both facility and/or community based.
- VMMC services should aim to attain saturation in the remaining priority regions with low coverage and high HIV burden.
- Targeted services for adolescent girls and young women (AGYW) should be expanded with a tailored services package including cash transfer schemes and should address structural barriers.
- Mobilisation of resources from external and domestic sources is critical to meet the country's needs for HIV prevention, care, treatment and support. The cost estimates of NMSF III should be updated to take into account needs arising from more ambitious targets for epidemic control. Increased efficiencies as well as improved resource reallocation to cost-effective interventions such as ART, condom provision and programming, targeted for KVP and VMMC will be necessary.
- Effective coordination of HIV and AIDS programmes at all levels continues to be critical to guide cost-effective resource allocation and utilisation as well as planning of service delivery tailored for local epidemiology.
- Improved programme monitoring and tracking of progress against targets will require a review of targets, regular analysis of disaggregated (granular) data, the tracking of new priority strategies and cascades among all populations groups at all levels to ensure attainment of a sustainable epidemic control.

In order to make significant progress towards ending HIV epidemic as a public health threat by 2030, HSHSP IV will address outstanding barriers and meet or surpass the ambitious global targets for 2020.

Key Strategies to guide implementation of the Strategic Plan

The HSHSP IV focuses on sustaining progress made in during HSHSP III and addressing gaps and emerging needs. The main goal is to realize the 90-90-90 global goal. The key strategies for each thematic area are as follows:

HIV Prevention

- To significantly reduce HIV incidence by implementing interventions that target major sources of new infections, namely; heterosexual relationships, casual heterosexual sex, and KVP. Stronger emphasis will be placed on STI

management by shifting from the vertical disease-specific approach to an integrated approach where STI treatment is provided at every entry point and reviving STI reporting as an important indicator of sexual transmission of HIV.

- Sustaining gains in condom distribution from the HSHSP III to ensure availability and accessibility of condoms in public and private outlets with greater efforts on ensuring that condoms are distributed more effectively to reach all populations in need, especially KVP, men in workplaces and AGYW. Also to continue with social marketing related activities to promote use of condoms
- To encourage male involvement, the strategy will include the provision of male-friendly services to address the needs of men such as diagnosis of prostatic cancers and common NCDs like diabetes, hypertension and sexual dysfunction. This will be coupled with interventions for increasing awareness about the critical role of men in the success of HIV prevention interventions and influencing behaviour change that supports HIV prevention efforts
- To improve the efficiency of national blood transfusion services provided at zonal centres so that safe blood is available on demand and reducing incidences of HIV infection through blood transfusion of unsafe blood. Also to reduce the risk of HIV exposure through blood borne infection including through injecting drug use, in health care settings and mother-to-child transmission
- Rigorous Combination Prevention Campaigns to address societal causes of HIV risk, vulnerability of young people, particularly young girls and stigma and discrimination against PLHIV and populations at highest risk.
- For secondary prevention, the strategic plan contains a cluster of HIV prevention strategies centred on ART including PMTCT, PEP and Pre EP. The preventive effect of ART is enhanced if viral suppression is achieved in PLHIV.
- Increased efficiency of HTS for co-infections and co-morbidity including TB/HIV, Hepatitis/HIV etc.
- Integration of HIV prevention services including joint planning, joint supervision, joint training activities, co-location of ART, TB and RMNCAH services (“one stop shop”) to facilitate service integration and promote efficiency. Integrated services will also improve access to HTS testing through the different entry points and reduce stigma. Where integration of services is not feasible, linkage to special services will be encouraged such as HIV and Diabetic clinics, Chronic Obstructive Pulmonary Disease (COPD), Hypertension.
- To address cultural and socioeconomic issues that affect access to services for AGYW

Care, Treatment and Support

Provision of antiretroviral treatment for PLHIV is a critical strategy for mitigating the impact of the HIV epidemic by reducing morbidity and mortality. Also, treatment-leading to viral suppression is a prevention strategy that forms the basis for the “treat all” approach. In order to meet the “second 90” of the 90-90-90 (triple 90) fast track targets, the HSHSP IV will strive to significantly increase ART enrolment and viral load monitoring of ART clients. In particular, the HSHSP IV will

- Ensure universal coverage of ART services in all public, faith based and private health facilities. As a starting point, HSHSP IV will support targeting CTC services in strategically positioned health facilities to maximize reach and establish ARV refill sites in health facilities that do not provide ART services
- Strengthen mechanisms for linkage from HIV testing services to care for all HIV positive individuals and entry points for HIV exposed infants, pregnant women, children, adolescents and men
- Strengthen community level follow-up and treatment support mechanisms for PLHIV on ART.
- Enhance early initiation into ART and adherence support services for all PLHIV with special focus on adolescents and elderly
- Intensified action to enhance paediatric ART, specifically improving EID for identification of children with perinatal HIV infection and improving availability of cost effective paediatric ARVs
- .Introduce interventions to address barriers for enrolling men into ART services (currently lagging behind in ART coverage) and to increase access
- Reduce barriers to the provision of ART to KVP including provider (institutionalized) discrimination. This will have the double benefit of enhancing HIV prevention efforts.
- Strengthen and improve integrated prevention, screening and management of TB reproductive cancers and other co-morbidities within CTCs and other HIV/AIDS services,

Health Systems Strengthening

The strategies under this thematic area clearly define what needs to take place to build a strong and sustainable health system for the HIV response. These include;

- Rectifying weaknesses in health care delivery systems that are slowing the scale-up of HIV treatment services.
- Specific and targeted improvements focusing on service delivery, improvements in health care infrastructure, procurement systems, cold chain systems, laboratory systems, health information systems and monitoring and evaluation.

- Mobilizing resources to support efforts to ensure universal access to HIV and AIDS Care and Treatment services, including the number of health facilities with CTC services and RCH clinics that provide Option B+ for pregnant women. It is estimated that in 2015 there were a total of 1,385,779 PLHIV in Tanzania (Spectrum 2015 Estimates) of which 846,527 (63%) were on ART.
- Continuing to provide community based care and support to both bedridden clients as well as ambulatory individuals for adherence to treatment. The strategy focuses on community and home-based HIV prevention, care, treatment and support services for PLHIV, their families and the communities at large and the service package will include community HTC; complimenting care and treatment through enrolment, retention and adherence; eMTCT; psychosocial support; paediatric HIV; TB/HIV collaboration; nutrition; STI management; GBV and Violence Against Children (VAC); VMMC and KVP services, social and economic support; as well as IEC and SBCC. In addition to maintaining the existing service package, the HSHSP IV will also implement the differentiated services delivery model (DSDM) for ART where community-based distribution (CBD) of ARVs as well as supporting adherence and retention strategies will be introduced.
- M&E to ensure evidence-informed programming and decision making will be given priority in the HSHSP IV. The importance of accurate, relevant, complete and timely reporting of data is being emphasized and the data will be used in the quantification of needs to ease procurement and supply chain activities, commodity control, identifying trends as well as informing decision making processes. The HSHP IV will focus on increasing data visibility at the central level and increase data use for decision making at all levels. Routine age-disaggregated Health Management Information System (HMIS) data and information collection will be complemented by surveys and studies, surveillance and evaluation and operational research to ensure improved HIV and AIDS programming and informed (evidence based) policy decisions. Improved monitoring will be ensured by using disaggregated data when tracking cascades among all populations groups, with the main thrust on guiding the health sector's response from grassroots level all the way to national level.
- The mobilization of financial and human resources necessary for accomplishing the above strategies.

Conclusion

HSHSP IV is geared to sustain and perpetuate the successes attained through implementation of HSHSP III while aiming to fast-track combination prevention to reduce HIV incidence and eliminate the AIDS epidemic as a public health threat by 2030. The strategy embraces the epidemiological synthesis, programmatic, and economic analysis conducted during the development of the country's Investment case. In implementing HSHSP IV, Tanzania has chosen the "Maximum coverage technical efficiencies" scenario which matches the country's epidemiology and

current funding landscape. The scenario entails the maximization of efforts and coverage of HIV prevention and treatment services with focus on KVP. This will accelerate progress towards attaining the SDGs, in particular SDG 3 to end the epidemics of AIDS, TB, Malaria and Neglected Tropical Diseases (NTDs) and combat Hepatitis, water-borne diseases and other communicable diseases by 2030.

Moving towards universal access to HIV prevention, treatment, care, and support is an important step in the direction of an effective, sustainable HIV response. However, the collection of epidemiological data is a crucial component of the M&E activity which will help in defining national and local priorities. National action needs to be based on sound evidence of what works to address identified national needs while ensuring full implementation of evidence-informed policies and programmes.

The epidemic also needs to be localized with conversations about HIV and AIDS being a normal everyday topic all the way from family level, and risk reduction regarded as a societal norm. This will help to generate a strong demand for prevention services but it requires strong leadership at community (grassroots) level for effective community mobilization to complement the scale up of measures to reduce societal factors that increase HIV risk and vulnerability, including gender inequities, stigma and discrimination, and social marginalization.

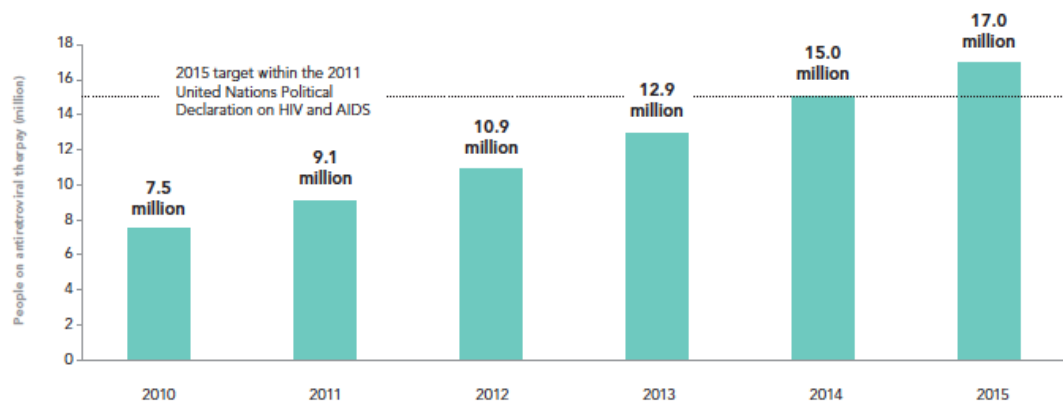
Because the AIDS epidemic will last through generations, it is a long standing challenge that requires a clear vision, persistence, flexibility and innovation. There is also a need for longer term planning beyond the 5-year implementing strategic planning cycle, particularly with regard to monitoring and evaluation mechanisms and resource mobilization. The mobilization of sufficient financial resources to reach the global target of universal access to HIV prevention, care, treatment and support services requires innovative mechanisms to mobilize and more importantly to sustain financing for the long term. Resource mobilisation from external and domestic sources to bridge funding gaps and to sustain current funding streams is a critical challenge that needs to be addressed during the implementation of HSHSP IV. Efforts will be made to mobilize additional resources to support more ambitious targets and evolving strategies. This will go hand in hand with increased efficiencies in resource mobilisation and resource allocation. Mobilisation of resources from domestic sources will include the national budget, local government contributions from own resources, and operationalization of the AIDS Trust Fund (ATF) to ensure sustainability. This is critical because as Tanzania moves towards middle income status, there will be an increasing demand for the government to match donor funding with domestic contributions.

Last but not least the HSHSP IV will be translated into costed annual operational plans with programme goals, detailed programme costing and identified funding sources. The NACP will also prepare a monitoring and evaluation plan for the strategy.

1. Background and Introduction

1.1 Global HIV Response and Strategies

The last decade has witnessed a great transformation in the global response to the HIV pandemic. At the beginning of the decade, people living with HIV (PLHIV) in low-income countries did not have access to life-saving Highly Active Antiretroviral Therapy (HAART) as was the case in developed countries. This was due to financial and health system challenges including lack of human resources to support HIV prevention, care, treatment and support. Guided by global strategies from the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) international efforts spurred a global response that resulted in an increasing number of PLHIV being put on Antiretroviral therapy (ART) (Figure 1). Major initiatives that helped to transform the global response include: support by the US President's Emergency Plan for AIDS Relief (PEPFAR) to low-income countries to put PLHIV on treatment and prevent new infections; the provision of performance-based financing to low and middle income countries by the Global Fund for AIDS, Tuberculosis and Malaria (GFATM or GF); the work of the Clinton Health Access



Initiative¹ (CHAI) to lower the price of antiretroviral drugs (ARVs), UNITAID's innovative funding mechanism to accelerate access to high-quality drugs and diagnostics for HIV, Malaria and Tuberculosis in countries with a high disease burden; support from the Bill and Melinda Gates Foundation for innovation and technology for better tools for HIV prevention and delivery of ART and the support of many bilateral and multilateral partners for national HIV and AIDS programmes either directly or through health sector support aimed at strengthening health systems to respond to all health challenges including HIV and AIDS.

More recently, the global community has committed to the bold target in the Sustainable Development Goal (SDG) of ending the AIDS epidemic by 2030. The UNAIDS, in its Fast-Track Combination Prevention strategy, recommends a

¹ It was formerly known as the Clinton HIV/AIDS Initiative

substantial increase in front-loaded investments in the next five years to accelerate efforts towards reducing new HIV infections to less than 500,000 by 2020 (UNAIDS 2015) as an intermediate step towards ending HIV as a public health threat by 2030. The Fast-Track strategy calls for renewed commitment and accountability for sustained funding and the scaling up of a mix of proven high-impact HIV prevention interventions, putting increased focus on pockets of high rates of transmission, expanding the dimension of service delivery to community level for demand creation, and treatment adherence support. On the other hand, the WHO Global Strategy 2016-2021 outlines what fast-track actions the global community, led by WHO and countries, need to do perform to accelerate and intensify the HIV response in order for the “end of AIDS” to become a reality (WHO 2015). While there have been enormous gains as evidenced by the high number of PLHIV on ART, there are persistent challenges that must be addressed if the SDG targets are to be met by 2030. The WHO Global Strategy positions the health sector response as a critical element towards the achievement of universal health coverage. It also promotes a people-centred approach with a focus on human rights and health equity as it aims to achieve a radical decline in new HIV infections and HIV related deaths.

In line with the UNAIDS Fast-Track Strategy and the WHO Global Health Strategy, major global initiatives and programs such as PEPFAR, GFATM and other international actors (through multilateral and/or bilateral arrangements) are making available resources for low-income countries to build programs for sustainable control of the HIV epidemic. Building on previous achievements, PEPFAR 3.0 is pivoting to a data-driven approach that strategically targets geographic areas and populations where investments can realize the highest impact and reach the UNAIDS ambitious 90-90-90 global goal: 90 percent of people with HIV diagnosed, 90 percent of them on ART and 90 percent of them virally suppressed by 2020. Similarly, the Global Fund Strategy 2017-2022: Investing to End Epidemics, outlines actions to maximize impact against HIV, TB and Malaria by building resilient and sustainable health systems, promoting and protecting human rights & gender equality, and mobilising increased resources to support low-income countries to achieve SDGs.

In summary, the Global response has been unprecedented. In 2015, almost every country was implementing HIV prevention and treatment programs hence making major progress against the disease. The number of adults and children newly infected with HIV globally declined by 35% during the period 2000–2014; and the number of people dying from HIV-related illnesses declined by 24% during that same time period and by over 40% since 2004. By 2015, almost 17 million people were accessing treatment, the majority of which are in Sub-Saharan Africa and other low income countries (GF Strategy 2017-2022, Global AIDS Update 2016).

1.2 The Tanzanian Country Context

Tanzania is the largest country in East Africa covering 947,300 square kilometres. It is an ethnically and culturally diverse, low-income country with an estimated population of 50 million (Tanzania Mainland/Zanzibar based on 2012 Census projections), distributed in 31 regions and 178 districts. Tanzania Mainland has a total of 7,992 health facilities offering a wide range of health care services. Of these, 1,998 (25%) are private and 6,058 (75%) are public.

Tanzania's Gross Domestic Product (GDP) has continued to rise reaching 7% in 2016 and is projected to continue increasing. Since the Tanzanian economy is dependent on the labour intensive sector of service provision in agriculture, industry, mining and construction, having a healthy and skilled human capital base is critical. It is anticipated that given this favourable economic outlook, the Tanzanian government will continue to invest in health and other social sectors hence making available the required resources to combat the three main killer diseases in the country, namely; AIDS, TB, and Malaria. Also, with the post Millennium Development Goals (MDGs) focus on 'Health-in-all-Policies' and inter-sectoral action for addressing social determinants for health and investments, other sectors are likely to benefit from the health sector and national HIV and AIDS response.

1.2.1 HIV situation in Tanzania

HIV Prevalence: The HIV prevalence has steadily declined over the past decade

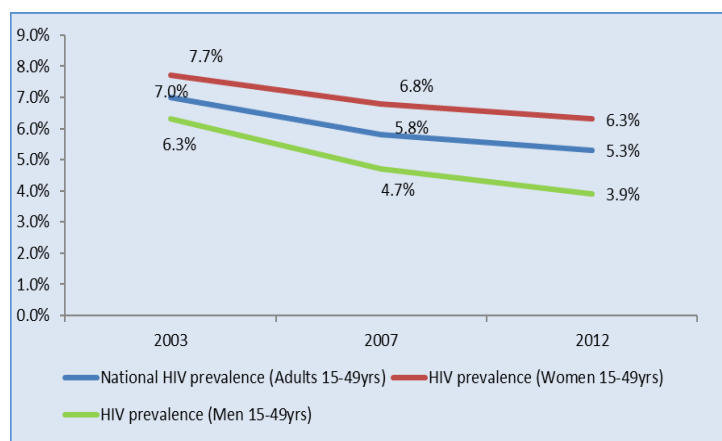


Figure 1: HIV Prevalence trends 2003 -2012 (THMIS, 2012)

will soon be available.

from 7% in 2003 to 5.3% in 2012². The main limitation of current HIV estimates in Tanzania is that they are based on the outdated 2012 Tanzania HIV and Malaria indicator Survey (THMIS). There is an ongoing nationwide population-based Tanzania HIV Impact Survey (THIS) and it is expected that more current estimates for the epidemic

HIV prevalence in Tanzania is characterized by significant heterogeneity across age, gender, social-economic status and geographical location, which implies differentials

²THIMS, 2012

in the risk of transmission of infection. HIV prevalence is higher among Key and Vulnerable Populations (KVP) including Men who have Sex with Men (MSM), People Who Inject Drugs (PWID) and Female Sex Workers (FSW). The HIV prevalence of FSW is estimated at 26%, MSM at 25% and PWID at 36% (Consensus Estimates on Key Population Size and HIV prevalence in Tanzania through Integrated Biological and Behavioral Surveillance (IBBS) Survey conducted between 2010 and 2014). There are significant considerations in the design and selection of interventions to ensure compliance with the differentiated care approach to HIV prevention, care and treatment.

UNAIDS estimates that in 2015 Tanzania had approximately 1,385,779 PLHIV. Of these, 120,000 were children aged below 15 years and 750,000 were women aged 15+. The THMIS 2012 shows that HIV prevalence is higher among women than men, standing at 6.3 % and 3.9% respectively. The prevalence of HIV is less than 2% among 15-19 years for both males and females and then increases with age for both sexes. However ART coverage is proportionally higher in women, demonstrating that there is work to be done to pull men into services

The general age structure of the population demonstrates that 63% of the population is aged 24 years and younger. The age disparities in new HIV infections suggest an increase in numbers of new infections among younger populations. This highlights the need to improve prevention and treatment among younger populations for the health of the future adult productive population.

The 2015 Spectrum estimates that the mother-to-child (HIV) transmission (MTCT) rate has decreased to 7.6% at the end of breastfeeding. Available data suggest that HIV infection rates begin to rise much earlier in girls than boys, and these differences persist until much later in adulthood. Given the epidemiologic evidence of their early and heightened vulnerability, addressing sexual health services and age-tailored HIV prevention for adolescent girls is a priority.

Geographical Heterogeneity of the HIV epidemic: Mainland Tanzania is demarcated into 26 administrative regions, of which nine show HIV prevalence above the national average. In general, HIV prevalence is higher in urban areas than in rural areas, 7.5% versus 4.5% respectively. Njombe region has the highest prevalence estimate (14.8%) followed by Iringa (9.1%) and Mbeya (9%). Manyara and Tanga regions have the lowest HIV prevalence estimated at 1.5% and 2.4 respectively. There is also evidence from programme data that even among regions, there is marked heterogeneity among the constituent districts. Specifically, some high prevalence districts and hotspots have been identified within regions that formerly had relatively low HIV prevalence.

HIV Incidence: The number of new HIV infections has been declining steadily over the years. UNAIDS estimates show a decline from 62,000 new HIV infections in 2013 to 58,000 in 2015 and the trend continues to decrease in 2016 and 2017. The country is on track to achieve the NMSF III objective of attaining a 50% reduction in HIV incidence during 2014-18 from 0.32% to 0.16%. This is attributable to the effectiveness of the scale-up of interventions in the national HIV response. The trend is expected to continue if the current efforts are sustained.

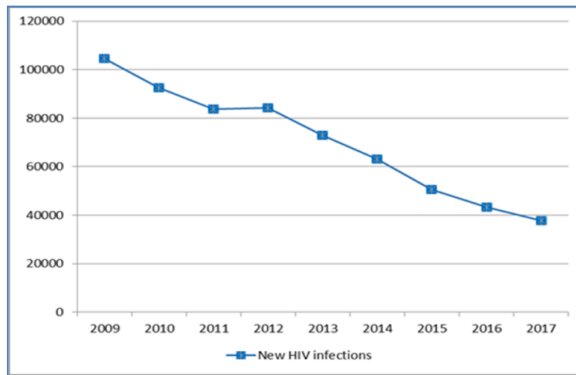


Figure 2 HIV Incidence projections, Tanzania 2009 - 2017 (UNAIDS)

Sources of new infections and risk factors: The 2014 Modes of HIV Transmission (MOT) study in Tanzania mainland showed that the majority of new infections in Tanzania occur in the context of stable heterosexual relationships (38.8%), casual heterosexual sex (28.9%), sex workers (1.3%) clients of sex workers (8.7%), partners of sex worker's clients (3.3%), partners of people engaged in casual sex (7.6%), PWID (2.1%) and MSM (6.8%). To significantly reduce HIV incidence, interventions are being targeted towards these major sources of new infections, namely; heterosexual relationships, casual heterosexual sex, MSM and clients of sex workers. Tanzania has not yet conducted a nationally representative IBBS to estimate the prevalence of HIV and size of KVP. However, there is a national consensus report which provided national estimates and prevalence for FSW, MSM and PWID. To more accurately gauge the proportionate burden of different KVP groups, there is a need to conduct national size estimation and mapping survey for KVP.

1.3 National Strategies and Legal Framework

The National Health Policy (2007) provides guidance for the development of the health sector and is implemented through a series of sector strategic plans, currently the fourth Health Sector Strategic Plan 2017-2022 (HSSPIV). On the other hand, the health sector HIV response is also guided by the NMSF. The current NMSF III covers the period 2013 -2017. These two national strategic guidance documents inform the development Health Sector HIV and AIDS Strategic Plans (HSHSP). The HSSP IV stipulates the Government's expectations by 2020 under which it is envisaged that the coverage of the national response to HIV and AIDS will have improved to ensure that 90% of all people living with HIV know their HIV status, and 100% of pregnant women with HIV receive anti-retroviral treatment for prevention of mother to child HIV transmission (PMTCT). While the HSHSP III, as guided by NMSF III and HSSP III (2009-2015) was tailored towards the country's efforts to attain the global goals summed-up in the three zeros slogan (i.e. "Zero new Infection, Zero

AIDS related Deaths and Zero Stigma and Discrimination”), the HSHSP IV will lead the country towards attaining the “triple 90” global goals through which 90% of people living with HIV will know their status; 90% of all people diagnosed with HIV will be enrolled on ART; and 90% of all people receiving ART will attain sustainable viral suppression.

The country conducted a Legal Environment Assessment (LEA) in 2015 which reviewed laws, policies and practices which maintain structural conditions that leave populations without access to HIV services. HIV-related discrimination (in the workplace, health care setting, community, etc.) is often deeply interwoven with other forms of discrimination based on gender, disability, and lifestyle choices including drug use, sex work, crime (prisoner), etc. This strategy has made a provision for funding some of the prioritized components of the action plan to ensure noted legal barriers to service access by vulnerable groups are addressed. Issues around advocacy for the modification of existing acts of parliament that infer restrictions to certain population groups especially the young are also being addressed.

The violation of women’s rights, including violence or denial of sexual and reproductive health rights, continues to render women and girls more vulnerable to HIV and prevent them from accessing services and care. Practices that restrict women’s equal access to decision-making, education, and employment reinforce these conditions.

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2. The Tanzania Health Sector HIV/AIDS Response

2.1 Evolution of the response from Short term Plan 1985 to HSHSP III 2017

The MOHCDGEC has led the national health sector response to HIV and AIDS since the epidemic broke out three decades ago. This began with a health sector response in the Short Term Plan (STP) 1985-1986 and the first Medium Term Plan (MTP I) 1987-1991. Multisectoral participation was introduced in MTP II 1992-1996 and was enhanced in MTP III 1998-2002. From 2003, the health sector started developing 5-year Health Sector HIV and AIDS Strategic Plans (HSHSP) to provide specific guidance for the health sector response. The first Health Sector HIV and AIDS Strategic Plan 2003-2006 (HSHSP I) is associated with an important milestone in the health sector response when, in 2003, the Government of Tanzania with support from CHAI and other partners developed the National Care and Treatment Plan (NCTP) 2003-2008 to complement the HSHSP I. The NCTP became operational in 2004. This was followed by HSHSP II (2008-2012) and the now ending HSHSP III (2013-2017).

In terms of coordination structures, the Task Force on AIDS established in 1985 was responsible for the STP that led to the establishment of the NACP in 1987 to oversee MTP I, MTP II and MTP III. A major milestone from that process was the formation of TACAIDS in 2001 and the passing of the National AIDS Policy. TACAIDS took over the role of coordination, overseeing and guiding the multi-sectoral response while NACP remained with the responsibility of leading the health sector responses of the NMSF. At the same time, from 2003, the health sector started developing 5-year Health Sector HIV and AIDS Strategic Plans (HSHSP).

While NMSF I (2003 – 2007), NMSF II (2007-2012) and NMSF III (2012-2017) were developed to guide the multi-sectoral response, specific guidance for the health sector was derived from the Health Sector HIV and AIDS Strategy Plan 2003-2006 (HSHSP I), followed by HSHSP II (2008-2012) and the now ending HSHSP III (2013-2017). It should be noted that during the health strategy development process, the development of HSHSP I and HSHSP II, started well in advance of the NMSF process giving little opportunity for the latter to properly guide the health sector response. The development of the HSHSP III followed immediately after the review of NMSF III and therefore benefited its guidance.

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

expanded to community and household level. The epidemic was also being monitored in a more systematic manner and the data used to inform policy, strategic and programmatic direction.

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

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

The MOHCDGEC has developed a costed elimination of mother-to-child HIV transmission (eMTCT), national plan (2012 – 2015) with the goal of reducing new HIV infections in children from 26% to less than 5%. In line with the decentralised government systems, councils with high HIV prevalence have developed plans with district-specific eMTCT targets and periodic monitoring of key indicators and a mechanism to identify bottlenecks and corrective actions. These plans were reviewed and updated as needed during the roll-out of Option B+.

The HSHSP III was tailored to respond and contribute to NMSF III 2013 -2017 developed by TACAIDS, to ensure the matching of needs and investment in HIV national response for the period 2013 –2017. During the implementation of HSHSP III efforts to increase key interventions such as HIV testing services, coverage of ART for all PLHIV and focus on KVP resulted in a decrease in HIV incidences, the

reduction of HIV-related deaths and the elimination of stigma and discrimination against PLHIV. In this way, the health sector contributed to Tanzania's efforts in attaining the global goals summed-up in the three zeros as; "ZERO new HIV Infections, ZERO AIDS related Deaths and ZERO Stigma and Discrimination."

2.2 Key Achievements of the HSHSP III 2008-2017

The implementation of the HSPSP III benefited from strong partnership between the Government of the United Republic of Tanzania (GoT) its Development Partners (DPs) that ensured availability of financial and technical support through bilateral programs such as PEPFAR, multilateral support through the Global Fund and the UN System (WHO, UNAIDS, UNICEF, UNFPA and other UN programs). In addition, Tanzania benefited from support from International and local Non-Governmental Organisations (NGOs) or Private Foundations such as CHAI, Benjamin William Mkapa Foundation (BMF) and Bill and Melinda Gates Foundations (BMGF). The Sector Wide Approach (SWAp) dialogue structures i.e. the Development Partners Group for AIDS and Health (DPG-AIDS and DPG-Health) provided opportunities for the leveraging of investments across the sector thus increasing efficiency and expanding coverage of services. As such, HSHSP III implementation was indirectly supported by DPs that support general sector investments such as the Health Basket Fund and the World Bank's Basic Health Services Project or those that support specific health programs and services that intersect with the HIV response such as Reproductive and Child Health (RCH) services, blood transfusion safety (BTS) and TB control. At the implementation level, the public, private partnerships (PPP) approach increased the potential for success as it facilitated resource sharing and complementarity of activities

The NACP developed the operational plan for Year 1 and Year 2 of HSHSP III to guide the implementation of HSHSP III at national and sub-national levels. The operational plans were intended to inform and guide the development of annual plans and budgets in the Medium Term Expenditure Frameworks (MTEFs) of the MOHCDGEC and PORALG, Regional Health Plans (RHPs) and Comprehensive Council Health Plans (CCHPs) at local government level. National level updates on the Implementation of the strategy are as stipulated in the Care & Treatment and surveillance reports. On the other hand, the success of the interventions can be measured by trends of HIV and AIDS outcome and impact indicators as measured by national surveys, both general surveys, e.g. Tanzania Demographic Health Surveys, Household Budget Surveys, Service Availability and Readiness Assessment, and HIV specific surveys, such as Tanzania HIV Indicator Surveys and HIV epidemiological surveillance. The review of the HSHSP III undertaken as part of this process and the Mid-term Review of NMSF III provided valuable information to measure the achievements to date. Key achievements towards the elimination of new HIV infections and reduction of HIV related mortality are described below. The report of the NMSF III Review provides more detailed information for reference.

2.2.1 HIV Prevention (Elimination of new HIV infections)

Interventions in this thematic area were geared towards the elimination of new HIV infections and reduction of incidence from 0.32% in 2014 to 0.16% in 2017. UNAIDS estimates (2015) show a decline of new HIV infections of all ages from 62,000 in 2013 to less than 58,000 new HIV infections in 2015.

Tanzania has scaled prevention interventions including HIV testing, condom distribution, VMMC and ART (treatment as prevention) and their coverage during implementation of HSHSP III were within national targets. Prevention and care programs for KVP including MSM, PWID and FSW have been established³.

HIV Testing Services: An increase in HIV testing services coverage and uptake was evident during the implementation of HSHSP III. Although the proportion of HIV-infected individuals who currently know their HIV sero-status awaits the results of the THIA to be definitively established, program data shows that the country surpassed its HIV testing targets in 2015 and 2017, reaching about seven million individuals tested for HIV in 2016.

Comprehensive Condom Programming: During the implementation of HSHSP III, Tanzania made progress in adopting the National Condom Promotion Strategy, launched a new public sector-brand condom – “ZANA” and condom provision through the public and private sectors. The number of condoms distributed in a year also increased to over 100million in 2016 meeting the national target. Evidence from the field shows that condoms are available and accessible in public and private outlets; however, the distribution mechanism needs to be strengthened in order to ensure focus on populations in need.

Voluntary Medical Male Circumcision: By 2016, the targets for coverage of VMMC in priority regions were already met; twelve priority regions attained VMMC saturation coverage levels of 80%. The VMMC strategy in Tanzania aims at achieving 80% coverage in all regions of the country by 2018. VMMC services were almost entirely supported by PEPFAR in priority regions, where 1.7 million procedures were conducted by the end of 2016 compared to a target of 2.8 million that were required to meet the coverage target of 80% saturation in all regions of the country. The service delivery model for VMMC in Tanzania gives priority to regions with low coverage of male circumcision and high burden of HIV transmission in order to meet the requirements for a sustainable epidemic control.

³Although recent prevalence data is not available, it is expected that the results of the on-going THIS study will confirm positive impact of these interventions or will lead to strategic adjustments

Blood Safety: Under this area, while all donated blood distributed through the national Blood Transfusion Services (NBTS) was tested for HIV and other markers of transfusion transmissible infectious agents, the target for the indicator that tracks the amount of safe blood collected, screened and used for transfusion was not met. Although blood collected and distributed through the NBTS increased during the HSHSP III, it remained below the estimated need in the country.

Treatment of Sexually Transmitted Infections: The STI management guidelines were recently updated in line with the latest epidemiological data on antimicrobial susceptibility, and services were integrated in the provision of care. There was limited direct investment in this area as such the coverage of STI management may not have changed much during the HSHSP III.

Social and Behaviour Change Communication: SBCC across strategic programmes were being implemented to increase demand for services, enhance knowledge, and lead to positive changes in risky behaviours at personal, community and national level. Interventions such as the ‘Best “Jiongeze” Campaign, the “Baki Njia Kuu; Michepuko Sio Dili” Campaign, and “Tuko Wangapi, Tulizana” Campaign contributed to awareness raising efforts aimed at behavior change. However, behavioural interventions and programmes addressing structural drivers of the epidemic in Tanzania were patchy during the implementation of HSHSP III and not monitored systematically for coverage. In this regard, coverage could not be easily measured in this review. The lack of effective monitoring, coverage gaps and weak SBCC will constitute the focus of improvement efforts during the implementation of HSHSP IV.

2.2.2 HIV and AIDS Care, Treatment and Support Services (Reduction of HIV related mortality)

Comprehensive Antiretroviral Therapy: During the implementation of HSHSP III, ART services were scaled up to increase number of PLHIV (adults and children) reached from 432,338 clients in 2012 to 846,527 (63%) by end of 2016. Figure 4 shows the increasing trends from 2011 to 2016.

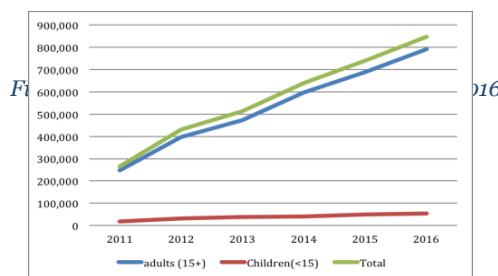


Figure 3 Trends of PLHIV put on ART 2011-2016

Tanzania first adopted the 2013 WHO guidelines that set the cut off point for ART eligibility to be 500 CD4 T-cell/ μ l, and more recently, adopted the 2015 guidelines for treating all HIV-infected individuals irrespective of disease stage. Tanzania adopted Option B+ for eMTCT i.e. lifelong HAART for all HIV-infected pregnant women upon diagnosis, which has changed the landscape of paediatric HIV in the country. Significant progress has

been made towards virtual eMTCT of HIV during the implementation of HSHSP III, with 90% of HIV-infected pregnant women enrolled on ART in 2014, and nearly universal coverage in 2015. The percentage of HIV-exposed infants receiving a DNA-PCR test within two months of birth increased from 47% reported in 2013 to 64% in 2014 and 82% in 2015. Vertical infections fell to 8,520 in 2015. The MTCT rate at 6 weeks fell to 3.6% at mid-term while that after breast feeding declined to 7.6%. These rates fell short of the targets for virtual eMTCT by 2015. The bottlenecks continued to be the high LTFU by mothers started on ART during pregnancy (with approximately one-third of enrolled mothers defaulting by the first anniversary); low EID testing (specifically the confirmatory test) and low male involvement.

In order to meet the “second 90”, of the 90-90-90 (triple 90) fast track targets, Tanzania needs to significantly increase ART enrolment during the HSHSP IV. Viral load monitoring of ART clients was introduced, but now there is a need to monitor viral suppression as part of the monitoring strategy for epidemic control.

2.2.3 Building Strong and Sustainable Health Systems for the HIV response

Service Delivery

Over the years, the country has made progress towards universal access to HIV and AIDS Care and Treatment services, whereby the number of health facilities with Care and Treatment Clinic (CTC) Services increased from 1,176 out of 6,342 (18.5%) health facilities in 2012 to 6,155 out of 7,494 (82%) health facilities by December 2016. These facilities provide care, treatment and support services through CTCs and RCH clinics that provide Option B+ for pregnant women. It is estimated that there were a total of 1,350,037 PLHIV in Tanzania by 2016 (UNAIDS 2015 estimates) of which 846,527 (63%) were on ART.

Quality Improvement

During the implementation of HSHSP III, quality issues continued to be implemented under the leadership of the Directorate of Quality Assurance of the MOHCDGEC. Each program has a Quality Improvement (QI) unit to ensure continuous quality improvement. The National Essential Health Sector HIV and AIDS Intervention Package (NEHSHIP 2010) has continued to be the reference framework with core services specified for each level of the health service delivery system. Other important documents that still guide the quality improvement matters include the National guidelines for QI of HIV and AIDS services (in the form of manuals and tools for comprehensive supportive supervision and mentoring and training packages). Although the regional and council levels were instructed to establish quality improvement teams, the review of HSHSP III revealed weakness in the functioning of these teams and in some regions and councils they are completely absent. QI is also challenged by a segmented component of quality with wide

variance in the way quality is defined; data quality assessment is quite different from QI inferences for medicines and laboratory systems. The health facility assessment tool which is used to assess health facilities before approving them to provide care and treatment services remains to be among the invaluable tools for assessing quality issues in relation to HIV and AIDS activities across the health system.

Medicines and Technologies

There has been remarkable improvement in the availability of HIV medicines and commodities which was largely a result of timely availability of funding and procurement by the GF- PPM, PEPFAR and MSD. The Government's contribution to the procurement of ARVs has been increased in terms of allocation of funding to the Government Budget. For HVL services, there has been a major improvement in capacity of HVL laboratory testing which has increased from 4 zonal centres to 16 centres countrywide. Stock out rates for ARVs reduced to less than 4% by end of 2016. There has also been a progress in the roll-out of the electronic system for capturing consumption data for ARVs among high volume sites that provide ARTs; about 380 CTCs out of 500 high volume sites are documenting their ARV consumption through the Pharmacy Module, making approximately 76% achievement. ARV reporting rates by health facilities has improved in more than 85% of the CTCs.

The quantification of ARV commodities has also been done with improved data from health facilities, particularly from the Pharmacy module and ELMIS. Rational use of medicines (RUM) activities planned during the HSSP III were initially focused on the training of health care workers (at least one person per facility) and the major achievement has been RUM assessment of health facilities whereby the aim was to establish correct usage of ARVs, prescribing and dispensing habits, and adherence to national guidelines for the management of HIV and documentation of adverse reactions of medicines.

Procurement, national supply chain management and pharmacovigilance: The HSHSPIII has shown improvement in the mobilization of domestic resources. In the fiscal year 2016/2017 the Government of Tanzania allocated Tanzanian shillings 10 Billion to its health budget for the procurement of HIV commodities and Tanzanian Shillings 5.5 Billion from the AIDS Trust Fund to support HIV services. The rollout and utilization of electronic database (eLMIS) has been improved where 40% of hospitals and 19% of HCs were covered leading to an achievement of more than 80% timely reporting. The eLMIS helps in timely logistic data collection and increased the logistic data visibility for decision-making. In addition, the use of the Pharmacy Module database in care and treatment facilities has increased significantly from 8% in 2012 to about 22% in 2016 facilitating 80% collection of consumption data for quantification purposes and other decision making processes. Under HSHSP III, there was no demonstrable progress with monitoring of drug safety (pharmacovigilance) using TFDA forms in care and treatment sites

The HSHP IV will focus on increasing data visibility at the central level as well as increasing data use for decision making at different levels. Furthermore, key stakeholders will be engaged to increase the contribution of domestic resources in supply chain activities. The care and treatment sites will increase the use of Pharmacovigilance reporting system to communicate with the TFDA on drug safety.

During the implementation of the HSHSPIII, a Logistic management Unit (LMU) was introduced and personnel were placed at the MOHCDGEC and zonal Medical Supplies Department (MSD). The LMU has improved the supply chain management for essential medicines and HIV commodities. As a result different surveys and data collection tools instituted showed that less than 5% of health facilities experienced Stock out of ARVs medicines; Tracer medicine (TLE) showed a stock out rate of less than 1% (eLMIS Dec 2016). There has been improvement in the availability of HIV test kits in most facilities. The RUM assessment report shows that 70% facilities appropriately use the HIV management guideline. However, push system and re-distribution strategies were also used at some situations to address stock outs and overstocking in health facilities

Under HSHSP IV, the MOHCDGEC will work more closely with PORALG at all levels and other stakeholders to ensure that all essential HIV commodities are continuously available and deployed at all levels to collect the necessary consumption information.

Laboratory Services and Laboratory equipment maintenance: The HSHSP III set out to improve the quality of laboratory services. Regional Hospitals (24) were successfully enrolled on the Strengthening of Laboratory Management Towards Accreditation (SLMTA) process and the process to enrol District Hospitals (25) started. Furthermore, a reagent rental methodology was piloted as a Preventive Planned Maintenance (PPM) system to ensure constant availability of laboratory reagents. Consequently, CD4 testing was successfully improved whereby 100% of health centres and 10% of dispensaries now have the capacity to perform the test through Point of Care (POC) testing. There has been an increase in health laboratories (16) performing HIV Viral Load (HVL) tests and EID using conventional platforms and HVL/EID POC testing is underway. To improve HVL and EID services, during HSHSP III implementation, the NACP has established 309 hubs to improve the sample transportation system, including sorting, storage, transportation and the feedback of results. Also, an improvement in quality of laboratory data has been observed.

The HSHSPIV will aim to further the gains made under the HSHSPIII and establish a system to track laboratory equipment that has broken down as part of PPM. In addition, all machines will be placed under PPM.

Community-based Care and Support: As a result of advances in the management of HIV and AIDS, the scope of home-based care (HBC) services during the implementation of HSHSP III changed from caring for bedridden clients to supporting ambulatory individuals to adhere to treatment. Up to the end of 2015, up to 64.2% (2,327) wards had comprehensive community-based care (CBHS) and support services in line with the national guidelines. The number of PLHIV receiving CBHS increased from 222,375 at the end of 2013 to 282,455 in 2014. The current CBHS strategy includes community and home-based HIV prevention, care, treatment and support services for PLHIV, families and communities. The service package includes community HTC; complimenting care and treatment through enrolment, retention and adherence; eMTCT; psychosocial support, paediatric HIV, TB/HIV collaboration, nutrition, STI, Gender Based Violence (GBV) and Violence Against Children (VAC), VMMC and KVP services, social economic support; and IEC and SBCC. One emerging area during the implementation of HSHSP IV will be the differentiated services delivery model (DSDM) for ART where community-based distribution (CBD) of ARVs as well as supporting adherence and retention strategies will be crucial.

Coordination, Governance and Management: Tanzania's multisectoral HIV response is coordinated by structures involving key stakeholder groups at all levels. These coordination structures are responsible for developing and reviewing work plans, compiling and sharing reports, reviewing service delivery and epidemiological data in order to define national and local priorities, and resource mobilisation and allocation. However, there are multiple coordination structures at different levels which are poorly coordinated. An objective organisational review of the coordination structures will be undertaken during the implementation of the HSHSP IV to address these short-comings, and a capacity building plan developed to enable each stakeholder to execute their identified roles. In particular, a reporting system based on the Government administrative structure will be instituted. This will allow the national level structure and NACP to have access to regular and reliable progress updates on the implementation of HSHSP IV.

Resource mobilisation and tracking: The resource requirements for the HSHSP III were estimated at the outset but they may have increased with evolving strategies and ambitious targets. Tanzania mobilised resources mainly from external partners especially the United States Government (USG) through PEPFAR and the Global Fund to support HIV and AIDS prevention, care and treatment services during the implementation of the HSHSP III. However, the funds remained inadequate with funding gaps across all areas of primary and secondary investment. Resource mobilisation from external and domestic sources to bridge funding gaps, as well as sustainability of the current funding streams remains critical during the implementation of HSHSP IV. Mobilisation of additional resources to support more ambitious targets as well as evolving strategies will also be critical, but this will go hand in hand with increased efficiencies in resource mobilisation and resource allocation. Mobilisation of resources from domestic sources will include the national

budget, local government's own resources and operationalisation of the AIDS Trust Fund (ATF) for sustainability. This is critical because as Tanzania moves towards middle income status there will be an increased demand for the country to match donor funding with a domestic contribution.

Monitoring and Evaluation: During the implementation of the HSHSP III, efforts to strengthen the national M&E system for the HIV response were made on several fronts, including the integration of multiple sectoral reporting databases that provide routine data from facilities and other reporting entities; regular triangulation of data obtained from various sources to better inform strategic planning and decision making processes; and routine data quality assessment (DQA) and strengthening especially for health facility information systems. Capacity building for M&E in various institutions was undertaken but remained patchy. Annual mathematical modelling was decentralised to regional level in Tanzania and a national population-based survey i.e. the Tanzania HIV Impact Survey (THIS) provided data on a wide range of monitoring indicators including the 90-90-90 cascades for various population groups. In the HSHSP IV, a need for investing in data quality improvement has been given a high priority. In addition, monitoring indicators will be refined to track progress towards epidemic control and obsolete or poorly defined indicators dropped. Improved tracking of local epidemics with more granular services and epidemiological data will be done to make sure no population group or geographical area is left behind. The reporting systems (CTC 2 and DHIS2) will be integrated or made more interoperable to enable linkages from testing to the final outcome. During the HSHSP III, lack of an annual update report showing progress towards achieving HSHSP III targets was a major gap. Under HSHSP IV, the NACP will ensure periodic national HIV/AIDS updates showing progress towards the achievement of HSHSP IV goals and targets are regularly produced and made available. In addition, the NACP will initiate a joint annual program review jointly between GOT PEPFAR, GF and Health Development Partners to feed into the annual planning processes for the MTEF, COP and GF-Funding Request Applications (GF-FRA).

2.3 Opportunities for ending the HIV epidemic as a public health threat by 2030

Although significant progress towards achieving the triple 90 goals was been during the implementation of HSHSP III, some outstanding and/or persistent challenges remain. The review of HSHSP III and mid-term review of NMSFIII show that:

- i. HIV testing services need to be more efficient and ambitious to meet the 90-90-90 targets through more focused testing approaches ensure linkage to care for all who newly test positive.
- ii. ART services remain critical to epidemic control in Tanzania but need to be more ambitious to meet the Fast-Track's 90-90-90 targets, through increased enrolment based on the new "Treat All" approach, and paying attention to monitoring, adherence and retention in care and viral

- suppression. This will especially require better coordination between facility and community activities.
- iii. eMTCT services need to consolidate gains made so far by reducing Lost To Follow Up (LTFU), promoting male involvement, and addressing the unmet need for family planning.
 - iv. Condom provision and programming requires innovative approaches for distribution and improved monitoring mechanisms to increase access and targeted condom promotion and provision to high-risk groups during the implementation of HSHSP IV.
 - v. KVP are at a high risk of HIV transmission; there is a need for an aggressive scale up of targeted services tailored to the unique requirements of these groups. These services should as much as possible be integrated into the health service delivery system – both facility and community based.
 - vi. VMMC services should aim to attain saturation in the remaining priority regions with low coverage and high HIV burden. At the same time, early infant male circumcision (EIMC) be gradually scaled up.
 - vii. Targeted services for AGYW should be expanded with a tailored services package including cash transfer schemes and should address structural barriers.
 - viii. Mobilisation of resources from external and domestic sources to bridge funding gaps is critical. The cost estimates of NMSF III should be updated to take into account needs arising from more ambitious targets for epidemic control. Increased efficiencies as well as improved resource reallocation to cost-effective interventions such as ART, condom provision and programming, targeted for KVP and VMMC will be necessary.
 - ix. Effective coordination of HIV and AIDS programmes at all levels continues to be critical to guide cost-effective resource allocation and utilisation as well as planning of service delivery tailored for local epidemiology.
 - x. Improved programme monitoring and tracking of progress against targets will require a review of set targets, regular analysis of disaggregated (granular) data, the tracking of new priority strategies and cascades among all populations groups at all levels to ensure attainment of a sustainable epidemic control.
 - xi. Improved use of data to better target the populations, sub-populations, and geographic areas where testing uptake is low or where there many PLHIV have not yet come into HIV services.

In order to make significant progress towards ending the HIV epidemic as a public health threat by 2030, the HSHSP IV needs to address outstanding barriers and meet or surpass the ambitious global targets for 2020.

3. Strategic Framework for HSHSP IV

3.1 An Overview of the health sector HIV response 2018-2020

Tanzania's national response has performed relatively well during the implementation of HSHSP III, and appears to be on course to meet the requirements for sustainable epidemic control under the Fast track triple 90 targets. During the implementation of HSHSP IV, there will be more resolute efforts to scale up priority interventions in order to maintain the country sustainably on the path for epidemic control. A combination of prevention, care, treatment and support interventions remain relevant as confirmed by Tanzania's investment case analysis. However, the strategies and targets will need realignment in order to meet the requirements for sustainable epidemic control. To ensure that "*no one is left behind*", including KVP, AGYW, etc., monitoring of the attainment of the HIV prevention and treatment targets will be informed by disaggregated cascades by geographical area and population sub-group during the implementation of HSHSP IV.

The HSHSP IV provides clear guidance for the HSHSP IV towards the triple 90 targets. It is envisaged that by 2020, the coverage of the national response to HIV and AIDS will have improved to ensure that 90% of all people living with HIV know their status, and 100% of pregnant women eligible for PMTCT receive treatment in 2020. In addition, the HIV care and treatment programme will improve coverage in at-risk children and adolescents so that overall, 90% of all people diagnosed with HIV are followed and receive timely and efficacious HAART, and 90% of all people receiving ART will attain sustainable viral suppression. Furthermore, during HSHSP IV, HIV and AIDS interventions to further reduce the incidence of new cases of HIV infection and provide access to HIV prevention, care, treatment, and support services will be implemented at all levels. A special focus will be placed on geographical areas characterised by higher than national average HIV prevalence, high burden in terms of the number of PLHIV, increasing prevalence over several years, and relatively lower performance on key HIV and TB indicators. Maintenance activities will continue in other areas, but active scale up will be the approach of choice in the prioritised geographical areas.

HIV prevalence in women is higher than in men in all age groups, but differentials are the highest among young women and girls, reflecting a strong gender element in risks of and vulnerability to HIV infection in the country. Prevention is a priority, especially in vulnerable groups like adolescent girls. Awareness about HIV risks and prevention of STIs in adolescents is key, e.g., through education on and access of condoms. Preventive activities will be given a high priority for other high-risk groups like PWID, FSW and MSM. HTS will continue as an integral part of adolescent-friendly health services. VMMC activities will be stepped up as well. The Government in collaboration with partners and stakeholders will scale up quality ART services for adults, adolescents, pregnant and breastfeeding women and children through

decentralised and integrated care and treatment services, as well as improved monitoring of response to ART and retention in care. The limited access to services by children, particularly for TB diagnosis, EID for HIV and paediatric ART will be prioritised through stronger integration of HIV care and treatment into the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) platform. Investments will be targeted to ensure improved access to optimum care and treatment for HIV exposed babies. Co-infections and co-morbidities in PLHIV will be addressed while community-based HIV and AIDS services will be strengthened, in particular, follow up systems and linkages between health systems and communities for people in care and treatment. The planned joint TB and HIV program reviews, supervisory visits, joint planning and training activities, co-location of ART, TB and RMNCAH services (“one stop shop”) will facilitate service integration and promote efficiency. There will be more attention on reducing stigma by providing integrated care and by counteracting acts of discrimination in order to enable PLHIV to live a normal life. In close collaboration with TACAIDS, the campaign against multiple sex partners and unsafe sex practices shall be intensified. The National Blood Transfusion Service (NBTS) will continue to play the core role of mobilising and recruiting blood donors to ensure increased availability and access to safe and quality blood and blood products so as prevent transmission of HIV and other TTIs. The national response to HIV and AIDS will benefit from health system strengthening, including Quality Improvement (QI) programmes, integrated procurement and pharmacovigilance and laboratory services. Surveys and studies, surveillance, evaluation and research will complement routine, age-disaggregated Health Management Information System (HMIS) data and information collection for improved HIV and AIDS programming and policy decisions.

Efforts to meet the ambitious targets for coverage and uptake of HIV testing, ART enrolment, retention, adherence and viral suppression, PMTCT, VMMC, condoms and demand creation, should be reinvigorated and where necessary strategic shifts made towards achieving the 90-90-90 targets. Prioritisation will be necessary to ensure that cost-effective interventions are funded optimally, with funds reallocated away from less cost-effective interventions. Prioritisation by population-group and geographical location will be critical, and will be informed by more granular data generated from the active involvement of decentralisation, coordination and implementation structures of the national response.

Sustainable epidemic control will require additional resources, improved resource allocation and efficiencies, and more effective monitoring to work towards an AIDS free Tanzania during the implementation of HSHSP IV.

3.2 Strategic Orientation of HSHSP IV 2018-2022

As stated earlier, the HSPSP IV provides guidance for the mission and goals of all health sector interventions including the national health sector HIV response. Since the NMSF III ends in June 2018, the HSPSP IV will depend on the HSPSP IV for its

strategic direction and will be guided by the Tanzania Investment Case and other international processes such as the WHO Global Strategy on HIV 2016 – 2021, UNAIDS fast track strategy (90, 90,90), PEPFAR 3.0 Strategy and SDG3.. The vision of the health sector as derived from the Vision 2025 and the HSSP IV is ***“to have a healthy society with improved social wellbeing that will contribute effectively to individual and national development”*** and its mission is ***“the provision of basic health and social welfare services that are of good quality, equitable, accessible, affordable, sustainable, and gender sensitive.”***

The HSHSP IV is geared to sustain and perpetuate the successes attained through implementation of HSHSP III at the same time aiming at fast-tracking combination prevention to reduce HIV incidence and eliminate the AIDS epidemic as a public health threat by 2030. The strategy embraces the epidemiological synthesis, programmatic, and economic analysis conducted during the development of the country's Investment case. As such, in implementing HSHSP IV, Tanzania has chosen the “Maximum coverage technical efficiencies” scenario which matches the country's epidemiology and current funding landscape. The scenario entails the maximization of efforts and coverage of HIV prevention and treatment services with focus on KVP. This will accelerate progress towards attaining the SDGs, in particular SDG 3 to end the epidemics of AIDS, TB, Malaria and NTDs and combat Hepatitis, water-borne diseases and other communicable diseases by 2030.

The Vision

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

The Mission

To provide a results-oriented framework to lead and guide the decentralized health sector HIV response in the intensification, optimisation and scaling up of quality evidence-based interventions for HIV prevention, care, treatment and support services for PLHIV to facilitate the attainment of the “triple 90” targets in Tanzania.

Goal

The goal of the HSHSP IV is to increase coverage of HIV and AIDS services in the general population and sub-populations to ensure that by 2022:

- There will be universal access to combination prevention services designed to reduce new HIV infections, HIV-related mortality, stigma and discrimination
- 90% of people living with HIV will know their status
- 90% of all people diagnosed with HIV are enrolled, followed up and receive timely and efficacious HAART
- 90% of all people receiving ART will attain sustainable viral suppression, and
- the capacity of the health system is strengthened to support quality HIV and AIDS interventions and foster integration within the health sector

Impact Results and Outcomes for the HSSP IV

The following impact and outcome indicators will be used to measure the achievement of the goal of the HSHSP IV:

1. Estimated percentage of HIV infection in children from HIV-positive women delivering in the past 12 months
2. Number of AIDS-related deaths per 100,000 population
3. Percentage of young people aged 15–24 years who are living with HIV
4. Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of ART
5. Percentage of people living with HIV and on ART who are virologically suppressed (among all those currently on treatment)
6. Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of MTCT

3.3 Guiding principles

The following nine key principles will guide the HSHSP IV and move its implementation towards results-oriented management:

Equity

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

Universal Access

The principle of universal access helps to facilitate the provision a specified package of health benefits to all members of a society with the end goal of providing financial risk protection, improved access (including coverage) to health services, and improved health outcomes. Universal access is critical for HIV and AIDS services because the impact is greatest in the poorest segment of the population. To achieve this, the health sector will require a strong, efficient and well-run health system; a system for financing health services; access to essential medicines and technologies; and sufficient human resource capacity in the form of well-trained, motivated health workers. The success of the strategy depends on the success of other health sector initiatives/strategies such as the Health Financing Strategy (HFS), the HRH Strategic Plan, the Community Based Health Program (CBHP) and the National Pharmaceutical Action Plan (NPAP).

Gender and rights-based approach

This principle is based on the recognition that gender roles and relations influence the vulnerability of women and men and girls and boys to HIV infection, their access to quality treatment, care and support, and the extent and manner in which the negative social and economic consequences of HIV/AIDS affect them. While more women than men are seen to access HIV testing and ART services, women are on the other hand disproportionately affected by HIV and AIDS as well as other social determinants of health (higher prevalence, incidence, poverty, low education), which in turn is compounded by gender-based discrimination and violence. As guided by the NMSF III, interventions in the health sector strategy promote alignment with the “Medical Management Guidelines for Gender – GBV and Child Abuse.”

Decentralisation

Decentralization is an important principle in guiding implementation of strategies because although vertical programs can achieve significant progress they often result in disparities, inefficiency and duplication of effort and resources. HIV/AIDS is a multi-sectoral concern which requires the involvement of all stakeholders and the devolution of resources and key responsibilities including planning, organization, coordination and control of service delivery from the centre to local government councils where health services are provided through health facilities and community based organisations in their jurisdictions. In particular, implementation of the HSHSP IV will benefit from Direct Facility Financing (DFF) introduced by the Big Results Now (BRN) and Health Basket Fund (HBF) where primary health facilities will have increasing autonomy over financial resources to implement health facility plans.

Integration

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

Community Participation in planning, monitoring and evaluating the response

Community participation is crucial in the implementation of HIV/AIDS programs because community awareness of and reaction to the disease determines the success of prevention efforts as well as outcomes of care and treatment interventions. Participatory approaches for planning, monitoring and evaluating the response will ensure that communities through community based organizations

(CBOs) participate in demand creation and in planning, monitoring and evaluating service delivery. This includes success in mainstreaming gender in HIV/AIDS programmes and reaching key and vulnerable populations.

Meaningful Involvement of PLHIV

This principle advocates for a more active and meaningful participation and involvement of PLHIV in programmes that affect their lives. The health sector recognises the important role that PLHIV can play in pushing the national response and has strived to ensure their involvement early in the process i.e. from the review process of the previous strategy to development of the next one. The interventions in the current strategy provide for meaningful involvement of PLHIV in the implementation and monitoring of the health sector response. All actors at sub-national level, including local government authorities, health facilities (both public, faith based and private) are expected to adhere to this guiding principle.

Fostering Partnership, Effective Mobilization and Efficient Allocation of Resources

This principle recognises that successful implementation of HIV/AIDS interventions is dependent on the existence of strong and meaningful partnerships and effective and efficient resource mobilization and allocation. Having strategic partnerships will ensure focused delivery of services through the leveraging of mechanisms, systems and processes that each partner brings to the table, a strong multisectoral platform and institutional sustainability, while effective mobilization of resources will ensure sustainable financing and efficient allocation of resources using a performance-based approach and taking into account optimal investment scenarios that will help to maximise gains already made. It will also facilitate the achievement of global goals.

Governance and Accountability

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

4. Health Sector HIV and AIDS Prioritized Interventions

This chapter details the priority strategies and interventions in the health sector response towards the “triple 90” targets. The strategies are grouped into five strategic areas, (i) HIV testing Services, (ii) HIV Prevention Services, (iii) Treatment, Care and Support for PLHIV, (iv) Health System Strengthening and (v) other cross-cutting interventions. In previous strategies, HIV Testing and Counselling was part of HIV Prevention but in reality, and particularly with the “*Treat All*” approach, it is also an entry point for Treatment, Care and Support services for PLHIV. In each strategic area, is a detailed account of the current situation, strategic outcomes, priority strategies and indicators for the main and sub-components under HIV prevention.

4.1 HIV Testing Services and Linkage to Prevention, Care, Treatment and Support

HIV testing services are the gateway to prevention, treatment, care and support services. HTS provide an opportunity to link clients to both prevention and treatment services. Therefore, HTS are crucial to the success of HIV response in the country.

4.1.1 HIV Testing Services

Current Situation

HTS are provided through a mix of modalities including Client Initiated HIV Testing and Counselling (CITC) and Provider-Initiated Testing and Counselling (PITC) provided in health facilities and community settings. The number of testing sites has increased from 1,600 in 2006 to more than 2,200 in 2014. (a 38% increase). PITC services have been rolled out to all hospitals, health centres and most dispensaries. In 2016, seven million four hundred thousand (7,400,000) individuals tested for HIV which is an increase from 2.5 million people who tested in 2014. The annual target was 5,469,260 tests. Data from the PMTCT program show that partner testing had increased to 53% by end of 2016. Also, the proportion of people who had tested for HIV and received results in Tanzania Mainland was 62% among women and 47% among men (THMIS 2012). By end of 2016, about 63% of estimated PLHIV (the minimum number who knew their status) in Tanzania were already enrolled into ART care. For the past two years (2015 and 2016) the annual TB screening rate among PLHIV was 97% and 95% respectively; above the WHO target of 85%. According to NTLP program data; 34% of TB patients were co-infected with HIV in 2016, this is a decrease from 37% in 2013.

Some of the gaps and challenges observed in implementing HTS activities include:

- Recurrent stock-outs of HIV rapid test kits.
- An inadequate health workforce for maximum coverage of HIV testing according to set standards.
- Inadequate infrastructure to support HTS.
- Low uptake of HTS among adolescents and children mainly constrained by the existing age of consent (18 years) which affects access to HTS especially for AGYM who are often vulnerable to HIV, stigma, and lack of appropriate community-based HTS for children and their families.
- Low up-take of HTS among men. Despite an increase in partner testing there is still low involvement of male partners in HIV testing especially outside the PMTCT setting.
- Lack of a reliable data collection and reporting mechanism which can provide updates on progress toward increased numbers of people with HIV who know their status
- Poor quality of rapid HIV testing in terms of compliance to testing standards among testing points and testers.
- HIV testing does not always reach the people at highest risk of HIV, particularly those who do not interact regularly with the health system.⁴

The stipulated challenges have been taken into consideration during the development of the HSSP IV in order to fast track the achievement of the first of the “triple 90” targets.

Strategic Outcome:

Ninety per cent (90%) of people living with HIV are aware of their status by 2020.

Priority strategies

To ensure realization of the above strategic outcome, the following four priority strategies will be implemented:

- ***Intensify existing and/or identify new alternative service delivery models for HTS:*** Service delivery models that have proved to and/or can increase uptake of HIV testing services and improve yield will be intensified and/or introduced to meet the Fast Track target for HIV testing (the first 90). HIV

⁴Mitchell S, Cockcroft A, Lamothe G, Andersson N. Equity in HIV testing: evidence from a cross-sectional study in ten Southern African countries. *BMC international health and human rights*. 2010;10:23.

testing services will continue to be provided in both facility and community settings including workplaces. At facility level, HTS will be integrated into all entry points including STI, TB, FP, etc. The overall quality of HIV testing is of paramount importance to ensure quality (reliable, efficient and effective) results and improve interventions. As such, the scale up of HTS will focus on regions with high HIV prevalence and incidence and low knowledge of HIV status. Marginalised and often stigmatised groups including KVP and especially prisoners and mobile populations (fisher folk, truckers, miners, other mobile populations with money) will be targeted.

- ***Scale up targeted HIV testing:*** This will be done by scaling up index client HIV testing (at facility and community level), community home-based HTS and mobile HTS targeting hotspots, prisons, orphanages and selected workplaces. Voluntary Assisted Partner Notification (VAPN) will also be scaled up to support index client testing as part of a comprehensive package for testing and care, and the integration of HTS into other health services (TB, STI, OPD, ANC, FP, BTS, etc.) will be scaled up. In addition, male involvement will be promoted through couple/partner testing, targeted combination prevention (CP) and workplace HIV testing campaigns. Marginalised and often stigmatised groups including KVP and especially prisoners and mobile populations (fisher folk, truckers, miners, other mobile populations with money) will be targeted. Other strategies will include the scaling up of demand creation activities (e.g. use of index clients and peers) to promote HTS uptake, the promotion of HIV testing for adolescents through youth-friendly services, the introduction of an HIV self-testing initiative and facilitation of the review of the 2008 HIV Act to address structural barriers e.g. age of consent.
- ***Strengthen health systems to support HTS:*** This strategy will entail monitoring the quality of HTS services, strengthening the supply chain for HTS commodities to eliminate stock outs of test kits and accountability for test kits at all levels, strengthening the M&E system for HTS and improving data utilization at all levels.
- ***Address human resource needs for the scaling up HTS while improving quality of HIV testing:*** In this effort, capacity building of providers on HTS will be enhanced. The HIV rapid testing quality improvement initiative (RTII) will also be an expanded linkage to care, treatment and support through task-sharing using community health care workers, community development officers and social welfare officers improved and a framework for sustainable stepwise improvement and certification of testers and testing points established. The HIV rapid testing quality improvement initiative (RTQII) will also be expanded. Linkage to care, treatment and support through task-sharing using community health care workers, community development officers and social welfare officers will be improved and a framework for sustainable stepwise improvement and certification of testers and testing points established.

4.1.2 Linkage to HIV Prevention, Care, Treatment and Support Services

Current Situation

HIV testing presents an opportunity to identify client's HIV status and link them to appropriate services. However, experience in Tanzania shows that not all clients who are diagnosed with HIV are promptly linked to ART Care. Likewise, those who are found to be HIV negative are not referred to appropriate prevention services.

The national guidelines recommend post-test counselling for all clients in order to continue to provide prevention, care and support services. Currently, HTS providers are either sending a client who is found to be HIV positive to care, treatment and support through a referral form, or by escorting them to the clinic. Feedback is provided through the referral feedback form and in some cases, if the referral is within the same facility or catchment area, the receiving provider may provide feedback to the referring provider via a phone call. Referral completion is not linked to performance of HTS providers.

Gaps and challenges that constrain linkage of HIV-positive individuals to prevention, care, treatment and support services include:

- Lack of a systemic approach to facilitate referral
- Lack of a reliable data collection and reporting mechanism to link clients who are identified positive from testing centres to those who are enrolled to care (completed referral)

Strategic Outcome:

All (100%) people who are identified to be HIV positive during community and facility HTS are linked to HIV Care, Treatment and Support services by 2020.

Priority strategies

- **Enhance post-test counselling:** HIV post-test counselling services will be enhanced to ensure effective referral to care services. Counsellors who identify HIV positive clients will be required to ensure that their clients are enrolled into care. Clients identified HIV positive at community and facility HTS will be recorded and appropriately linked to care. This indicator-the number of clients enrolled to care. –will be included into the performance measure of HTS service providers.
- **Establish effective referral and linkage to prevention and care, treatment and support services:** This strategy will involve the promotion of combination prevention campaigns, and provision of an effective referral mechanism through facilitated referral and linkages from testing centres to prevention, care, treatment and support services while scaling up the use of modern technology to link HIV positive or negative clients to different HIV services.

- **Improve integration of data between testing and Treatment centres:** This strategy will involve introduction of a case-based registration system to register and follow up clients from HTS to ART/CTC. A unique identification which is linked to a biometric marker should be used to track client receiving care.
- **Strengthen post-testing clubs:** Post-test clubs are important in ensuring peer supported risk reduction for clients who are HIV negative and psychosocial support to facilitate among PLHIV.

4.2 HIV Prevention Services

HIV prevention services under the HSHSP IV are focused on averting new HIV infections. In implementing the HSHSP IV, Tanzania recognizes the need to balance both HIV prevention and treatment efforts because while treatment is considered part of prevention due to its overarching impact in reducing viral load and thus transmission, effective prevention interventions are equally if not more important.

In Tanzania, new infections among adolescents and adults have moderately declined by 20% from approximately 56,000 in 2010 to 45,000 in 2016. This calls for a renewed push on primary prevention.

HIV prevention strategies implemented under the HSHSP III will be intensified during the HSHSP IV with particular focus on condom programming, male circumcision and programmes for KVP including AGYM, which are identified in the Tanzania Investment Case as effective strategies to prevent HIV in Tanzania. The focus of the HSHSP IV is to build on past prevention approaches and enhance HIV prevention alongside the ambitious efforts to increase treatment coverage. Below are details of the different HIV prevention strategies.

4.2.1 Comprehensive Condom Programming (Promotion and Distribution)

Current Situation

Consistent and correct condom use reduces the risk of transmission of HIV and other sexually transmitted infections. Hence condom promotion and distribution is featured in the national HIV response as a key strategy for prevention of new HIV infections. Condom distribution in public health facilities is done through traditional (pharmacies, supermarkets, accredited drug dispensing outlets (ADDOs) and non traditional outlets such as kiosks guest houses. Social marketing appears to have increased condom accessibility. However, the market potential for condoms has not been adequately exploited; there are disparities in accessibility among population subgroups; and deficits in condom use during high risk sexual encounters in general.

Among young people, only 37% of women and 41% of men reported to have used a condom the last time they had sex.⁵

Tanzania developed a condom strategy in 2016 which aims at strengthening condom promotion and distribution in the country. Through this strategy, Tanzania embraced a total market approach to expand the provision of condoms in both, via the public sector and private sector. The quantity of condoms distributed, especially through social marketing continued to increase. Efforts to promote and distribute condoms for HIV prevention are evident throughout the country. Male condoms are available in health facilities, commercial outlets and in some hotspots. However, the availability of condoms in hotspots is not reliable. Female condoms, on the other hand are less popular and not easily accessible.

In 2016 alone, Tanzania distributed a total of 116, 687,576 condoms (MSD Condom Distribution Data). For the period 2018 to 2020, the MOHCDGEC estimates the country condom need to be **498,919,196** for male condoms and **9,978,384** for female condoms. (*Condom Multisectoral Strategic Plan 2016 – 2018*). In 2016 Tanzania launched a new male branded public sector condom “ZANA”, which has been well received and is expected to increase demand among youth. Furthermore, the distribution plan for this brand of condoms includes making condoms available in diverse settings.

The following key barriers continue to constrain condom programming.

- Weak condom distribution system along with the absence of proper monitoring and evaluation for condom distribution
- Stigma associated with accessing and using condoms
- Lack of confidence to negotiate condom use by women, particularly young girls
- Barriers in accessing condoms from public sector health facilities by young people most of whom cannot afford to buy them from commercial outlets
- Prevailing myths and misconceptions around condoms
- Irregular availability of condoms in hotspots such as bars, guest houses and night clubs and other community settings such as the office of the Village Executive Officer and Higher Learning Institutions (HLIs)
- Barriers to access to public sector condoms among KVP who do not regularly visit health facilities
- Low coverage of public condom outlets beyond health facilities.
- Lack of national standard operating procedures (SOP) on condom distribution within and outside health facilities
- Inadequate condom promotion activities (mass media campaigns, text messages, social media etc.) especially for the female condom

⁵ TDHS 2015

- Absence of public sector female condom (branded)
- Inadequate supply of public sector male condoms
- Inadequate knowledge on correct and consistent use of condoms
- Scarcity of data and other related information on condom utilization
- Reliance on donor funding

Strategic Outcomes

- By 2022, male and female condoms are available and accessible at all times to meet the needs for family planning and for preventing HIV and other STIs.
- By 2022, an increased percentage of women and men engaged in multiple sexual partnerships reporting use of a condom at last sexual intercourse (*target to be set after the THIS results are released*).

Priority Strategies

In implementing the HSHSP IV deliberate efforts will be made to promote and distribute condoms outside health facilities with a focus on KVP, clients attending STI clinics, young people populations at hotspots including fish landing sites, road construction sites, mining sites, plantations, truck stops along highways, etc. This will be achieved through the following priority strategies:

- Strengthening the quantification, projection and procurement of condoms for the public and private sector to ensure that adequate quantities are available and are equitably distributed. Condom distribution targets will be determined to ease forecasting of condom needs at all levels.
- Promoting correct and consistent use of condom through mass media and social media strategies.
- Promoting creative non-traditional outlets for the distribution of public sector condoms beyond public health care facilities. This will include community distribution channels such as community groups, Ministries, Departments and Agencies (MDAs), institutions, workplaces, etc., including networks of PLHIV that have been proven to work well for this in Tanzania.
- Strengthening community-based condom distribution networks using individual distributors and non-traditional but effective outlets to complement distribution in stand-alone outlets like bars, guest houses, health facilities, pharmacies etc. Such non-traditional outlets include hair salons for men and women, night daladala parking areas, bus stands, petrol stations that operate 24/7, hostels and other public areas in HLIs.
- Increasing targeted condom distribution and promotion to high risk groups and hotspots

- Establishing/Improving the national M&E system for condom programming to ensure timely collection and reporting of condom data including lessons learnt and best practices for programming.

4.2.2 Programming for Key and Vulnerable Populations (KVP Programming)

Current Situation

In Tanzania Mainland, key and vulnerable populations are at higher risk of HIV infection. In addition to known key populations namely, SW, MSM, PWUD and PWID, vulnerable groups such as OVC, AGYW, students in HLIs who live in rented accommodation outside campuses, mobile populations including long distance truck drivers, people in mining and construction industries, fisher folks and fishing communities, plantation workers, displaced people, people in closed settings, e.g. prisoners, and people with disabilities are also at risk

HIV prevalence, in estimated populations (N) in the key sub-groups is as follows: FSW 26% (N=155,450), MSM 25% (N= 49,000), PWID 36 % (N=30,000) PWUD 22% (N=300,000). In prisons, HIV prevalence is estimated at 6.7%, (14.7% Female inmates versus 5.2% male inmates).

In 2014 a national guideline to guide and harmonise the implementation of a comprehensive package of HIV and health interventions for KVP was formulated. It was reviewed in 2017 to incorporate the new WHO recommendations for ART initiation and to clarify the community interventions package. A national M&E system for KVP was also developed.

Combination prevention interventions such as HTS, condom programming, STI management and ART initiation were implemented to reach KVP using both static and outreach services. Between 2015 and 2016 a total number of 1290 HCW were trained on the provision of KVP friendly services using the national training curriculum for KVP friendly services. The trained HCW came from 300 health facilities in 61 councils from 19 regions.

Building on the successes of the first Methadone clinic in Sub-Saharan Africa, Tanzania expanded Medication Assisted Therapy (MAT) services to 3 clinics in Dar es Salaam and plans are underway to scale up the program countrywide.

Despite the above achievements, effective KVP programming is hindered by a number of challenges including:

- Stigma (including self-stigma) and discrimination among providers, beneficiaries and the community at large
- KVP mobility which makes tracking them to reach them with appropriate HIV services difficult
- Inadequate coordination of KVP implementing partners which has resulted into duplication of effort and unequal distribution of available resources

- Inadequate interventions to reach sub groups like nomadic, fishing and mining communities
- Limited accessibility and low utilization of condoms at community level
- Inadequate integration of different services for KVP programming
- Inadequate sensitization of community gatekeepers including religious and traditional leaders, media and political bodies on health issues (both at central and local levels)
- Inadequate strategic information to inform policy makers and program implementers on KVP issues including sharing and dissemination of local data.

Strategic Outcome: Increased access and utilization of HIV services by KVP

Priority Strategies

- Systematic and coordinated KVP programming that is informed by local epidemiology to ensure improved access to and utilization of HIV services by KVP.
- Establish regional and district coordination and implementation structures for the regular review of local data and identification of population groups or geographical locations and corresponding priority actions
- Scale up tailored programmes which started under the DREAMS initiative to address the unique HIV prevention needs of AGYW as a vulnerable population.
- Scale up access and utilization of comprehensive evidence-based HIV services by KVP including innovations such as self-testing and pre-exposure prophylaxis
- Advocate for an enabling environment to facilitate access to services and address stigma and discrimination in health and community settings
- Promote health seeking behaviour among KVP
- Strengthen and coordinate public- private partnerships with appropriate stakeholders working with KVP so as to ensure tangible investments
- Strengthen M&E system and operational research so as to inform policy makers and program implementers and to track interventions for KVP
- Strengthen the provision of comprehensive sexual and reproductive health and HIV education at community and in schools
- Engagement of KVP beneficiaries in the design, planning, implementation, monitoring and evaluation of HIV KVP programmes, and in decision making fora

4.2.3 Voluntary Male Medical Circumcision

Current Situation

Tanzania has traditionally had high male circumcision coverage. In a survey conducted in 2011/2012 it was estimated at 72% of men aged 15 – 49 years, a slight increase from the 67% in the 2007/2008 survey. However, there is wide

heterogeneity among geographical regions and even within regions. Over half of the regions had male circumcision coverage of over 50%, but some regions had substantially lower coverage such as Rukwa (28%), Simiyu (30%), and Shinyanga (32%). In addition, VMMC coverage varies among demographic subgroups; it was higher among urban (94.2%) than rural men (64.2%); and varied by age with the lowest levels among 15-19 year olds (66.2%), rising to 74.4% among 30-39 year olds. Consistent with findings from other countries, the HIV prevalence among circumcised men was substantially lower (3.5%), compared with 5.2% among uncircumcised men.

A VMMC modelling exercise for 12 selected regions indicated that scaling up male circumcision among 10 - 29 year-olds would avert substantial level of HIV infections. This modelling exercise also indicated that the optimal long-term effectiveness of VMMC by 2050 would best be achieved through circumcision of men aged 15 - 29 years⁶. Based on this study, the National VMMC operational plan identified disaggregated targets into a primary target (males ages 10–24) and a secondary target (males aged 25–34)⁷.

Tanzania's VMMC strategy developed in 2010 had a target of circumcising 2,800,000 adult males in 12 priority regions by 2015 in order to achieve 80% coverage of VMMC countrywide⁸. The priority regions are: Kagera, Mwanza, Tabora, Shinyanga, Simiyu, Njombe, Geita, Rukwa, Mbeya, Iringa, Katavi and Rorya district in Mara region.

Efforts to roll out VMMC services have shown good results with the target of 80% coverage reported to have been achieved in 2 regions, (Iringa and Njombe) which would thereafter be transitioned to the maintenance phase. By end of 2016, 2.2million (78.6%) men had been circumcised – which falls short by 0.6 million of the target in the 2010 VMMC strategy.

During the implementation of HSHSP III, Early Infant Male Circumcision (EIMC) was piloted in Iringa region in 2013-2015, where approximately 3,800 EIMC procedures were conducted. According to the national strategy, further roll out of EIMC will be in supported regions that will have attained saturation (at least 80% coverage) as part of the consolidation of services for long-term sustainability. However, the likely impact will not be realised for at least 15 years.

⁶Kripke K, Perales N, Lija J, Fimbo B, Mlangi E, Mahler H, et al. (2016) The Economic and Epidemiological Impact of Focusing Voluntary Medical Male Circumcision for HIV Prevention on Specific Age Groups and Regions in Tanzania. PLoS ONE 11(7)

⁷The United Republic of Tanzania MOHSW, The National AIDS Control Programme, Voluntary Medical Male Circumcision Country Operational Plan 2014–2017. Toward an HIV-Free Generation. November, 2014.

⁸United Republic of Tanzania MoHSW, National AIDS Control Programme, National Strategy for Scaling Up Male Circumcision for HIV Prevention. 2010.

The current VMMC strategy provides for VMMC services to be offered in fixed sites (health facility) and when necessary through outreach services. Because of the workload on health workers, the strategy calls for task sharing among health care workers.

Despite the achievements mentioned above, a number of challenges were identified during the review of the HSHSP III including the following:

- Tanzania's VMMC services were almost exclusively funded from external sources. During the implementation of the HSPSP III development partners realigned their support to specific districts which left funding gaps in some priority regions / areas within regions that did not have committed support for VMMC services. This may have contributed to the failure by some regions to meet their targets.
- The current VMMC program does not adequately meet adolescent needs in terms of age-appropriate approaches including counselling, communication and client-provider interactions.
- Tanzania's new VMMC strategy focuses on young men aged 10 – 29 years for immediate impact. However, HMIS data shows that up to 40% of VMMC clients are aged 10-14 years, where the HIV prevention impact is delayed till these teenagers start sexual activity. This implies that the targets for VMMC might have to be revised to take this target group into account.
- VMMC services appear not to be adequately focused to high risk groups or locations such as mines, fish landing sites, other hotspots, yet it is a critical element for HIV prevention among these high risk groups that have low access to health services but high risk of HIV transmission.

Strategic Outcome: Ninety per cent (90%) circumcision rate will be attained by all regions by 2022.

Priority Strategies

During the implementation of HSHSP IV, VMMC will be strengthened with a focus on priority areas in order to attain saturation. It will be guided by the following priority strategies:

1. Increase focus on priority regions that have not yet attained the saturation target of 80% VMMC coverage through a mix of static and outreach services, while at the same time ensuring sustainability in all regions through integration of VMMC and EIMC services in Health facilities.
2. Mobilise resources for VMMC and EIMC services especially in areas that are not PEPFAR supported.

3. Expand VMMC services for high risk groups and locations (including workplaces) in order to reach out to groups that are at high HIV risk but have low access to services.
4. Scale up EIMC services in regions that have attained or are close to attain the 80% coverage target for adults and in non-priority regions as part of long-term sustainability.
5. Create demand for VMMC services in priority regions through age-appropriate messages and with a focus on targeting older men
6. Strengthen continuous quality improvement of VMMC and EIMC services, by ensuring the services are safe and culturally acceptable, tracking adverse events resulting from the procedure and developing SBCC materials that address myths and misconceptions associated with VMMC and EIMC.

4.2.4 STI Management

Current Situation

Despite strong scientific evidence on the effectiveness of STI management for HIV prevention, the coverage of STI control services for the general population and particularly among high risk populations including KVP is low. Most programmes providing tailored services for KVP do not adequately integrate STI management.

Tanzania has a high prevalence of viral STIs such as HSV-2, HPV, HCV and HBV that don't have effective curative treatment and are not managed syndromically. The implementation of integrated management of STI/RTI in HIV care and reproductive health services is still weak.

Moreover, there are persistent supply chain constraints which result in inadequate and irregular supply of STI test kits, pharmaceutical and medical supplies. Clients seeking STI services often have to buy drugs from outside sources due to stock out of commodities in facilities. This is a significant barrier for accessing STI services. Funding for STI services from the government and development partners is also inadequate.

Other contributing factors to high incidences of STIs include low health seeking behaviour, weak partner notification and poor management of these infections in facilities. This is compounded by self-medication (over-the-counter) with antibiotics that are readily available with minimal regulation. Last but not least, the changing patterns of antimicrobial susceptibility have a negative impact on the efficacy of syndromic management of STI.

Major gaps and challenges in the provision of STI services include;

- Poor recording and reporting of STI cases

- Inadequate capacity for effective implementation of STI as part of Focused Antenatal Care (FANC) interventions
- Inadequate funding to conduct antimicrobial susceptibility studies
- Poor health seeking behaviour and self-medication practices
- Shortage of Syphilis test kits
- Insufficient funds for STI drugs
- Poor contact tracing

Strategic Outcome

The incidence of STIs in the general population and of Syphilis among pregnant women will be reduced by 50% respectively by 2022.

Priority Strategies

The place of STI management in HIV prevention needs serious review in the national response. In the HSHSP IV, the following priorities are given due weight:

1. Strengthen STI management services for PLHIV and KVP as part of the standard package of HIV prevention.
2. Strengthen Integration of STI management into HIV care and treatment and KVP programming.
3. Improve quality of STI services in RMNCAH as part of the quality improvement approach.
4. Ensure availability of medical and pharmaceutical supplies for STI treatment in all health facilities.
5. Mobilize resources to support STI management services.
6. Scale up KVP and youth-friendly STI management services
7. Strengthen M&E, research and surveillance services

4.2.5 Blood Safety

Current Situation

In 2004 national blood transfusion services were established with a decentralized network of six zonal blood banks in Dar es Salaam, Mbeya, Moshi, Mtwara, Mwanza and Tabora. Through this network, health facilities countrywide are regularly supplied with safe blood that has been screened for Transfusion Transmissible Infections (TTIs) such as HIV and other infectious disease markers based on a rigorous quality-assurance scheme. Tanzania's main strategy for blood transfusion is to obtain blood

for transfusion from voluntary non-remunerated blood donors rather than family replacement blood donors.

The efficient coordination of BTS at national level is a pre requisite for an effective and sustainable national blood screening program. Greater efficiency and safety can be achieved by bringing together key blood screening activities into a network of strategically located central and/or regional blood centres with well trained staff and appropriate equipment. Councils have started to recruit and mobilize blood donors within their districts. The donated blood is stored in the nearest available blood bank while the blood samples are transported to zonal blood bank laboratories for screening of TTIs. (WHO recommendations on the screening of donated blood for TTIs, 2010).

NBTS and CDC Tanzania conducted a survey in 2014 aimed at estimating national blood needs. Based on this survey, the annual blood demand to meet blood transfusion requests from all transfusion hospitals in the country was estimated at 300,000 units of blood.

During the HSHSP III, NBTS in collaboration with regional and district councils collected and screened 196,735 blood units using quality assurance criteria. This means the blood safety requirement was met by 66% by the end of 2016(NBTS Annual report, 2016).

Gaps and constraints that continue to affect blood transfusion safety in Tanzania Mainland include:

- Inadequate mobilization of blood from non-remunerated voluntary blood donors due to resource constraints. Some facilities have continued to use replacement donors.
- Partly arising from the above, there is limited capacity to screen all blood donated in the network of zonal blood banks amidst transportation constraints. Some zonal blood banks have extensive catchment areas.
- Lack of a proper blood sample transportation systems. Blood banks have inadequate transportation facilities as well as facilities for blood collection and storage both at blood banks and within health facilities where the blood is supplied.
- Some of transfusing facility staff do not comply with WHO standards; they are still testing blood using Rapid Test kits. As a result, approximately 34% of the collected blood units were not screened in a quality assured manner.
- Long turn-around time due to limited capacity of the machines (semi-automated ELISA machines) and limited number of staff at zonal laboratories.
- Insufficient advocacy to sustain community initiatives and lack of volunteerism at community level.
- Weak referral system and the absence of feedback mechanisms to follow up on HIV positive blood donors.

Strategic Outcomes

- By 2022, the National Blood Transfusion Services is meeting 80% the national requirements for safe blood.
- By 2022, all (100%) donated blood units (collected by NBTS and hospitals) will be screened for TTIs (HIV, HBV, HCV and Syphilis) as per the WHO quality standards.

Priority Strategies

Building from the achievements of the NTBS, the HSHS IV will work towards sustainability by increasing the allocation of local funding (public and private) to blood transfusion safety and increased focus on the mobilization of blood donors (especially among young people). The following strategies will help to ensure this:

- Strengthen advocacy and media campaigns to meet the national annual requirement of 300,000 blood units by 2022.
- Strengthen capacity (in terms of staff, transport, supplies and finances) of Zonal NBTS Centres, Regions and Local Government for recruiting blood donors and conducting blood donation campaigns to meet national requirements
- Develop innovative initiatives to increase and retain voluntary, non-remunerated, repeat blood donors. The initiatives will include community-based initiatives, public private partnerships and the establishment of youth blood donor clubs that integrate HIV prevention, life skills, sports / recreation and blood donation.
- Design an appropriate and sustainable system for transporting blood units and/or blood samples from blood collection facilities to Zonal NBTS centres and transporting safe blood from Zonal NBTS centres to transfusing facilities.
- Strengthen the capacity of zonal laboratories by installing automated machines to handle a large volume of samples and improve the turnaround time for results of screened bloods.
- Support zonal blood transfusion centres to implement robust internal quality control procedures and participate in accredited external quality assurance (EQA) programs for HIV and tests for other TTIs including syphilis and hepatitis B and C.
- Enforce and build capacity of staff at transfusing facilities on WHO and African Society for Blood Transfusion (AfSBT) standards so that they can comply with the requirements to send samples to NBTS zonal centres for screening.
- Promote linkages between blood donation and HTC services individuals who test HIV-negative are referred as potential donors, and HIV positive donors to CTCs for enrolment into ART care.

4.2.6 Reproductive Health Cancers

The burden of cervical cancer in Tanzania is high, with age-standardized incidence rate (ASR) is at 50.9 cases per 100,000 women compared to an incidence of 25.2 per 100,000 in other African countries (GLOBOCAN, 2008). One-tenth of the estimated 72,000 new cases and 56,000 cervical cancer deaths in Sub-Saharan African countries in the year 2000 occurred in Tanzania.⁹ In 2009 alone, cervical cancer patients accounted for 35.3% of all cancer patients seen at Ocean Road Cancer Institute (ORCI) (MOHSW, 2011a). Mortality rate due to cervical cancer is 37.5 per 100,000. Furthermore, 80% of patients diagnosed with cervical cancer die within 5 years of diagnosis. This low survival rate is mainly because most of the women are seen with advanced stage of disease at their first presentation and there is limited access to cervical cancer services for screening, diagnosis and treatment of precancerous lesions.

The major cause of cervical cancer is HPV sub type 16 & 18 infection and HIV infection being the risk factor for the disease. The association between HIV and invasive cervical cancer is complex with several studies now clearly demonstrating an increased risk of precancerous cervical lesions and more rapid progression to advance cervical cancer among HIV-infected women. In Tanzania women with cervical cancer are twice as likely to be HIV-infected and HIV-positive women also develop cervical cancer 10 years earlier than HIV- negative women¹⁰. The HIV prevalence rate of 6.2% among women aged 15-49¹¹ and increased risk of 4-5 times for developing cervical cancer among women living with HIV both bring significant implications for the national program and highlight the need to leverage the synergies to save the lives of women. Although about 40–90% of women in developed countries are screened for cervical cancer, less than 5% of women in developing countries undergo cervical cancer screening.^{12, 13}

In 2011, the MOHCDGEC developed a Strategic Plan and service delivery guidelines for national cervical cancer prevention and control. This led to introduction of cervical cancer screening using Visual Inspection with Acetic Acid (VIA) combined with cryotherapy and Loop Electro-surgical Excision Procedure (LEEP) as one of the strategies for cervical cancer prevention (MOHSW, 2011a). The screening has been introduced in about 250 sites in all the mainland regions; mainly at regional and

⁹Parkin DM, Pisano P, Ferlay J: Estimates of the worldwide incidence of 25 major cancers in 1990. *Int J Cancer* 1999, 80:827-841.

¹⁰Kahesa C, Mwaiselage J, Wabinga HR, Ngoma T, Kalyango JN, Karamagi C (2008). Association between invasive cancer of the cervix and HIV-1 infection in Tanzania: the need for dual screening. *BMC Public Health* 8(1):262.

¹¹Tanzania Bureau of Statistics, TACAIDS et al: Tanzania HIV and Malaria Indicators Survey (2011/12)

¹²Hakama M, Chamberlain J, Day NE, Miller AB, Prorok PC: Evaluation of screening programmes for gynaecological cancer. *Br J Cancer* 1985, 52(4):669-673

¹³Chirenje ZM, Rusakaniko S, Kirumbi L, Ngwalle EW, Makuta-Tlebere P, Kaggwa S, Mpanju-Shumbusho W, Makoe L: Current situation for cervical cancer diagnosis and treatment in east, central and southern African countries. *Bull World Health Organ* 2001, 79(2):127-132

district hospitals (RCHS, 2014). Further primary prevention of cervical cancer by using HPV vaccination has been introduced in Tanzania.

The burden of other reproductive cancers such as prostate cancer and breast cancer is not so well documented and there is a need to collect baseline information to inform and guide interventions. As part of the One Plan II implementation, the MOHCDGEC plans to scale-up training of health providers in cervical cancer prevention and management, equip the facilities to be able to offer routine screening and management for cervical cancer, increase community awareness on RH cancers in general and prevention as well as to develop guidelines and scale up prostate and breast cancer screening and care. In line with the HSHSP IV, the MOHCDGEC will introduce screening for cervical, prostate and other RH cancers in Care and Treatment Clinics for HIV and AIDS in addition; community awareness and communication will be stepped up using CHWs and CHVs to address the low knowledge about cervical cancer risk factors.

Strategic Outcomes

- Prevention of reproductive health cancers improved by 2020
- Reduction of cervical cancer mortality and morbidity in Tanzania

Priority Strategies

- Increased coverage screened for cervical cancer screening with Visual Inspection with Acetic Acid/VIA and expand to include screening of other reproductive cancers within CTCs
- Scale up of cryotherapy or LEEP programs and advanced treatment
- Raise Community awareness in particular among PLHIV and knowledge on reproductive health cancers
- Strengthen primary prevention through vaccination of girls aged 9-14 years against HPV.

4.3 Decentralized and Integrated HIV and AIDS Care, Treatment and Support Services

Introduction

Access to ART and other Care, Treatment and Support services (comprehensive HIV care) has improved the health and wellbeing of PLHIV by reducing both mortality

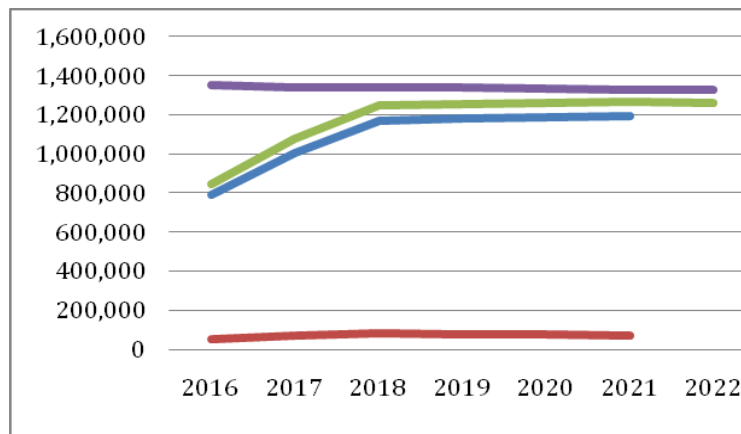


Figure 5: Projected Number of PLHIV on ART in Tanzania 2017-2021 (SPECTRIUM 2015)

and morbidity associated with HIV. The number of PLHIV accessing CTCs has continued to increase and majority will now be on ART. Figure 5 shows the projected trends of PLHIV to be placed on ART during HSHSP IV. With the adoption of “Treat All” the facilities and health systems will be faced with increased numbers of PLHIV

seeking care with different needs.

Some are clinically well as opposed to those with advanced AIDS who need more care to stabilize their conditions.

The NACP has developed the HIV and AIDS service delivery module that describes the organization of HIV and AIDS services in Tanzania. The specific roles and responsibilities of CTC staff from client registration, triage to the exit from the health facility are defined. In addition, the service delivery module illustrates the recommended differentiated service delivery models based on which PLHIV will have to be grouped in categories in order to determine the type of the service provider, frequency, type of service and place of service.

Provision of comprehensive HIV Care services is decentralized to local government councils that provided both facility and community based services. The council's health facilities (dispensaries, health centres and hospitals) are supported by public regional referral hospitals, FBO referral hospitals in the regions and zonal referral hospitals. The sections below describe the strategies for facility based services for Care and Support for PLHIV, ART services for adults, Paediatric ART Services, ART for Pregnant and Lactating Women and management of HIV co-infections & co-morbidities. Community based services are described in section 4.4.6

4.3.1 Facility Based Care and Support for PLHIV

Current situation

The number of health facilities providing HIV/AIDS CTC Services has continued to increase. In 2012, there were 1,176 out of 6,342 health facilities (18.5%) providing CTC services while by December 2016 these had increased to 6155 out of 7494 health facilities (82.1%). The review of HSHSP III and mid term review of NMSF III has shown that, care and treatment services are going fairly well in most CTCs and are offered without stigmatizing clients. Many CTCs have started using a block appointment system to manage client congestion and take into consideration the patient's convenience. The expert patients, lay counsellors and community volunteers provide invaluable support in CTC clinics in offering health education including individual testimonies. Also, in collaboration with Community based volunteers they offer home based care patient tracking in case of missed appointments and LTFU. In addition, they support to make sure that people diagnosed with HIV are linked to CTC (patient escort), retained in treatment (adherence counseling and follow up) and their viral loads suppressed (VL monitoring)

Despite the steady progress towards near universal coverage of CTC services in all health facilities, there are still major gaps and bottlenecks to be addressed in order to ensure quality care and treatment services for PLHIV. These include:

There is no routine mechanism to track individuals from HIV testing points to care services. However, a study in 4 districts in Mbeya (Sanga et al 2017) found that Only 84% of those tested were linked to care.

Strategic Outcome: 90%% of all PLHIV are enrolled into HIV care by the year 2022.

Key Strategies:

1. Strengthen mechanisms for linkage from HIV testing services to care for all HIV positive individuals
2. Strengthen HIV care entry points for HIV exposed infants, pregnant women, children, adolescents and men
3. Strengthen community level follow-up and treatment support mechanisms for PLHIV on ART (Health facilities provide back up and support to CBHCW).
4. Provide a guideline of uniform package of care to implementing partners to scale-up implementation of prevention and treatment of AIDS-related opportunistic infections
5. Strengthen integration of nutrition assessment, counselling and support in HIV care and treatment services

4.3.2 ART services for adults

Current Situation

The number of PLHIV on ART has increased over time. From 432,338 PLHIV on ART in 2012 and it is expected to reach 1,077,033 (approximately 80% of 1,339,411 total estimated PLHIV) by December 2017 and thus achieving the target for HSHSP III (2013-17) which was to have 80% of PLHIV on ART.

In harmonizing UNAIDS targets of 90-90-90, Tanzania has committed to continue with the “*Treat all*” approach which started (as “Test and Treat”) in October 2016 as a new approach towards achieving universal coverage of ART for all PLHIV. This approach is expected to increase ART coverage. The goal of this strategy is to reach and put on ART 1,261,170 PLHIV by the end of 2022 (89%) Table 1 shows the estimated number of PLHIV that need to be put of ART during the HSHSP IV and the proposed annual targets.

Table 1 Estimated number of PLHIV and proportion on ART during HSHSP IV

	PLHIV on ART			Estimated Total PLHIV	% on ART
	Adults (15+)	Children (<15)	Total		
2017	1,006,650	70,383	1,077,033	1,428,215	75%
2018	1,167,007	79,879	1,246,886	1,442,611	86%
2019	1,179,207	75,639	1,254,846	1,457,430	86%
2020	1,188,752	72,418	1,261,170	1,470,523	86%
2021	1,259,373	70,874	1,330,247	1,479,985	90%
2022	1,276,949	70,003	1,346,952	1,491,076	90%

Expansion of ART coverage is affected by with several factors including: individual factors (patient knowledge and attitudes to ART), environmental factors (stigma and discrimination), socio economic factors (transport costs, purchasing power for medicines out of stock in health facilities, education level, gender issues), structural factors (financial, logistical, human resources barriers) and clinical factors (lack of CD4 reagents, ART stock-out) (HIV Investment case 2016). With the implementation of “Treat All”, retention in ART will become a big challenge as healthier clients who have increased tendency to default will be initiated on ART.

Strategic Outcome:

By 2022, 95% of people diagnosed with HIV will be on ART

By 2022, 80% of PLHIV on ART will achieve viral suppression

Strategies:

- 1 Strengthen decentralized ART services with inclusion of community and home-based HIV treatment
- 2 Enhance early initiation into ART and adherence support services for all PLHIV with special focus on adolescents and elderly
- 3 Initiate/expand ARV refill sites in health facilities that do not provide ART services
- 4 Establish quality assurance and quality improvement activities at all HIV care and treatment sites
- 5 Strengthen adherence counselling, health education and linking clients to community groups to reduce stigma and discrimination

4.3.3 Paediatric ART Services**Current Situation**

By December 2016, the number of children >15 years Current on ART reached are 54,880 which represents 70% coverage (NACP report). The country has been implementing Tanzania Initiative for Accelerating Children on Treatment (TI-CoT). This initiative showed great success in enrolling children into ART services. The country intends to build on the successes and lesson learnt from paediatric HIV AIDS interventions including TI-CoT initiative to increase the paediatric ART coverage to 95% by 2020.

Despite noted achievements in enrolling children into ART, there are still barriers to access, active process of case detection and linkage to treatment. Capacity of health care workers to manage HIV AIDS in children is also another bottleneck in efforts to scale up paediatric ART coverage. Furthermore, handling and availability of appropriate paediatric formulations at facility level has remained a challenge. To address these gaps, the HSHSP IV will capitalize on evidence based strategies to improve paediatric services. These include, scaling up policy initiatives that create enabling environment for paediatric HIV services, community engagement, intensified HIV case identification, intensified care and treatment, improved linkage of HIV infected children to care and treatment services, improved strategic Information for paediatric HIV treatment initiation, monitoring, adherence and retention.

Opportunities to further scale up paediatric ART services is supported among others by global and national declarations to end HIV epidemic by 2030 as well as the global plan towards the elimination of new HIV infections among Children

Strategic Outcome

All children under 15 years initiated and 90% are retained on ART

Key Strategies

1. Strengthen case identification strategies to all Pediatric entry points in order to enhance early ART initiation for HIV positive children
2. Early initiation of ART to HIV positive children and strengthen adherence and retention on treatment to ensure viral suppression
3. Strengthen linkages between RCH and CTCs, or integration of paediatric ART within RCH clinics that are implementing PMTCT Option B+
4. Scale up implementation of PITC in all health facilities attending children (RCH clinics, OPD, hospital paediatric wards) and test all admitted children
5. Strengthen linkage mechanisms for facility and community based services and adherence support packages to increase retention in care and treatment services
6. Strengthen paediatric nutrition assessment, counseling and support (NACS) and treatment of severe acute malnutrition (SAM) including use of ready to use therapeutic food (RUTF, F75 & F100) for severely malnourished children

4.3.4 ART for Pregnant and Lactating Women

Current situation

With the focused efforts under eMTCT plan 2012-2015, Tanzania has achieved a 72% reduction in new paediatric HIV infections since 2009, the second highest among the priority countries. It has also achieved the Global Plan goal of 90% of pregnant women living with HIV receiving antiretroviral medicines. Even though virtual elimination of mother to child transmission could not be achieved, building blocks have been put in place which will help in accelerating progress in the coming years for achieving the goal:

- Updated guidelines and policies have been developed in key programme areas, incorporating current technical knowledge.
- Even though Option B+ was adopted one year after the Plan began, its roll out was quickly achieved with active support of all stakeholders.
- Training packages have been developed for important interventions, and pre-service training is being strengthened.
- Community level initiatives through CHWs and peer mechanisms are being strengthened.
- Monitoring formats and systems have been developed and implemented.

- The programme responded to an important emerging challenge, of retention of PWLHIV on ART, by introducing a mother-baby cohort monitoring system and initiating training for the same (it is planned for scale up).
- A data driven model for supportive supervision, coupled with on-job training and mentoring (LLAPLa Assessment and Response System/ LARS) was introduced and is being scaled up. This is an efficient use of resources targeting facilities with most need for improvement.
- Logistics systems have been integrated and online mechanisms developed.
- AIDS Trust Fund has been set up to help mobilise domestic resources and reduce dependence on donor funding.
- There is active engagement of and commitment from all stakeholders in the programme.

Despite the above achievements still a final HIV transmission after complete cessation of exposure to Breast milk among HIV exposed infants is 7.6 % (UNAIDS, 2016), clearly above the elimination target of 4% as indicated within the 2017-2020 eMTCT Strategic Plan.

Reasons for this persistent high transmission amidst very effective interventions for PMTCT is attributed to two main reasons, first; there is still a large proportion of women who initiates antenatal care late in pregnancy (third trimester) and test positive for HIV for the first time (Also represents recent HIV infections that are associated with high viral loads). Second; a high proportion of PMTCT clients drop out of care, highest drop out within the first twelve months (26%, 30% and 33% at 3, 6 and 12 months respectively). (Annual PMTCT programme report 2015). Further analysis of dropouts reveals that the highest risk is among those younger than 25 years, and those testing HIV positive for the first time (Annual PMTCT Programme Report, 2016).

These data underpin two facts; despite high coverage of PMTCT, pre-treatment preparations and adherence support are suboptimal in the context of LLAPLa implementation in Tanzania, and secondly; younger women are more at risk of late care seeking and defaulting PMTCT care.

In order to ensure improved retention into PMTCT Care and outcomes of both HIV infected Pregnant and Lactating Women together with their respective HIV-Exposed Infants, the Ministry of Health in Collaboration with PMTCT Partners, developed, piloted, evaluated and disseminated the Mother-Child Cohort Monitoring System

The next phase of the eMTCT plan for 2017-2020 extends commitment towards achieving elimination of transmission and saving new born lives. It builds upon the achievements of the earlier phase and concentrates in sustainable efforts to institutionalize the convergence of HIV/AIDS services in the health facilities. The bottlenecks identified during the review of 2012–2015 eMTCT plan, are key focus

areas of improvement and effective implementation of the programme. The success of the next phase of plan necessitates political commitment, extensive resource mobilization and convergence at all levels.

Strategic Outcomes

- Reduction of Mother to Child Transmission of HIV from an estimated 8% in 2015 to 4% at the end of breastfeeding by 2022
- Reduction of new HIV infections among child-bearing women by 50% by 2022

Key Strategies

- Expand provision of HIV services for Primary prevention among WRA and their partners, with a focus on adolescents and young women
- Expand provision of services that prevent unintended pregnancies among women living with HIV
- Expand provision of appropriate treatment; care and support to women living with HIV, and their infants and family
- Strengthen follow up of HIV infected mothers and infants at facility and community
- Increase adolescent's access to and utilization of integrated quality reproductive health services
- Implement the community interventions service package for eMTCT and Paediatric HIV care and treatment, and the community MNCH package for CHWs
- Strengthen community systems and structures to deliver the community interventions service package of eMTCT and Paediatric HIV care and treatment
- Improve community knowledge, awareness, attitudes, perceptions, behaviours and practice in eMTCT and Paediatric HIV care and treatment through communication interventions
- Increase male involvement in eMTCT services through improved awareness, reduction in stigma, and community engagement
- Increased focus towards adolescent friendly services for HIV prevention and transmission
- Develop mHealth services for increased follow up and retention
- Strengthen community involvement and enhanced participation of community structures in comprehensive eMTCT and Paediatric care and support

4.3.6 HIV co-infections & co-morbidities

Current situation

HIV infection lowers the immunity of those infected with the virus leading to opportunistic infections such as TB, Cryptococcosis and Toxoplasmosis and co-infections such as Hepatitis and Human papilloma virus which have the same mode of transmission. Moreover, even though HAART helps to prolong the lives of PLHIV,

it predisposed them to other morbidities such as diabetes and hypertension (age-related and life style conditions). It may also lead to ARV toxicities leading to dyslipidemias, lactic acidosis and renal failure. In addition, some malignancies such as Kaposi's sarcoma and lymphomas are more prevalent among HIV infected individuals. In addition, HIV infection is associated with increased psychosocial conditions including various forms of mental health (e.g. depression) and substance abuse.

All HIV clinics actively screen for active TB. In 2016 up to 88% of PLHIV were screened for TB. This is above the WHO target of screening 85% of PLHIV in care. About 1% of those in care were initiated on anti-TB therapy and 30% of health facilities were implementing IPT by December 2016. All other HIV co-infections and co-morbidities are passively managed.

There are a number of gaps and challenges in managing HIV co-infections and co-morbidities. TB case notification among PLHIV is below the expected proportions despite rigorous TB screening. The most common diagnostic method for TB is sputum microscopy which is less sensitive in HIV compared with molecular tests like Gene Expert. IPT coverage is also low (only 30% health facilities instead of the target by 2017 (100%). Moreover, only 3% of PLHIV were initiated on IPT (the target by 2017 was 50%). All other co-infections and co-morbidities are passively managed and prevention strategies were not well stipulated in the HSHSP III.

Strategic Outcome

95% PLHIV actively screened for TB by 2022

Key Strategies

1. Strengthen and improve integration of TB, HIV and other sectors such as Reproductive and Child Health at all levels to reduce the burden of HIV among TB patients and TB among PLHIV
2. Improve TB case notification among PLHIV by improving the quality of TB screening and facilitating increased use of GeneXpert MTB/RIF
3. Scale up IPT to all eligible PLHIV
4. Consolidate TB infection control measures in congregate settings
5. Increase knowledge and awareness of other HIV co-infections & co-morbidities among health care workers and community
6. Establish prevention, screening and management of other HIV co-infections & co-morbidities

4.4 Building resilient and sustainable systems for health to support the national response

Introduction

Over the years, Tanzania has made progress towards universal access to HIV and AIDS services provided through community based and health facility interventions. In health facilities these services are provided through CTCs and RCH clinics (Option B+ for pregnant women). The number of health facilities providing ART services has increased from 1,176 out of 6,342 (18%) in 2012 to 6,155 out of 7,494 (82%) by December 2016.

Strong and resilient community and health systems are needed to support a sustainable national response to HIV and AIDS. However, the approach must be holistic to respond to the multitude challenges experienced in HIV testing, prevention, treatment and care of HIV/AIDS. In strengthening health systems, HIV-related infrastructure, service delivery, logistics systems, and human resource capacities need to be inbuilt in the national program and not dealt with in isolation. While the HSHSP III took this into consideration, some of the interventions implemented in the previous strategy must be innovated in order for them to be sustained.

In this regard, the HSHSP IV will continue to support the improvement and strengthening of the health system infrastructure within the WHO health system framework which recognizes the influence of Human Resources for Health (HRH), Health Information Systems (HIS), medicines and technologies, health financing and leadership and governance, on the ability to deliver quality health services.

The strategies, outcomes and targets for building resilient and sustainable community and health systems proposed in this strategy have considered lessons learned from the review of the HSHSP III, NMSF report and plans, global strategies and broad literature consultation which pointed to a number of strengths and weaknesses with respect to the implementation of health systems strengthening in relation to HIV and AIDS.

4.4.1 Quality Improvement of HIV and AIDS services

Current situation

Currently, most QI activities are implemented as projects implemented through direct to project donor funding. The revised guideline for supportive supervision and mentoring (January 2017) summarizes the challenges in quality improvement and proposes mitigation approaches. To ensure sustainability of QI initiatives, the MOHCDEGC has instructed RHMTs, CHMTs and HFs to incorporate and budget for QI activities in their annual plans to improve coordination of QI activities and refrain

from piecemeal implementation which resulted into duplication of effort (especially supervision and reporting) in some geographical areas, while others were not reached at all. HSHSP IV will therefore adopt, and ensure alignment with, QI approaches outlined in HSSP IV.

The MOHCDGEC developed the Tanzania Quality Improvement Framework (TQIF 2011-2016) and National Health and Social Welfare Quality Improvement Strategic Plan (NHSWQISP 2013-2018) to guide improvement of the quality of service delivery. These two documents provided guidance and enabled a number of hospitals to establish Quality Improvement Teams (QITs¹⁴) and Work Improvement Teams (WITs) and run improvement cycles; however, the coverage could not reach the set targets due to different systemic reasons. The HSHSP III aimed to have 75% of hospitals and 50% of primary HFs with active QITs by June 2017. Through Site Improvement Monitoring Systems (SIMS) assessments conducted in 2016, only about 30% of HFs had active QITs while none of the RHMTs and CHMTs had active QITs.

The HSSP III also aimed at better coordination and integration of QI approaches among disease control programmes as well as the introduction of a recognition system based on QI performance. The inclusion of QI activities in the CCHP was envisioned as a way to achieve sustainable quality service delivery and the target was to achieve 3-stars and above rating in 50% of primary health facilities by 2020. However, the baseline assessment done in 2016 covering 6,650 facilities in 25 regions recorded the said rating in only 111 (2%) HFs.

Currently, QI topics are incorporated in the training curriculum for National Technical Award (NTA) Levels V & VI but the content is still influenced by specific programs (particularly Improvement Collaboration for HIV, Standard Based Management and Recognition (SBMR) for Maternal Health Services and Client Oriented Provider Efficient (COPE) for Family Planning) instead of generic improvement. To address this shortfall, during the HSSP IV, QI topics will be incorporated in all pre-service training programmes for health and social welfare workers. The challenge of inadequately functioning QITs and WITs in health facilities will be addressed through the introduction of QI Focal Persons (FPs) at regional and council levels and support towards QITs/WITs and health service provider practices through supportive supervision and On-Job-Training (OJT). This is a collaborative effort between the PORALG and MOHCDGEC aimed at ensuring improved planning and coordination of the implementation of QI activities at regional and council level. Also, since the QI reporting system was not structured, the Health Services Inspectorate and Quality Assurance section (HSIQAS) in collaboration with the HMIS plan introduced QI

¹⁴The NACP defines an active QI team as one that has finished at least one QI cycle in the quarter. The QI cycle means covering the four steps of QI Model: i.e. 1. Identify what needs to be improved 2. Analyzing what needs to be done 3. Developing hypothesis on what needs to be done 4. Implementing the change process, a) Plan b) Do c) Study d) Act.

indicators in routine data collection systems to facilitate easier access to HMIS data during supportive supervision.

The MOHCDGEC also introduced a Technical Working Group (TWG) for Quality Management to assist in the coordination of QI activities. There are no similar structures at regional and council level. HSHSP IV will support the introduction and strengthening of QI coordination at regional and council levels.

Strategic Outcome

RHMTs, CHMTs and health facilities have active quality improvement teams that oversee the implementation, documentation and reporting of quantitative data on the quality of HIV and AIDS services.

Priority strategies

- Implement patient-centred quality improvement as an integral part of HIV and AIDS service provision and general health care
- Foster coordinated efforts among implementing partners to optimize the use of resources, standardize quality standards and harness the benefits of technical support from all partners
- Strengthen monitoring and evaluation on QI systems including appointing QI focal persons at all levels with definitive roles
- Improve and harmonize reporting tools
- Capacitate QI teams in RHMTs, CHMTs and facilities
- Integrate HIV/AIDS in the RHMT/CHMT supervision tool and budget
- Develop mechanisms for QI feedback and accountability

4.4.2 Medicine and Technologies

Current situation

The Procurement and Supply Chain Management (PSCM) system for HIV commodities in Tanzania is among core functions of the MOHCDGEC implemented through the NACP. It comprises both supply chain management (product selection, demand planning, procurement, inventory management and monitoring at central level) and pharmacovigilance, and is jointly coordinated by the Pharmaceutical and Laboratory Services Unit (PLSU) at the NACP, the logistics Management Unit (LMU) in the Pharmaceutical Services Unit (PSU), Diagnostic Services Section in the Directorate of Curative Services and key partners in the HIV commodities supply chain to ensure uninterrupted supply of medicine. Product selection is done in alignment with the WHO recommendation adopted in the National Guidelines with

specifications based on the country requirements, namely; quantification to establish needs for HIV commodities; resource mobilization from development partners and government for procurement, storage and distribution; supply chain monitoring to ensure sufficient stock levels at all MSD stores, timely delivery of shipments to MSD and onward distribution to health facilities; and timely reporting of quality logistics information by health facilities and MSD.

In terms of distribution of roles, MSD is responsible for procurement, storage and distribution of health commodities while the Tanzania Food and Drug Authority (TFDA) is responsible for product evaluation, registration and monitoring to ensure quality of medicines and health commodities in the market.

During the implementation of the HSHSP III, there was improvement in the financing of HIV commodities whereby the government gradually increased domestic resources. In the 2016/2017 fiscal year, the Government allocated Tanzania Shillings 10 Billion to its health budget for the procurement of ARVs and Tanzania Shillings 5.5 Billion to the ATF, of which 55% will support the procurement and distribution of HIV commodities. However, the financing for HIV commodities is still highly donor-dependent which poses a risk to sustainability.

During the implementation of the HSHSP III, the procurement of HIV commodities (ARV and test kits) has shifted from MSD to the Pooled Procurement Mechanism (PPM) for commodities supported by the Global fund and GHSC-PSM for PEPFAR-funded HIV commodities. MSD has continued to be responsible for the procurement of medicines for OIs and laboratory commodities for HIV services, as well as storage and distribution of all HIV commodities.

Generally, there has been delayed delivery of the laboratory commodities procured through MSD due to delays in disbursement of funds and challenges associated with the global market for laboratory commodities. There have also been challenges in the distribution of HIV commodities from central level to facility level mainly due to poor infrastructure, inadequate capacity, the in-efficiency of business processes at MSD and challenges arising from the process of ordering medicines and other health commodities by health facilities.

The HSHSP III aimed at ensuring that all hospitals and health centres are using the electronic logistic data management system and great success was achieved through the rollout of the eLMIS and pharmacy module database. All logistics reports for C&T facilities are uploaded on the eLMIS which resulted in over 80% timely reporting. This made it possible to access individual facility logistics data and aggregate data by district, regional and national level. However, the number of health facilities uploading the reports directly is still low causing a heavy workload at the district level which may affect data accuracy. On the other hand, the proportion of C&T facilities using the pharmacy module database increased significantly from 8% in 2012 to about 22% in 2016. Despite these achievements, the HSHSPIV will

address challenges that hindered efforts to scale up and bridge the gap in coverage of the pharmacy module database. In addition, access to logistics data through the pharmacy module and eLMIS have greatly improved the availability of consumption and stock-in-hand data used for quantification, whereby, over 95% of C&T facility data can be accessed at national level. Data quality is still a challenge that needs to be prioritised in the HSHSPIV.

Other factors that contributed to success in improving availability of logistics data and commodities include the presence LMU personnel at the MOHCDGEC and the zonal MSD. The LMU provided supportive supervision and mentorship and assisted facilities in undertaking effective interventions to address supply chain challenges. However, due to the expanded mandate that included support towards Malaria, TB/L and Laboratory commodities and the increased number of facilities offering C&T services, there is inadequate capacity in terms of numbers of logistic personnel which needs to be addressed in HSHSPIV.

The HSHSP III targeted at reducing stock out rates of all HIV commodities at all levels of health delivery to less than 1%. Through different surveys and data collection tools it was established that less than 5% of health facilities experienced stock outs of ARVs medicines; but the situation was a bit different for HIV Test kits. Tracer medicine showed a stock out rate of less than 1% (eLMIS December 2016). There has also been a challenge with stock outs of STI and OI medicines.

In terms of reporting, the capturing of data of clients who get adverse reactions related to ARVs has faced challenges and this has resulted in the unavailability of pharmacovigilance reports to inform decision making at both TFDA and facility level. The HSHSP IV will focus on addressing data and information gathering services at service delivery points to increase data visibility at the central level and facilitate the use of data in decision making at different levels. In order to ensure sustainability, the MOHCDGEC will engage key national stakeholders to ensure a higher allocation of domestic resources for supply chain activities proposed under HSHSP IV.

Strategic Outcome

Uninterrupted supply of medicines and commodities ensured by better coordinated, monitored and managed supply chain for HIV and related commodities

Priority strategies

- Advocate for increased allocation of domestic funds in the national budget for the AIDS Trust Fund (ATF) for procurement of HIV commodities.
- Advocate for sustainable resource mobilization mechanism to ensure timely and sufficient financial resources availability for continuous supply of HIV and related commodities.

- Improve national forecasting, quantification, procurement and delivery of HIV commodities
- Integrate the eLMIS and pharmacy module to improve availability and consistency of logistics data
- Strengthen the capacity of the HCWs to manage medicines and HIV and AIDS-related commodities
- Strengthen collaboration between government and implementing partners to reduce parallel systems
- Improve MSD capacity in terms of infrastructure and transportation to ensure the timely delivery of HIV and related commodities.

4.4.3 Health Facility Commodity Management and Rational Use of Medicine

Current situation

Appropriate management of and rational use of medicine is one of the core activities being implemented at the health facility level under the guidance of the PORALG. Health facilities generate key information to facilitate informed decision making with regard to logistics for use at that level. However, there are multiple logistic management tools and electronic systems for data management that focus on disease specific programs. These include the pharmacy module, eLMIS, ILS gateway and other program and disease specific information systems. However, these systems are not linked to each other as they have different ways of capturing their sources of data. This leads to duplication of efforts and overburdening the service providers.

Challenges in storage space and human resource capacity and quantity have been a persistent issue in this important level. Rational use of medicine and adherence to the guideline recommendation has also been to the required standards; particularly in the treatment of paediatric HIV on ART leading to inaccurate quantification assumption for paediatric dosages.

In addition to the above, there are a number of gaps and challenges that inhibit the logistical function related to commodity management. The RUM assessment report shows 70% of facilities appropriately use the HIV management guideline despite the fact that none of the facilities have clinical staff trained on the rational use of ARVs; there is limited information (if any) on patients experiencing adverse reactions to ARVs; and while there are no stock outs of ARVs, due to the lengthy and cumbersome procurement process, the shelf-life of the ARVs by the time they reach health facilities is very short – sometimes only 3 months to the expiry date. There

has been a challenge with stock out of STI and OI medicines, in particular cotrimoxazole.

During the implementation of the HSHSP IV, the MOHCDGEC will work with the PORALG to ensure constant availability of all essential HIV commodities and that the necessary consumption information is collected using the various data collection systems at each respective level. Furthermore, Councils will ensure that in the CCHPs, sufficient funds from all sources (council own sources, health basket funds and other charges) are allocated for HIV commodities, logistics management and procurement of OI medicines. To ensure sustainability of all these initiatives, the NACP will collaborate with implementing partners and Councils to ensure ongoing capacity building.

Strategic Outcomes

- Commodity management and logistic information generated and used at different levels of the health delivery system to improve decision making
- Improved tracking of adverse drugs effects

Priority strategies

- Expand the scope and mandate of Health facility therapeutic committees to include HIV and AIDS related commodities
- Continue providing medical education to build the capacity of health care workers on rational use of medicines
- Strengthen supportive supervision and mentoring of health facility management and prescribers that is educational and face-to-face, on the management of HIV/AIDS according to national guidelines
- Introduce prescription audit and feedback (analyzing prescription appropriateness and then giving feedback), peer review and group processes to support prescribers to understand and correct their weaknesses

4.4.4 Laboratory services

Current situation

Laboratory services are an important integral part of HIV and AIDS prevention, care, treatment and support services as laboratory tests provide important information on an individual's HIV status, CD4 count as baseline test, clinical chemistry, and haematology and HVL which help in the detection of treatment failure and/or HIVDR

(toxicities and adverse reactions). All infants born to mothers known to be HIV positive should be offered an HIV DNA PCR test at 6 weeks as part of HEID

External Quality Assurance is mandatory for all tests that are done as part of the management of HIV clients. This will include all areas that participate on testing and monitoring of HIV and AIDS clients (RCH, VCT, Laboratory and all PITC). EQA involves checking the laboratory performance using an external agent or facility, through Proficiency Testing (PT), Re testing and on site evaluation. In addition to providing comparison among different test sites, early warning for system problems and objective evidence of testing quality, EQA helps to identify areas that need improvement and training needs. The National Health Laboratory Quality Assurance and Training Centre (NHLQATC) is responsible for conducting, coordinating and overseeing EQA at all levels for all laboratory tests including HIV testing. By June 2017, the NHLQATC has conducted 21 rounds of HIV proficiency testing (PT) using Dried Tube Samples (DTS). In the 21st round, 3,982 out of 5,264 testing sites participated in the EQA. However were unable to report results of the PT due to lack of or insufficient PT buffer (46%), absence of trained staff in the facility (14%), did not receive PT panels 18 (9%), the testing facility has been closed, lack of test kits 8(4%) and other reasons (13%). For the 3775 that responded, only 1,921 sites (51%) had correct results with a score $\geq 90\%$ (optimum expected performance is 100%). Compared with previous rounds, the HIV EQA response for round 21 was higher (76%) as compared to other previous round, however the overall performance was lower (51%) mainly due to failure to follow the National Algorithm. Hence the remaining 1,854 (49%) with scores less than 90% were targeted for supportive supervision on the job training and mentoring. Hence during HSHSP IV laboratory mentoring will be given high priority

There has been an improvement in the delivery of laboratory services in Tanzania. During implementation of the HSHSP III considerable progress was made with regards to the availability of POC technology at the primary level. Currently, 100% of health centres and 10% dispensaries have the capacity to perform laboratory POC. Moreover, 16 health laboratories provide HVL testing using conventional technology.

HIV rapid testing capacity has also been improved. According to NACP supervision reports, all (100%) health centres and dispensaries have the capacity to perform HIV rapid tests. Other tests including CD4, haematology, biochemistry, EID and HVL tests are done at zonal and regional health laboratories. The future plan is to rollout the POC for HVL at district level.

Significant progress has been made in the Strengthening of Laboratory Management Towards Accreditation (SLMTA), whereby national and all zonal hospital laboratories

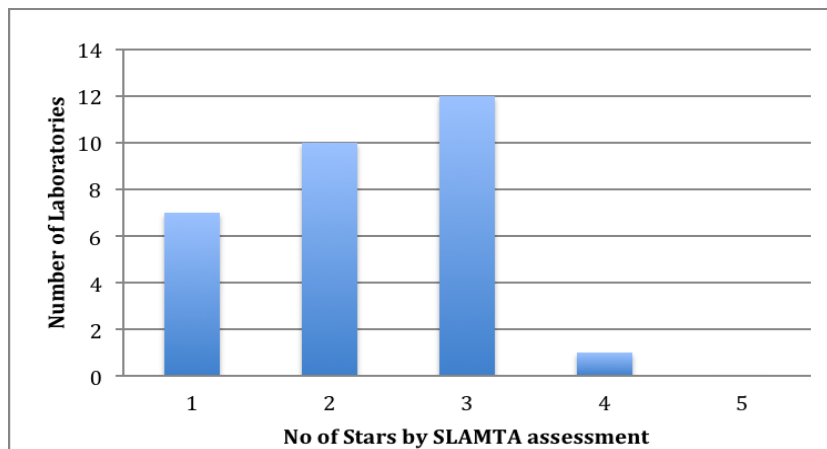


Figure 6 No. of Labs with 1-4 stars among 30 laboratories enrolled in SLAMTA

are accredited.

At the end of 2016, 24 regional and 25 district hospital laboratories were enrolled in SLAMTA and show improved star ratings (SLMTA report, December

2016). Figure 6 shows the

distribution according to number of Stars among 30 laboratories that achieved 1-4 stars in the SLAMTA assessment.

To improve HVL testing services in facilities providing care and treatment services, NACP has established hubs in 309 health facilities to facilitate the improvement of the sample transportation system, i.e. sorting, storage, transportation and feedback of results.

Despite these achievements, there still is a need to address the following gaps and challenges:

- Inefficient laboratory information system (LIS) in service delivery points
- Inefficient electronic logistics management information system leading to inadequate and/or interrupted supply of reagents
- Low coverage and uptake of HVL testing services
- Inadequate laboratory infrastructure at district and lower health facilities. Only 10% of the established HUBs are fully operational

Strategic outcome

The provision of uninterrupted quality laboratory services for HIV/AIDS clients at all levels

Priority strategies

- Expand and improve laboratory infrastructure (buildings and equipment) at district and lower health facility level

- Expand the scope of the SLMTA approach to include the strengthening of HIV laboratory assurance systems and coverage to district and lower health facilities
- Scale up HIV Viral Load testing through conventional technology and POC testing
- Strengthen the laboratory information system to address HIV related laboratory commodities management and functional status of laboratory equipment
- Strengthen the sample transportation system from facility to the hub and from the hub to HVL testing laboratories
- Strengthen data management systems to capture the number of samples managed at the hubs and monitor feedback of results

4.4.5 HealthCare Equipment Maintenance (Laboratory Equipment)

Current situation

The maintenance of HIV laboratory equipment is performed according to the Planned Preventive Maintenance (PPM) schedule because the equipment is used to test important parameters that monitor the progress of clients on ART. Efficient equipment maintenance prevents the likelihood of interrupted service provision and ensures accuracy of tests results.

Currently, laboratory equipment for HIV and AIDS services provided through NACP or implementing partners are covered by the PPM system except for CD4 machines, Point of Care (POC) equipment (PIMA machines), haematology and clinical chemistry machines. New technologies, such as self-testing equipment for HIV monitoring have evolved over time and will be adopted in new HIV strategy.

Among the challenges that hinder more efficient maintenance of laboratory equipment are the lack of a system to track laboratory equipment breakdown and inadequate resources for the carrying out of timely PPM of laboratory equipment. There have also been challenges with regard to insufficient number of Biomedical Engineers to perform equipment maintenance in zonal maintenance workshops. Moreover, the zonal maintenance workshops are not equipped with the required tools as per identified needs and training for biomedical technicians on equipment maintenance was not conducted.

Strategic Outcome

Uninterrupted HIV services as a result of timely PPM of laboratory and other health care equipment.

Priority Strategies:

- Establish a national system for monitoring the functional status of laboratory equipment and inform decision making at all levels
- Establish a pre-qualified and negotiated procurement system between government and suppliers for HVL and EID machines using the placement system or reagent rentals.
- Strengthen the health care equipment unit at the MOHCDGEC and zonal equipment maintenance workshops to facilitate PPM of laboratory equipment
- Ensure regular and timely PPM to ensure uninterrupted services at health facilities
- Ensure timely procurement and supply of reagents – including use of reagents rentals or equipment placement approaches
- Advocate for sufficient resources for laboratory PPM

4.4.6 Strategic Information for the Health sector HIV Response**Current situation**

Strategic Information (SI) is crucial for assessing progress in the implementation of various components of HIV and AIDS interventions. It is also necessary for target setting and prioritization of services to maximize coverage and ensure equity as it provides evidence to inform decisions. Key components of SI include data collection and processing, data quality improvement and control, and timely reporting. However, all these processes require sufficient numbers of human resources, training, tools, equipment and other resources. The design of SI and the extent to which the system is integrated with other components of the HMIS are important in determining whether SI for the HIV and AIDS response will be effective or not. There are a number of interventions that have recorded impressive levels of success through the use of SI. For example, the CTC2 database captures patient level data in more than 80% CTC sites. Also, efforts to link CTC2 and DHIS2 aimed at having a system that will capture aggregated data system are underway. However, the culture of valuing use of data in making informed decisions across all levels of the health system needs to be cultivated and promoted.

Other gaps and challenges that still need to be addressed with regard to SI include:

- Existence of multiple vertical recording and reporting systems
- Lack of effective use of routine health service data for planning and decision making

- Shortage of human resources for health in the majority of health facilities; service providers are overwhelmed by the multiple data collection tools that they have to fill on a regular basis. This compromises data collection and record keeping
- Inadequate utilization of data by Councils and regional level
- Insufficient funding for support supervision and mentoring, data quality assessment and procurement of equipment including computers. In some facilities, staff responsible for data-related functions are obliged to use their personal computers and modems to manage data
- Unreliable internet connection which affects the utilization of web-based data collection tools and the reporting

Strategic outcome

Strengthened routine information system for tracking HIV and AIDS services

Priority strategies

- Harmonize data management systems
- Establish mobile data management platforms for service provision points which are not permanently linked to central electronic database.
- Establish and strengthen linkage across different program components particularly HTS and care and treatment.
- Strengthen HIV Commodities reporting systems to provide timely and consistent data
- Designate and capacitate human resources for data management systems for the benefit of multiple disease programs
- Develop and use standard operating procedures for data dissemination and use

4.4.7 Monitoring, Evaluation and Research

Current situation

Monitoring and evaluation is a key function for tracking implementation progress and performance of the HIV and AIDS response. It is used to track attainment of planned program inputs, processes, outputs, outcomes and impact. Ideally, a comprehensive national M&E system should include numerous types of data collection and reporting tools and mechanisms. Currently, data collection receives greater attention than data analysis, dissemination and use. Consequently, the M&E component will need to advocate and promote data dissemination and information use at all levels of the health system. This is important because for health systems to function optimally, they need to have the right data at the right time and use at different levels as follows:

- i. Individual level – this includes patient's profile data, health-care needs and treatment requirements, which serve as the basis for clinical decision-making. Health-care records also provide the basis for sound individual clinical care.
- ii. Health facility level – this includes aggregated facility level records and administrative data such as drug procurement records, financial requirements and spending.
- iii. Population level – this includes survey and surveillance data that is essential for public health decision-making on access and use of services, priority and specific needs and other population-based aspects which inform interventions. Surveillance data is especially important when there is an epidemic.

Some of the gaps and challenges with regard to monitoring and evaluation include the need to strengthen coordination, accountability and information sharing between MOHCDGEC, NACP, TACAIDS and other partners implementing HIV/AIDS interventions to benefit from the comparative advantages of each stakeholder and ensure efficient and effective monitoring and evaluation of the national response. The review of the HSHSP III unveiled a number of governance, administrative and operational gaps that need to be addressed. These include, filling vacant M&E positions and adjusting the multiple positions at the regional, district, facility and community levels with HIV M&E responsibilities whereby the same individual has several positions/responsibilities and is not adequately trained.

A number of activities can be identified that will facilitate the execution of these strategies but for more effective accountability they need to be implemented together as Monitoring, Evaluation and Research (MER) to ensure systematic tracking of program performance. To facilitate the process of implementing MER, the HIV and AIDS information system must follow the standard guidelines governing any health information system which include; (i) data generation, (ii) compilation, (iii) analysis and synthesis, and (iv) communication and use.

Strategic outcome

A well regulated, monitored and evaluated program with up to date research relevant for HIV and AIDS that ensures improved data quality and informs program performance.

Priority strategies

- Strengthening Data Quality Assessment (DQA) at all levels
- Improve coverage of HIV databases and establish inter-databases linkages
- Conduct focused evaluations for Program improvement at all levels
- Promote research agenda so as to build evidence and disseminate strategic information for decision making and program performance improvement
- Broad dissemination of strategic information (routine data, survey and research results)

4.4.8 Community Based HIV/AIDS Care

Current situation

There is a global acknowledgement that community responses can play an effective role in addressing the HIV and AID epidemic. The Joint United Nations Programme on HIV/AIDS (UNAIDS) had projected that for any country to achieve broader HIV treatment and prevention targets, investments in community mobilization and services must be an integral part of country-specific HIV and AIDS strategic plans. The previous HSHSP III identified community responses as a “critical enabler” of service delivery.

The envisaged role linked to community based aspects include broadening the reach of services, supporting retention in care, increasing demand, monitoring quality, advancing human rights and combating stigma and discrimination. Building strong community programs will translate into louder community voices and facilitate the attainment of the HIV and AIDS service delivery targets.

Community based interventions for HIV and AIDS have continued to improve. Over the past couple of years more Councils are including Community Based HIV and AIDS Services (CBHS) in their plans and attracted more support from implementing partners for HIV-related community based interventions. The coordination of CBHS in regions and districts has improved significantly through the work of regional and district HBC coordinators.

Despite the progress made in CBHS, some of the challenges experienced in the previous strategy remain. For example, the coverage of CBHS is still low within regions/councils, there is irregular supply of HBC kits, diminishing funding is common, and there is poor linkage between CBHS and other facility-based HIV interventions including C&T, PMTCT and HTC. Moreover, there is inadequate community involvement and participation of PLHIV, poor retention of community-based HIV and AIDS services providers which impact on the sustainability of CBHS.

Strategic outcome

All councils have included CBHS programs in their comprehensive health plans and the programs are funded, monitored and evaluated.

Priority strategies

- Strengthen effective linkages and referrals between community and clinic-based services that will ensure a continuum of comprehensive and integrated services for PLHIV including children and retention in care of HIV positive individuals

- Strengthen the collaboration between CHACC, WMAC and VMAC in the provision of CBHS
- Improve the tracking system for PLHIV attending CTC

4.5 Cross-Sector HIV and AIDS Interventions and other Innovative Investments

4.5.1 Stigma, Discrimination and Gender Based Violence (GBV)

Current situation

Reduction of stigma and discrimination are core elements in the National HIV and AIDS response. The scale up of care and treatment services has enabled individuals to return to normal life and contribute to family and national income on the one hand, while partly addressing stigma associated with chronic illness and disability among PLHIV. However, there is still need for more strategic approaches in addressing HIV stigma and discrimination to improve access to health services because there is a close link between stigma and poor adherence and retention into ART care.

With regard to GBV, field experience and preliminary data show increased reporting of GBV cases including rape. Despite on-going national efforts, the 2015-16 TDHS-MIS show a decline in spousal physical and emotional violence in the 12 months preceding the survey; it declined by 6 percentage for spousal physical violence (from 33% to 27%) and by 4 percentage for spousal emotional violence (from 32% to 28%)¹⁵. Overall, 13.2% of women aged 15-19 years reported ever experiencing sexual violence⁵.

Programs to prevent GBV and violence against children (VAC) have been scaled up in Tanzania and GBV activities are implemented in close collaboration between health facilities, the police force gender desk and community leaders.

In implementing HSHSP IV the focus will be on addressing the impending legal, social and policy environment that contributes to stigma and discrimination and continuing efforts on GBV prevention.

Strategic Outcome

Proportion of PLHIV who reported experiencing stigma and discrimination from health care providers reduced from 40% to zero by 2022

¹⁵ TDHS-MIS 2015

Priority Strategies

1. Promote an enabling policy environment for HIV prevention, care and treatment for all PLHIV
2. Enhance institutional capacities to promote interventions aimed at reducing stigma and discrimination into comprehensive HIV and AIDS prevention, treatment, and care and support
3. Address stigma and discrimination among community leaders, health care providers and among PLHIV themselves
4. Enhance implementation of MER to track different forms of stigma
5. Scale up and integrate interventions that address gender inequality and GBV to facilitate safe disclosure

4.5.2 Targeted Social and Behaviour Change Communication (SBCC)

Current situation

During the HSHSP III there were noticeable SBCC efforts aimed at promoting safer sexual behaviours, reduce sexual and other forms of HIV transmission, as well as uptake and utilization of HIV prevention, care and treatment services. SBCC efforts are tailored to promote individual and public knowledge and preventive sexual behaviour, changes in social norms, and the generation of demand for HIV services.

Multiple channels of communication are used including mass media campaigns, school-based education, and community-based social mobilization. SBCC interventions are also implemented using various forms of Information Communication Technologies (ICT) such as social media and mobile phone applications including WhatsApp and text messaging. HIV/AIDS and RH programs have successfully used text messaging to influence behavior change.

Other SBCC efforts are designed to address structural factors that often constrain behaviour change, improve the uptake of HIV prevention, care and treatment services and promote the implementation of rights-based interventions and comprehensive sexuality education in schools. Youth-focused SBCC is further integrated into existing peer networks and sports programmes, using mass media for condom promotion, the uptake of HIV Testing and Counselling Services and community mobilization.

Interaction with council and regional level stakeholders revealed that most SBCC efforts are patchy, some aimed at the general population and a few targeted specific population groups. SBCC messages which have been aired through media such as '*Fataki*' (cross generational sex), '*Baki njia kuu*', '*michepuko sio dili*' (multiple concurrent partnerships) are among the famous messages widely discussed among

youth. However, there is no data on periodic monitoring system for SBCC interventions.

The HSHSP IV SBCC efforts will emphasize community mobilization specifically the involvement of parents and community leaders including faith and cultural leaders. PLHIV will also be involved in demand creation for services and promotion of adherence to treatment. In addition, SBCC interventions will focus on the prevention of GBV, elimination of stigma and discrimination and promotion of safer sexual behaviour based on local context.

In short, SBCC will play a leading role in raising awareness and appropriately communicating the “*treat all*” approach as the approach diverts from the previous messages on eligibility criteria for ART initiation.

The main gaps and challenges that still need to be addressed through SBCC programming include:

- The absence of effective M&E to systematically track and document the coverage, outcomes and impact of SBCC programs
- Low focus on comprehensive, age-appropriate, gender-sensitive sexual education that addresses prevention of HIV and GBV
- Inadequate use of ICT in SBCC

Strategic Outcomes

- The adoption of integrated SBCC programming that is designed to cohesively address more than one entity of HIV and AIDS related issues in the program
- Digitalized SBCC programming that is networked in favourable social media to increase message coverage and tracking using ICT platforms.

Priority Strategies

1. Strengthen demand creation and promotion of comprehensive services for HIV and AIDS prevention, treatment, care and support especially HTS, ART (*treat all*), VMMC and Condoms at all levels
2. Promote evidence based and targeted SBCC interventions for youth and KVP
3. Strengthen coordination of partners and sharing of best practices among implementers of SBCC
4. Promote effective parent-child communication on issues regarding HIV and reproductive health and other adolescent and youth friendly communication interventions
5. Increase the use of ICT in SBCC
6. Strengthen SBCC M&E to include comprehensive HIV and AIDS behavioural and social science operational research

7. Engage communities in addressing harmful social norms and cultural beliefs that create barriers to the uptake of HIV and AIDS services and protective behaviours

4.5.3 Health Sector Workplace Interventions

Current situation

Workplace health programmes focus on occupational health and safety of workers in the health sector and beyond. The MOHCDGEC advises on safety measures to prevent injuries and diseases and performs workplace inspections to enforce legislation. The Ministry prioritizes high-risk sectors where exposure to hazardous situations and substances is high, e.g. in the mining industry. As part of the national response towards the AIDS epidemic, prevention and control of workplace HIV, TB and Hepatitis B Virus was initiated to prevent transmission of these communicable diseases.

There is limited data on the magnitude of HIV infection among health workers measured in terms of morbidity and mortality; however, it is estimated that the rate of HIV infection among employees in the health sector is almost as high as that of the general population. For example, an anonymous screening for HIV was done in Lindi Region for 586 health workers and the HIV prevalence was found to be 13.3% (Lindi Regional Hospital Annual Report, 2009). Similar results were found in Mbeya and Bombo regional hospitals in Mbeya and Tanga regions, where the prevalence was 13 % and 12.9% respectively (TGPSH, 2004; TGPSH, 2005). Health workers are also affected or at risk of being infected with Hepatitis viruses. The prevalence of the Hepatitis B virus ranges from 5-11% to 16-50% in high-risk hospital based patients, while for Hepatitis C virus in the general community it is around 2% (Matee *et al.*, 2006). Another study by Manyere *et al.*, (2008) revealed that needle stick injuries are high (52.9%) among health workers, with the risk of infection following a needle-stick injury from infected sources estimated as 0.3% for HIV, 3% for hepatitis C and 6-30% for Hepatitis B (HPACI, 2006).

To address challenges of HIV and AIDS in the working population, the government through NMSF (2013-2017) directed sectors to develop workplace intervention programmes for HIV and AIDS. In response, the then Ministry of Health and Social Welfare (MOHSW) established a Workplace Intervention Programme for health workers to manage workplace HIV and AIDS, TB and HBV. Some of the successes of the said program include the implementation of the strategic plan for the prevention and control of workplace HIV and AIDS, TB and HBV in the health sector of 2006 – 2011 and recently, strategic plan II of 2013 – 2017.

Challenges facing the success of workplace interventions include unhealthy lifestyles among health workers, specifically lack of a work-life balance, lack of/insufficient physical exercise, and lack of a system to ensure periodic health screening of health

workers to pick occupational health-related problems early enough for an effective intervention.

Strategic outcome

- By 2022, the public (government ministries, departments and agencies) and private sectors (large private companies) have HIV Workplace policies.
- By 2022, HIV and AIDS mainstreamed into core businesses of public sector line ministries and agencies.

Priority Strategies

In implementing the HSHSP IV, the health sector will continue to play a central role in demonstrating an effective workplace intervention program while providing technical guidance to MDAs, RS and LGAs. The following priority strategies will be employed for this strategic intervention area:

1. Expand HIV workplace intervention to incorporate NCDs, access to occupational health and safety services among the health workforce, emergency responders, and economic empowerment interventions
2. Establish a routine combined HTS HIV prevention campaign in workplaces including the informal sector and hard-to-reach communities such as mining areas, fishing camps, and plantation workers
3. Strengthen access to and increase awareness of HIV prevention interventions including ART HIV test kits, Syphilis tests and workplace condom programming
4. Increase sensitization and advocacy for HIV social protection programmes (TASAF PSSN, NHIF, CHF, WCF etc.) to maximize the impact on HIV prevention among workers
5. Strengthen Infection Prevention (IP) screening, PEP services, vaccination programmes for workplace for viral Hepatitis and treatment for infected health workers according to the national guideline
6. Improve monitoring of HIV interventions at the workplace and support health workers living with HIV and other work-related diseases or injuries

4.5.4 Adolescents Girls and Young Women (AGYW)

Current situation

In Tanzania, HIV prevalence is higher among women than men (6.3 % and 3.9%, respectively). Young women and girls are particularly vulnerable to HIV due to several cultural, economic and biological factors. It has also been noted that HIV prevalence among young women aged 20-24 is higher (4.4%) than that of men (1.7%) in the same age group. AGYW are at a higher risk of HIV infection, they have limited access hence low uptake of HIV and reproductive health services compared to adults (TDHS 2015-16). The Tanzanian population is predominantly youth, with over two thirds (63%) of the total population below 24 years. Cases of new HIV infection in the general population show a consistent downward trend in recent years with a significant reduction noted among young people 15-24 years. In the last three years it went down by 18%. However, the proportion of new infections from the same age group has remained high at 30% of the overall in infections in the country (2015 UNAIDS estimates).

The behavioural, biological and structural factors that make young women and girls more vulnerable to HIV infection include but are not limited to their likely engagement in age-disparate and/or transactional relationships, limited schooling, early sex and child bearing, gender-based violence, vulnerability to frequent STIs and the amplification of the effects of transmission co-factors. The complexity of the overt and nuanced interactions of these predisposing factors underscores the crucial importance of a deliberate, objective and concerted effort to optimize access, coverage and quality of service provision for this vulnerable population. Cognizant of this fact, Tanzania has expressly prioritized investments in AGYW in national plans such as the HSHSP III, 2013 – 2017¹⁶, and The National Road Map Strategic Plan to Improve Reproductive, Maternal, New-born, Child & Adolescent Health in Tanzania (**One Plan II, 2016 - 2020**)¹⁷. Emerging experiences from programs such as DREAMS¹⁸ provide preliminary evidence of the potential to deliver appreciable health and social gains through objective targeting of program beneficiaries.

Some of the challenges and gaps in addressing AGYW population include:

- Inadequate prevention strategies focused on adolescents and young people and locations of high risk
- Age-of consent for HIV testing, (currently at 18years), affects HTS access especially for AGYW who are more vulnerable to HIV

¹⁶ www.nacp.go.tz/site/download/hshsp3final2014.pdf

¹⁷ http://www.globalfinancingfacility.org/sites/gff_new/files/documents/Tanzania_One_Plan_II.pdf

¹⁸ The DREAMS approach aims to reduce risk of HIV infection among young women through a layered approach that holistically addresses the multidimensional predisposing factors for increased vulnerability of HIV infection.

- Inadequate integration of HIV and AIDS services in school health programme interventions
- Inadequate SBCC programmes focusing on young people
- Inadequate community-based HIV and AIDS interventions targeting young people
- Inadequate focus on AGYW interventions due to lack of age disaggregated data on care and treatment services for adolescents and young people
- Few health facilities offering adolescent-youth friendly HIV services
- Lack of a standard service package for adolescents and youth living with HIV

Strategic outcomes

- By 2022, 95% of adolescents diagnosed with HIV are on ART
- By 2020, 80% of adolescents on ART achieve viral suppression
- By 2022, new HIV infections in young people reduced

Priority Strategies

1. Increase capacity of health facilities providing quality prevention, care and treatment services for adolescents and youth living with HIV and expand access to and utilization of integrated quality HIV and AIDS services by adolescents and youth
2. Strengthen linkage mechanisms for facility and community based services to increase retention in care and treatment services for adolescents and youth
3. Introduce initiatives to reach girls out of schools and domestic workers
4. Strengthen delivery of AGYW-friendly HIV and STI prevention, testing, care, and treatment and FP services
5. Strengthen the provision of comprehensive sexuality education at community and school levels and support girls with essential package to keep them in school and ensure a safe environment (boarding/hostels, uniforms, pads, etc.)
6. Support peer education activities on behaviour change and address structural barriers among vulnerable AGYW
7. Promote an enabling supportive policy and legal environment for the provision of adolescent and youth friendly HIV and SRH services and prevent GBV
8. Strengthen effectiveness and coverage of girl-centred combination HIV prevention approaches such as cash transfer / socioeconomic strengthening,

SRH education, safe spaces, etc. to maximize the impact of HIV prevention among vulnerable AGYW

9. Strengthen operational research and M&E systems for adolescent and youth HIV and AIDS services

4.5.5 Male Involvement

Current situation

In the past, family planning and reproductive health were often portrayed as the responsibility of women alone and the respective services were typically provided through maternal and child health clinics. Similarly, providers did not include spouses/partners when serving female clients especially when they presented with problems relating to reproductive health. Male involvement is now considered a best practice in reproductive and child health and specifically in HIV prevention, care and support interventions, following evidence of a stronger impact on the outcomes where men have been involved and empowered to make informed decisions. Experience in implementing family planning and reproductive health interventions has shown that men play a critical role in decisions that determine a woman's ability to seek health care, yet, more often than not, they are uninformed about women's reproductive health needs as well as their own needs.

In many areas of the country, efforts to engage men in health programs to overcome gender inequities and improve the health of men and women and their children are showing success. Strategies such as the re-branding of maternal and child clinics to reproductive and child health and inviting male partners of pregnant women to receive couple's counselling and testing have been employed, accepted and have shown a positive impact.

In the HSHSP IV, more emphasis has been placed on the shared responsibility of men in promoting responsible parenthood, and improving their sexual and reproductive behaviour by actively involving them in the said programs and providing them with information about the different services available. This is because male involvement in reproductive health interventions has wide and far reaching positive outcomes for their health status as well as for their behaviours that affect women's reproductive health. Male involvement in family planning, particularly their role in decision making is critically important as it affects family planning (when to have children and family size); STI prevention including HIV which can be addressed through increased condom use, reduction in sexual partners, STI treatment and voluntary medical male circumcision; and gender-based violence with its subsequent complications including miscarriage and the inability to use contraceptives out of fear

or accusations of infidelity. All these can have a direct positive impact on the sexual and reproductive health of women.

Strategic outcome

Improved male involvement in HIV prevention, care, treatment and support for their own health and the health of their partners and families.

Priority strategies

1. Consolidate lessons and best practices on male involvement to support the design of a national SOP on male involvement in sexual, reproductive, maternal and child health
2. Expand workplace programmes that sensitize men to participate in sexual, reproductive, maternal and child health for better health outcomes of their families
3. Introduce services for men, such as screening for prostatic cancer or non-communicable diseases (NCDs) in reproductive and child health services, especially for spouses of PMTCT clients
4. Engage male community leaders to address the needs and role of men in sexual, reproductive, maternal and child health services both as peer motivators and influencers
5. Increase the number of services that encourage male participation in sexual, reproductive, maternal and child health services, such as, joint clinics that will cater for both men's and women's needs. For example, partners/spouses of women receiving PMTCT services to receive their ARVs at the PMTCT site until their partner/spouse graduates then they will continue at the CTC together. This will enhance compliance.

4.5.6 Gender Based Violence

Current situation

Gender based violence or threat of violence can increase women and girls' vulnerability to HIV by making it difficult or impossible to set the terms for an equal relationship. In such circumstances, it becomes more difficult for women to refuse sex when in a relationship, to encourage their partners to be faithful, or to use a condom. Violence can also be a barrier in accessing HIV prevention, care, and treatment services. The linkage between sexual violence and HIV, especially among young women is well documented. Violence against women is associated with an increased risk of acquiring STIs, a risk factor for HIV.

Most cases of Sexual and GBV (rape, statutory rape, and sexual assault) go unreported. Hence the first step in addressing GBV is to provide a conducive environment for victims to report without fear of reprisal and repeated violence by the perpetrators. In this regard, GBV prevention is a collaborative endeavour, in

implementing the HSHSP IV, successes and lessons of the multi-sectoral approach for GBV prevention will be taken to scale.

Strategic outcome

- Reduce HIV associated sexual and gender based violence
- Mitigate effects of GBV on survivors especially women and young people

Priority Strategies

- Scale up one-stop centres for joint and collaborative interventions by the police force, communities and health facilities
- Build capacity of CSOs implementing GBV interventions in most affected regions on the identification and reporting of GBV survivors particularly among young people

4.5.7 Pre-exposure prophylaxis and Self-testing

Current Situation

Pre-exposure prophylaxis (PrEP): PreP is the use of an antiretroviral medication to prevent the acquisition of HIV infection by uninfected persons. PrEP may either be taken orally, using an antiretroviral drug available for treatment of HIV infection (tenofovir plus emtricitabine), or topically as a vaginal gel containing tenofovir. Randomized control trials have shown that the efficacy of oral PrEP is high when the drug is used as directed. Daily PrEP reduces the risk of getting HIV from sex by more than 90%. Also, PreP reduces the risk of HIV by over 70% among people who inject drugs. On the other hand, the efficacy of vaginal gel has been shown to be moderate. There is no wide experience of PreP outside the clinical trial setting. WHO 2015 guidance recommends that people at substantial risk of HIV infection should be offered PrEP as an additional prevention choice, as part of comprehensive prevention that involves condom use and other prevention method

HIV Self testing: As noted earlier, a considerable number of PLHIVs are unaware of their status. In order to benefit from the availability of highly active ART, simpler regimens that reduce the risk of HIV transmission and “treat all” strategy, it is important that all PLHIVs should be quickly diagnosed, counseled and offered treatment so that the second and third 90 targets are achieved. One of the strategies to increase the uptake of HTS is to extend HIV testing beyond health facilities and community based initiatives by the introduction of HIV self testing. Against this background WHO has recently issued a policy brief and guideline on HIV self-testing. These documents provide an insight on how countries can adapt their policies and guide clients who may seek HIV self-testing services.

However, in order to have much impact, Self HIV testing should be more focused to high risk groups such as CSW, MSM, fishermen and mining communities. Whether self-tests result in an overall increase in HIV testing in Tanzania would have to be monitored, but results from studies in other African countries^{19,20, 21} are encouraging. Along with probable increase in overall uptake, self-testing would enhance patients' choice. People would have more say over where, how, and when they would be tested for HIV. This promotion of patient autonomy is central to the case for self-testing.

On the other hand, there is skepticism on HIV self-test, the most common one being that the person would not receive face-to-face counselling before or after the test. Although such counselling can be beneficial, for some people a requirement for pre-test face-to-face counselling can actually deter some of the potential clients from being tested. One way to circumvent the absence of pre-test counselling is to enable the client to make an informed decision through provision of pre-test information that will prepare him or her for the test including steps taken to carry out the test, results interpretation and next steps in case of reactive or non-reactive results. The pre-test information can be provided in form of mobile telephony that in Tanzania has 80% penetration.

The other serious concern is lack of counselling after a self-test. Many health professionals have argued that people receiving a reactive HIV test result on their own would suffer greater distress and anxiety than those receiving their results in a health-care setting. However, this concern is addressed by the pre-test information as above.

Besides, the client with reactive test result will need to undergo a repeat testing at a health care setting where face to face counselling would also be available. Information directing people to the relevant health care services and support in their area would have to be available with every test.

Priority Strategies

- Self-testing and PreP demonstration studies:

Under HSHSP IV, demonstration studies will be conducted to determine the operational and implementation strategies required to roll out these interventions among different populations in Tanzania.

¹⁹Choko AT, MacPherson P, Webb EL, Willey BA, Feasy H, Sambakunsi R, et al. Uptake, accuracy, safety, and linkage into care over two years of promoting annual self-testing for HIV in Blantyre, Malawi: a community-based prospective study. *PLoS Med.* 2015;12(9):e1001873

²⁰Zanolini A, Chipungu J, Mafwenko M, Holmes C, Thirumurthy H. Acceptability and preferences for HIV self-testing in Zambia: a population-based formative study using a discrete choice experiment. Presented at: 21st International AIDS Conference; 18-22 July; Durban, South Africa; 2016.

²¹Kalibala S, Tun W, Cherutich P, Nanga A, Oweya E, Oluochet P. Factors associated with acceptability of HIV self-testing among health care workers in Kenya. *AIDS Behav.* 2014; 18_(Suppl. 4):S405 –S14.)

During the implementation of HSHSP IV Tanzania will conduct demonstration studies to inform the introduction of ethical, effective, acceptable and evidence-based approaches to HIV self-testing as a formal HTS intervention. These studies will use quality-assured products that are approved by WHO, TFDA and other international regulatory bodies.

In addition, proof of concept studies involving the provision of Pre-Exposure prophylaxis (PreP) for discordant couples who wish to conceive and MSM populations from two regions (Dar es Salaam and Tanga).

These interventions will be closely monitored and supervised to collect lessons and strategies that will inform the national guidelines before national roll out.

- Legal and policy framework

Based on the results of the self testing studies, HSHSP IV will support the development of legal and policy framework for the implementation and scale-up of HIV self testing services. HSHSP IV will then guide the integration of HIV self testing in both community-based and facility-based HTS approaches and be tailored to specific population groups. It is expected HIV self testing and assisted HIV partner notification services as HTS approaches that will contribute to closing the testing gap and achieving the UN's 90 –90 –90 and 2030 global goals.

5. Implementing the Strategy and Getting Results

5.1 Governance

Tanzania has a decentralized system of government with three levels of governance structures at national, regional and local government level, to oversee the implementation of the health sector HIV and AIDS strategy.

The national level is responsible for policy, legal and regulatory oversight, inter government agency coordination, and resource mobilisation, allocation and management and the regional level is responsible for capacity building, quality assurance and the coordination of local government structures. Local level authorities are from the community, village, ward and council (district) levels and are responsible for the implementation of the HSHSP IV and other strategies in the health, community development and other social services sectors.

5.1.1 National level Governance Structures

a) *The Prime Minister's Office*

The Prime Minister's Office (PMO) plays a pivotal role in the national response to HIV and AIDS through the Inter-Ministerial Technical Committee (IMTC) on HIV and AIDS and the Tanzania Commission for AIDS (TACAIDS). It is responsible for coordinating MDAs' response to HIV, a function performed through the Inter-Ministerial Technical Committee on HIV and AIDS. The PMO also provides oversight, guidance and financial support to TACAIDS.

(ii) *Inter-Ministerial Technical Committee on HIV and AIDS*

The IMTC on HIV and AIDS coordinates the response to HIV by MDAs. It is chaired by the Permanent Secretary PMO and involves permanent secretaries from all sector ministries involved in the response.

(iii) *The Tanzania Commission for AIDS (TACAIDS)*

The Tanzania Commission for AIDS is a Presidential Commission established by the Act of Parliament No. 22 of 2001. It is mandated to coordinate the national response to HIV and AIDS. It is also responsible for the development, review and coordination of the implementation of the National HIV and AIDS Policy, by translating it into a National Multisectoral HIV and AIDS Framework that guides all stakeholders involved in the national response, including the MOHCDGEC. Other mandates include:

- Developing a strategic framework for planning all HIV and AIDS control programmes and activities within the overall national strategy

- Fostering national and international linkages among all stakeholders through proper coordination of all HIV and AIDS control programmes and activities within the overall national strategy
- Mobilising, allocating and monitoring resources for HIV and AIDS and ensuring their equitable distribution

(b) Ministry of Finance and Planning (MOFP)

The MOFP is responsible for ensuring availability of financial resources for implementing HSHSP IV. This includes both domestic and external resources. A significant amount of external resources to support HIV and AIDS, Malaria and TB programmes is provided by the GFATM, Presidents emergency Plan for AIDS Relief PEPFAR, UN System, bilateral development partners and internal NGOs and private Foundations. Health basket Partners provide critical financial resource to support health system strengthening and service delivery at council level. While not specifically directed towards HIV and AIDS, HBF provides the base where the HIV services at facility and community level are implemented.

In relation to GF resources, the MOFP currently houses the secretariat of The Tanzania National Coordinating Mechanism (TNCM) that was formerly under the PMO. TNCM is a governance mechanism established according to the GFATM guidelines and it is mandated to provide oversight to Global Fund resource mobilization through proposal writing, grant implementation and reporting. The TNCM secretariat which ensures the smooth functioning of TNCM is led by the TNCM Secretary who reports to the Permanent Secretary, Ministry of Finance and Planning.

(c) Ministry of Health, Community Development, Gender, Elderly and Children

The MOHCDGEC is mandated to formulate health and social welfare policies as well as monitor and evaluate their implementation. It also ensures that all Tanzanians access quality health and social welfare services. With regard to HIV and AIDS, the Ministry of Health leads the health sector response to HIV and AIDS. It houses the NACP which is responsible for providing technical leadership and coordination of the health sector response and managing resources for implementing HIV prevention, HIV and AIDS care and Treatment and supportive crosscutting and health system interventions in the health sector. The governance structures under the MOHCDGEC include:

(i) The Senior Management Team (SMT)

The SMT is chaired by the Permanent Secretary. Other members of the SMT include the Chief Medical Officer (CMO), all directors MDAs and units under the MOHCDGEC. The SMT is responsible for oversight and management guidance to all

health programmes and activities. All plans (including strategic plans) and budgets are approved by the SMT.

(ii) The Sector Wide Planning Approach (SWAp) Technical Committee (TC-SWAp)

The MOHCDGEC has established a dialogue structure to guide the SWAp for the health sector. The SWAp provides an opportunity for the participation of all key stakeholders including development partners and civil society in health sector reforms and interventions. At the top of the dialogue structure is the Joint Annual Health Sector Review (JAHSR) which brings together all key stakeholders once a year to review progress made in the health sector and set/approve priorities for the next year. It is an important tool for resource mobilisation and accountability. In between the JAHSR, there is the SWAp committee and Health Basket Financing Committees that bring together the top Ministry leadership and all partners who have signed SWAp or basket funding agreements with the Government. The *Swap Technical Committee (TC-SWAp)* which is under the chairmanship of the PS-MOHCDGEC and PS-PORALG provides governance support to the SMT and provides a structure for coordination between PORALG, MOFP and MOHCDGEC

(d) President's Office, Regional Administration and Local Government

The mandate of the President's Office, Regional Administration and Local Government (PORALG), is to develop and oversee the implementation of policies for Decentralisation by Devolution (D-by-D), regional and local government administration, and rural and urban development. PORALG's mission is to create an enabling environment to facilitate Regional Secretariats (RS) and Local Government Authorities (LGA) to provide quality services to the community, using the developed policies, legislations, guidelines and standards as a reference point. PORALG also coordinates the critical interfaces between central and sector Ministries, Departments and Agencies (MDA), Non-State Actors (NSA), and RS and LGA.

With regard to Health including the health sector HIV and AIDS Response, PORALG provides support, guidance, coordination, and administration to facilitate equity in the distribution and provision of health services and sector development within RS and LGA. Through the Health, Social Welfare and Nutrition Division, PORALG participates in sector dialogue structures for the health sector and the national multi-sectoral HIV response (see PMO and MOHCDGEC above). It also provides management oversight for governance structures at regional and council level.

5.1.2 Governance bodies at the regional level

Regional Consultative Committee

The Regional Consultative Committee (RCC) is the highest governance body at the regional level. It is chaired by the Regional Commissioner and the Regional Administrative serves as Secretary. It is composed of all departmental heads at the regional level.

The functions of the RCC are to:

- Convene and coordinate stakeholder meetings on HIV prevention, care, treatment and support services
- Provide leadership and guidance for the dissemination of policies, guidelines, standards and regulations in HIV prevention care, treatment and support services to respective councils
- Conduct advocacy to regional and district heads and decision makers on HIV prevention, care, treatment and support services

In addition, the RCC is responsible for:

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

In as far as HIV and AIDS is concerned, the Regional Multi-sectoral AIDS Focal Person who is employed by the Regional Secretariat is a member of the RCC and represents all issues regarding HIV and AIDS (NMSF III and HSHSP III). The regional TACAIDS Coordinator and the RACC provide inputs with regard to multi-sectoral and health sector HIV and AIDS interventions. Sometimes, but not always, the RACC and the regional TACAIDS coordinator may be invited to the RCC.

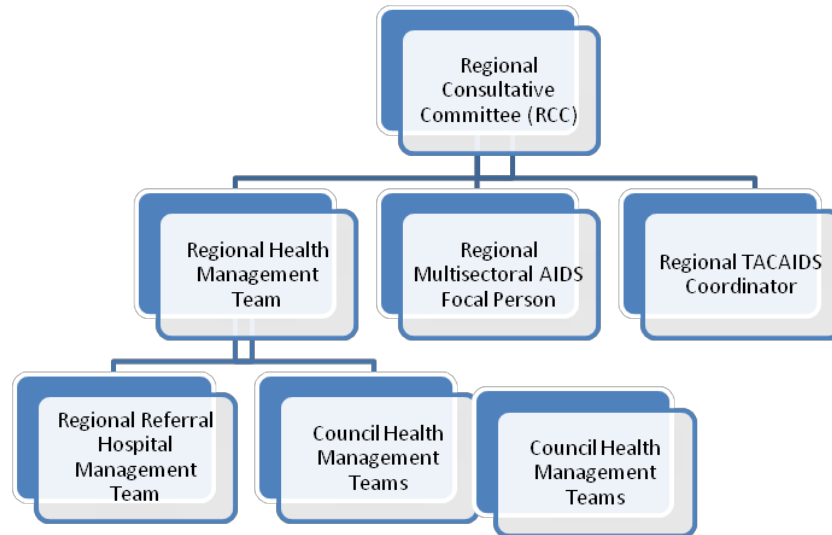


Fig 6: Regional level governance structure

c) Governance structure at local government authority level

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

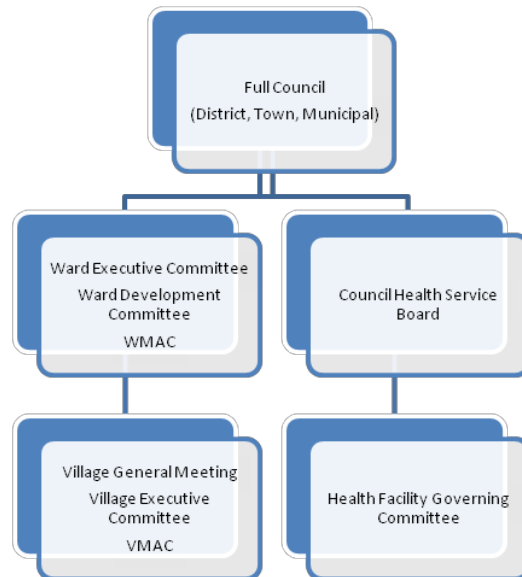


Fig 7: Local government governance structure

5.2 Programme Management and Linkages at regional and Local Government level

a) The National AIDS Control Programme

i. Organisation Structure of NACP

The organisation structure of NACP was revised to ensure effective implementation of the HSHSP III. The review took into consideration key functions to be undertaken, job analysis and a performance assessment of all key positions in management and technical leadership of the health sector response. The same organisation structure will be used in the implementation of the HSSP IV.

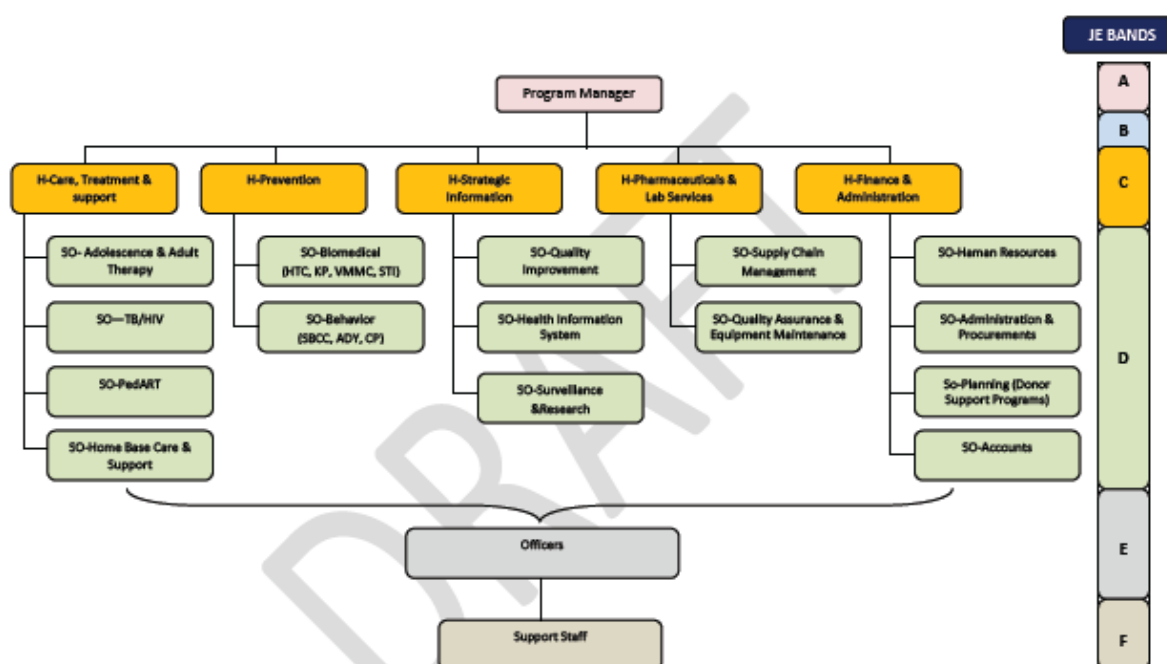


Figure 8: NACP Organisation Structure

ii. Regional level

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

iii. Council level

The CHMT is responsible for Health sector HIV and AIDS activities at the council and community level. There are two coordination points; the District HIV/AIDS Control Coordinator (DACC) and the Council HIV/AIDS Control Coordinator (CHACC). The DACC who oversees the health sector response

as the focal point for CHMT HIV and AIDS activities works closely with the CHACC who is responsible for the multi-sectoral activities. The CHAC is the secretary of the Council Multi-sectoral AIDS Committee (CMAC). The Council Social Welfare Officer (SWO) falls under the health sector, however, the SWO, works in collaboration with the DACC and the CHACC to support community based interventions and PLHIV groups. These council level structures will need to be revised to take into consideration the new structure of the health sector where health, community development, gender and services for the elderly and children fall under one ministry.

5.3 Partnerships: Collaboration, Dialogue and Coordination

In order to foster integration within the health sector, coordination of the HSHSP IV will continue to be entrusted to existing structures within the SWAp dialogue structure agreed upon by the Government, development partners and non-state actors. The NACP will actively participate in the disease specific programmes Technical Working Group (TWG-7) and in the M&E TWG both reporting to the TC-SWAp and heighten its participation in the TACAIDS TWGs and Joint Thematic Working Group (JTWG).

During HSHSP II, NACP established a National Advisory Committee for Care and Treatment (NACCT) to guide implementation of the National Care and Treatment Plan (NCTP). This committee was chaired by the Chief Medical Officer (CMO). The NACCT had sub-committees for Clinical Care, Laboratories, Information, Education and Communication, Training, Pharmacy and Drug Procurement, PMTCT, VCT, Social Support, and Monitoring and Evaluation. During the development of HSHSP III, it was proposed that the NACCT be transformed into a National HIV/AIDS Steering Committee to oversee all HIV and AIDS services. Unfortunately, this was not implemented and both the NACCT and its sub-committees did not meet in the entire period of the HSHSP III implementation. This has led to gaps in the response, such as weak follow up on annual operational plans and lack of periodic update reports on the health sector HIV response. With the ongoing discussions to harmonise the roles of TACAIDS and NACP, and the new structure of PORALG that has a new Health Department, the need for a stronger mechanism to ensure effective partnerships: collaboration, dialogue and coordination is critical.

In order to effectively oversee the implementation of the HSHSP IV, a National HIV/AIDS Coordination Committee (NHACC) will be established to play a stewardship role and provide leadership and technical guidance. This committee will be chaired by the CMO and the Director of Preventive Services or Programme Manager, NACP will serve as Secretary. Members will be drawn from MOHCDEG Directorates, the PMORALG Health Department, TACAIDS, Development Partners, the UN family, PLHIV groups, NGOs, CSOs and chairpersons of NACP sub-committees.

To ensure diversity of technical expertise in the NHACC, the following six sub-committees will be established:

- a. Prevention
- b. Paediatric ART and eMTCT
- c. Treatment, Care and Support
- d. Community HIV Response
- e. Medicines and Technology (Procurement and Logistics)
- f. MER

5.4 Financing the Strategy in a decentralized system

5.4.1 Government sources

Government funding for the HIV response is allocated through the MTEFs of MOHCDGEC and PORALG. Funding for implementation by local government councils is allocated through CCHPs funded with resources from central government, local government own sources and contributions of Development Partners into the Health Basket Fund (HBF) or as direct project support. The source of government funding is from taxes, World Bank credit and General Budget Support (GBS)²². The MOFP releases budget guidelines towards the end of November or early December with budget ceilings for each sector. These guidelines depend of Government priorities (central and sectoral). Priorities in the health sector and HIV and AIDS sector are also highlighted in the five year development plan. The MOHCDGEC has finalised the Health Sector Financing strategy (HFS) that is awaiting approval at the Cabinet level. The HFS outlines strategies for mobilising domestic resources for the health sector that will also impact the HSHSP IV.

Although HBF are not earmarked, they are available to support health system strengthening which also benefits HIV interventions such as diagnostic services, RCHS, M&E and HRH. The NACP will continue to engage with all MOHCDGEC sections, units and programmes to ensure that health system interventions that support HIV and AIDS services are fully covered in MTEF and CCHP plans supported by HBF.

5.4.2 Global initiatives

The Global Fund and PEPFAR are major global initiatives available for HIV and AIDS interventions. PEPFAR funds are channelled through a separate mechanism (outside GBS and HBF). PEPFAR channels its funds through a National Partnership Framework coordinated by TACAIDS which was guided by the PEPFAR blue print. Currently, PEPFAR 3.0 has been aligned to the 0-90-90 goals. Most of the PEPFAR

²²These monies come from contributions from Development Partners who prefer to provide general budget support rather than fund individual programmes. There has been a decreasing trend of partners and amounts provided through GBS

funds are channelled through implementing partners (international and local). The increasing tendency to use local partners initiated under HSHSP III appears to be reversing. The NACP will engage with USG Agencies (USAID, CDC, DOD and Peace Corps) and their implementing partners to ensure that proposals submitted for PEPFAR funding are in line with the HSHSP IV. Funding from the Global Fund for AIDS, TB and Malaria (GFATM) on the other hand is coordinated by TNCM. There is a new funding model for Global Fund Rounds which is based on the national strategies. The Funding request application for Global Fund allocation for 2018-2020 was made in line with the HSHSP still under development. A strategic guidance document was prepared and submitted to GF in place of the HSHSP IV. It elaborated the vision, goals, indicators and targets that are in line with HSHSP IV. Other sources of funding will be self-generated revenues from local government councils and community initiatives. Opportunities to tap into these sources will be identified by CHMTs and RHMTs.

5.4.3 Public Private Partnerships

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

5.4.4 AIDS Trust Fund (ATF)

Finally, the Tanzania Government has established the AIDS Trust Fund (ATF) which will be resourced through an annual government allocation and contributions from development partners (domestic and external). The ATF is managed through a board of trustees and a secretariat. Funding priorities for the ATF are in line with the NMSF III and HSHSP IV.

5.5 Monitoring, Evaluation and Research

As stated earlier, quality data is crucial to guide implementation and decision making. The HSHSP IV builds on existing or planned infrastructure for data management systems from the site and LGA level up to the national level. The importance of an effective monitoring, evaluation and research system for reporting on and guiding the national response to HIV and AIDS cannot be overemphasized. However, the existence of parallel systems for data capture and monitoring should be strictly avoided during the implementation of HSHSP IV.

The section that follows outlines the national M&E system for the health sector HIV/AIDS response, based on the selected indicators, set targets, and expected results. In HSHSP IV, the M&E system will be strengthened to be able to timely measure progress towards attainment of the HSHSP IV objectives.

5.5.1 Impact and Outcome Indicators

Both impact and outcome indicators measure the extent to which the programme has achieved its objectives. Explicitly, impact indicators relate to programme objectives, whereas outcome indicators relate to the programme goal. Table 2, highlights a few selected impact and outcome indicators for the HSHSP IV.

Table 2: Impact and Outcome indicators for HSHSP IV 2018-2022

Indicator Description	Baseline		Mid Term Targets		End Term Targets		
	%	Year	Target %	Year	Target %	Year	
Impact Indicators							
Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	1.9%	2016	1.45%	2020	1.30%	2022	
Percentage of young people aged 15–24 years who are living with HIV	12%	2016	TBD		TBD		
Number of AIDS-related deaths per 100,000 population	49.1	2016	24.14	2020	23.16	2022	
Outcome Indicators							
Percentage of adults and children with HIV, known to be on treatment 12 months after initiation of antiretroviral therapy	Adults 76% Children 80%	2016	Adults 90% Children 90%	2020	Adults 90% Children 90%	2022	
Percentage of HIV-infected pregnant women receiving ARVs to reduce the risk of PMTCT	TBD	2016	90%	2020	95%	2022	
Percentage of people living with HIV and on ART who are virologically suppressed (among all those currently on treatment who received a VL measurement regardless of when they started ART)	78%	2016	90%	2020	90%	2022	
Percentage of sex workers reporting the use of a condom with their most recent client	TBD	2016	85%	2020	90%	2022	

5.5.2 Coverage Indicators

The success of interventions proposed for the HSHSP IV will be measured through selected coverage indicators as presented in Table 3 which contains a list for key coverage indicators to monitor the implementation of each strategic area at all levels.

Table 3: Coverage Indicators for HSHSP IV 2018-2022

Indicator Description by Strategic Area	Baseline		Mid Term Targets		End Term Targets		Assumptions
	%	Year	%	Year	%	Year	
HIV Testing Services Number of people who were tested for HIV and received their results during the reporting period	33.1%	2016	42.0%	2020	50%	2022	In 2016 about 7400,000 people were tested. From that number the increment rate of 14% was the annual target for the first year of the plan. The increment rate in the next consecutive years will vary based on similar assumption. Thereafter, the 5% increment rate was applied towards 2020 to be able to test 42% of the target population in 2020. These increments were calculated to meet HSHSP IV goal of: 90% men and women (average of 90%) aged 15-49 years know their HIV status by 2020; The denominators are the projected populations as per Tanzania National Bureau of Statistics
PMTCT Percentage of pregnant women who know their HIV status	91.4%	2016	100.0%	2020	100%	2022	In order to achieve the UNAIDS goals of eliminating mother to child transmission (MTCT) and epidemic control in Tanzania, ambitious PMTCT targets were set with the goal of reaching 100% of pregnant women with HTS and initiate all 100% of HIV-positive women on ART.
PMTCT Percentage of HIV-positive pregnant women who received ART during pregnancy	73.2%	2016	100.0%	2020	100%	2022	In order to achieve the UNAIDS goals of eliminating mother to child transmission (MTCT) and epidemic control in Tanzania, ambitious PMTCT targets were set with the goal of reaching 100% of pregnant women with HTS and initiate all 100% of HIV-positive women on ART.
PMTCT Percentage of HIV-exposed infants receiving a virological test for HIV within 2 months of birth	55.2%	2016	84.3%	2020	90%	2022	The goal for EID is to reach 95% of HIV-exposed infants with HIV testing by the age of 12 months. At least 84.3% of infants born to HIV-positive mothers should receive EID testing by 2 months of age. The emphasis is to increase VL suppression rates to achieve at least 90% suppression rate in all PLHIV on treatment
Adolescents and Youth Number of adolescent girls and young women (AGYW) who were tested for HIV and received their results during the reporting period	58.6%	2016	79.1%	2020	90%	2022	Number of facilities has been identified based upon a core set of criteria which included existing adolescent utilization data, the availability of comprehensive set of a range of relevant health services including (HIV, FP & GBV) and the presence of ACT to ensure the ease of the transition of HIV+ adolescents into care. Much emphasis will put on testing all adolescents that access health care in this facilities and the rest

Indicator Description by Strategic Area	Baseline		Mid Term Targets		End Term Targets		Assumptions
	%	Year	%	Year	%	Year	
HIV Prevention Number of medical male circumcisions performed according to national standards/year	800.000	2016	800.000	2020			
TB/HIV Percentage of people living with HIV in care (including PMTCT) who are screened for TB in HIV care or treatment settings	87.6%	2016	95.0%	2020	100%	2022	All clients who receive HIV care are to be screened for TB. In 2016, 87.6% of people living with HIV were screened for TB. Knowing the importance of TB Screening, MOH will increase emphasis in TB Screening indicator monitoring in supportive supervision, trainings and data quality assessment
Treatment, Care and Support Percentage of people living with HIV currently receiving antiretroviral therapy	65.6%	2016	94.7%	2020	95%	2022	MOHCDEC aims to enroll 360,030 new patients on treatment with the goal of supporting 1,245,251 patients on ART by 2020. This represents an increase in national coverage to nearly 94.7% and contributes to the 95% adult and 90% children ART coverage targets by 2020 in the HSHSP IV. Based on these targets, the prioritized Scale-Up to Saturation Councils should reach 80% coverage of PLHIV by APR 2018. To reach these targets, MOH employed a cascade approach to setting HIV testing targets and considered several critical program streams to most efficiently identify HIV-positive individuals and effectively link them to care and treatment
HMIS and M&E Proportion of facility reports received over the reports expected during the reporting period	89.2%	2016	98.0%	2020	100%	2022	The aim is to make sure all facilities reports on time. Currently 89.2% reports were received by the end of 2016. Improve scale up of the use of CTC2 databases and directly uploading
HMIS and M&E Proportion of facilities with similar reported counts between three HMIS tools (register, tally sheet and summary form) and DHIS2	40%	2016	65.0%	2020	80%	2022	This is a newly introduced indicator for quality of HMIS data conducted by the Internal Auditor Genera as part of an annual independent verification of data between DHIS2 database, summary forms and source documents. The indicator is also used for Health Basket Funds
Percentage of men who have sex with men reached with HIV prevention programs	28%	2016	65%	2020	80%	2022	Data on size estimation (the denominator) was obtained from a consensus meeting held in 2014. Delf method was used. 2016 coverage data (the numerator) are from Programs implementing KVP programs.
Percentage of sex workers reached with HIV prevention programs	69%	2016	80%	2020	90%	2022	Data on size estimation (the denominator) was obtained from a consensus meeting held in 2014. Delf method was used. 2016 coverage data (the numerator) are from Programs implementing KVP programs.
Percentage of people who inject drugs reached with HIV prevention programs	21%	2016	70%	2020	80%	2022	Data on size estimation (the denominator) was obtained from a consensus meeting held in 2014. Delf method was used. 2016 coverage data (the numerator) are from Programs implementing KVP programs.

5.5.3 Planning for monitoring, evaluation and research

Standard monitoring and evaluation mechanisms will be employed to track performance and assess the success and challenges in implementing the strategy. The following will constitute the key interventions for monitoring, evaluation and research.

Coordination

Regular monitoring and evaluation of the strategy will be coordinated by the M&E unit of NACP in collaboration with the M&E section at the Ministry's HQ. The unit will be required to provide regular programme updates and consolidate technical guidance for HIV and AIDS programming in the country. It is expected that the unit will have the capacity to develop programme reports that clearly show national HIV and AIDS epidemiology and impact of proposed programmatic activities.

Routine Reporting

The HIV and AIDS programme will collect, compile, report, and analyse routine data on a continuous basis. Data for a cohort of clients on ART will be analysed on an annual basis and disseminated among implementers and other stakeholders. There will be an emphasis in monitoring treatment cascade for children, adolescents and adults (linkage and enrolment, retention and viral suppression). Capacity building to strengthen data management, target setting and routine implementation assessment of M&E activities will take place at regional and district level. NACP in collaboration with the HMIS unit at the MOHCDGEC and PORALG will also be responsible to make sure that review and printing of M&E tools are implemented.

Improving quality of data

A range of activities will be conducted in order to ensure that quality data are produced and utilized. The data will include but not be limited to supportive supervision, mentorship, data quality audits and verification for all interventions. Additionally, programs will periodically review consumption data to ensure that reported data accurately reflects actual counts of clients receiving services.

Surveillance, survey and research

The program will continue scaling up evidence based decision making through research and evaluation. The monitoring of the national research and evaluation priority agenda will be prioritized and the guidelines will be brought to the attention of key stakeholders (e.g. implementing partners, donor organizations, research and academic institutions, the National Institute for Medical Research etc.) for implementation and follow up. Along with national research and evaluation priorities, other research and evaluations by different partners will continue providing additional information about the epidemiology and trends of HIV/AIDS in the country.

In line with national research and evaluation priorities, NACP will coordinate surveys and surveillance studies including among others, ANC/PMTCT HIV prevalence surveys, HIV drug resistance surveys, assessment of HIV drug resistance Early Warning Indicators, IBBS among MSM and Sex Workers, and the development of an active case-based surveillance system. The surveys will be designed to provide outcome level progress on the implementation of TB, HIV and MNCH interventions in the country.

Data Dissemination and use

The M&E section will conduct routine and detailed data analysis and documentation and disseminate results thereof. Capacity building of technical personnel at sub-national levels in data analysis, scientific documentation, information dissemination and use to enhance data driven programming and decision making at all levels will be emphasized. Reports, policy briefs, epidemiological fact sheets etc. consequently produced at all levels will be utilized to highlight not only achievements but also requirements for timely remedial actions.

Mid-Term review

A Mid-term review (MTR) will be conducted around mid - 2020, practically two years after strategic plan implementation. The MTR will assess milestones for implementing the strategic plan, particularly targeting process and output indicators rather than impact indicators. The results of the MTR will facilitate timely response to identified challenges and built on identified facilitating factors. All activities during the mid-term review will be outsourced to national or international organisations/consultants who will work closely with staff from MOHCDGEC (NACP, M&E), RHMT and CHMTs. The selected indicators will be measured against their established baseline as reflected in the M&E framework.

End-Term Review/evaluation

The End-of-Term Review (ETR) will be conducted in 2022 and outsourced to national or international consultants/organisations. This evaluation will provide evidence to inform stakeholders in planning for the next Health Sector HIV Strategic Plan. The final evaluation will be costed for during review of the M&E Plan.

Annexes

Annex I: Participants to the HSHSP III Review/ HSHSP IV development workshops

Annex II: Persons met during the validation of HSHSP III Review Findings

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Reference/Bibliography

Chirenje ZM, Rusakaniko S, Kirumbi L, Ngwalle EW, Makuta-Tlebere P, Kaggwa S, Mpanju-Shumbusho W, Makoe L: Situation analysis for cervical cancer diagnosis and treatment in east, central and southern African countries. *Bull World Health Organ* 2001, 79(2):127-132

Condom Multisectoral Strategic Plan 2016 – 2018

Hakama M, Chamberlain J, Day NE, Miller AB, Prorok PC: Evaluation of screening programmes for gynaecological cancer. *Br J Cancer* 1985, 52(4):669-673

HPACI, 2006

http://www.globalfinancingfacility.org/sites/gff_new/files/documents/Tanzania_One_Plan_II.pdf

Kahesa C, Mwaiselage J, Wabinga HR, Ngoma T, Kalyango JN, Karamagi C (2008). Association between invasive cancer of the cervix and HIV-1 infection in Tanzania: the need for dual screening. *BMC Public Health* 8(1):262.

Kripke K, Perales N, Lija J, Fimbo B, Mlangi E, Mahler H, et al. (2016) The Economic and Epidemiological Impact of Focusing Voluntary Medical Male Circumcision for HIV Prevention on Specific Age Groups and Regions in Tanzania. *PLoS ONE* 11(7)

Lindi Regional Hospital Annual Report, 2009

Matee *et al.*, 2006

Mitchell S, Cockcroft A, Lamothe G, Andersson N. Equity in HIV testing: evidence from a cross-sectional study in ten Southern African countries. *BMC international health and human rights*. 2010;10:23.

Parkin DM, Pisano P, Ferlay J: Estimates of the worldwide incidence of 25 major cancers in 1990. *Int J Cancer* 1999, 80:827-841.

Tanzania Bureau of Statistics, TACAIDS et al: Tanzania HIV and Malaria Indicators Survey (2011/12)

TDHS 2015

TDHS-MIS 2015

TGPSH, 2004; TGPSH, 2005

The United Republic of Tanzania MOHSW, The National AIDS Control Programme, Voluntary Medical Male Circumcision Country Operational Plan 2014–2017. Toward an HIV-Free Generation. November, 2014.

THIMS, 2012

THMIS 2011/2012

United Republic of Tanzania MoHSW, National AIDS Control Programme, National Strategy for Scaling Up Male Circumcision for HIV Prevention. 2010.

www.nacp.go.tz/site/download/hshsp3final2014.pdf