THE UNITED REPUBLIC OF TANZANIA

NATIONAL AIDS CONTROL PROGRAMME

Strategic framework

For

The Third Medium Term Plan (MTP-III) For Prevention and Control of HIV/AIDS/STDs

1998-2002

Ministry of Health, Tanzania (Mainland)

Dar es Salaam

July, 1998

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

AIDS	Acquired Immuno-Deficiency Syndrome
AMOs	Assistant Medical Officers
AMREF	African Medical and Research Foundation
BAKWATA	Baraza Kuu la Waislam Tanzania - The Muslim Council of Tanzania.
CSW	Commercial Sex Workers
DHMIS	District Health Management Information System
DHMT	District Health Management Team
DHS/KAP	Demographic Health Survey/Knowledge, Attitude, and Practice.
DMC	District Management Committees
EU	European Union
GDP	Gross Domestic Product
GTZ	German Agency for International Development
HBC	Home Based Care
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus.
IEC	Information Education Communication
MA	Medical Assistant or recently Clinical Officer (CO)
MCDWAC	Ministry of Community Development Women, Affairs and Children
MIS	Management Information System
MJCA	Ministry of Justice and Constitutional Affairs
MLYD	Ministry of Labour and Youth Development
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
MOs	Medical Officers
MSD	Medical Stores Department
MSTHE	Ministry of Science, Technology and Higher Education
MTP	Medium Term Plan
MUTAN	Mpango wa Kudhibiti UKIMWI Tanzania na Norway
NAC	National AIDS Committee
NACP	National AIDS Control Programme
NGO	Non-Governmental Organisation
PHCC	Primary Health Care Committees

PLHA	People Living with HIV/AIDS.
PSI	Population Service International
RAD	Range of Acceptable Deviation
RAP	Rapid Assessment Procedures
SAREC	Swedish Agency for Research Co-operation with Developing Countries
STD	Sexually Transmitted Diseases
TACOSODE	Tanzania Council for Social Development
TACs	Technical AIDS Committee
TAHEA	Tanzania Home Economics Association
TAMWA	Tanzania Media Women Association
TANESA	Tanzania-Netherlands Support on AIDS
FHI	Family Health International
TB	Tuberculosis
TGNP	Tanzania Gender Network Programme
TOT	Training of Trainers
TV	Television
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations International Emergency Children s Fund.
USAID	United States Agency for International Development
WAMATA	Walio Katika Mapambano na UKIMWI Tanzania
WHO	World Health Organization.
YEGS	Youth Economic Groups
YMEGS	Young Mothers Economic Groups

FOREWORD

Todate HIV/AIDS has been with us for almost two decades. During this period, this epidemic has not only been with us, but it has also affected the health of our people, depleted our household savings, killed our loved ones and affected our economic development.

While each one of us has been directly or indirectly affected, our individual and collective responses to HIV/AIDS have been overshadowed by silence and false confidence. We all have a false confidence that it is not our problem but someones problem. This is a wrong perception and we need to change it.

If we don t change our perceptions to HIV/AIDS, the epidemic will continue to spread and exert its toll on the lives of our young generation. Most of our youth will not live to see adult hood. Their energy and education will all be in vain.

The nation will have a large number of sick people which will be a big burden to the rest of population. Our household and national savings will be spent on providing care to sick people and our economy will shrink. Our social, political, economical and even religious dreams will never come true in the presence of such a severe HIV epidemic as it is today.

If we are to survive as a nation, we must not allow this situation to continue. Since HIV spreads mainly through sex, there are only a few measures that we can take. For married men and women, I appeal to them to be faithful to each other. To young people, who constitute our country s future generation, abstain from sex for as long as is possible. When you finally decide to take up a partner, be faithful to each other. If you have to involve yourself in casual sexual encounters, always use a condom.

The power to prevent further spread of HIV infection is with us. All of us as women and men, business people, civil servants, politicians, religious leaders, parents and teachers, traditional leaders and peasants, the rich and poor, professionals and unemployed and most important of all, as individuals, must today do something to prevent further spread of HIV infection.

The Medium Term Plan III articulates what each one of us must do to prevent further spread of HIV infection. This plan will only be useful if all of us comply with it and undertake activities within its framework. In order for the plan to remain strategic, it will have to be constantly reviewed to ensure it evolves with the epidemic. Let all of us join in partnership against HIV/AIDS and resolve to save the nation. As partners, let us commit ourselves to pass information on HIV/AIDS to each other, care for those living with HIV/AIDS and pool resources for HIV/AIDS prevention and protect ourselves from HIV infection.

Together as partners against HIV/AIDS we shall win.

Frederick T. Sumaye, (MP)
PRIME MINISTER
UNITED REPUBLIC OF TANZANIA
DECEMBER, 1998

Executive Summary

Introduction

During the last sixteen years, Tanzania has undertaken many different approaches in attempting to slow the spread of HIV infection and minimize its impact on individuals, families and the society in general. Since 1983, when the first 3 AIDS cases in Tanzania were reported, the HIV epidemic has progressed differently in various population groups while national response has developed itself into phases of programme activities led by the National AIDS Control Programme since 1985. The programme phases started with a two-year phase called Short Term Plan (1985-1986). Subsequent phases were termed Medium Term Plans lasting for five year periods beginning with MTP-I (1987-1991), followed by MTP-II (1992-1996) and now approaching MTP-III which will begin in 1998. Through these programme phases successful national responses have been identified, the most effective ones being those touching on the major determinants of the epidemic and addressing priority areas that make people vulnerable to HIV infection.

This document consists of the Strategic Plan for MTP-III, which is essentially a framework of implementing an expanded national response based on current knowledge about HIV/ AIDS/STDs in Tanzania. The document also provides the basis for which formulation of future operational plans of the Programme will be undertaken.

Situation analysis and the country s response

A situation analysis of HIV/AIDS in Tanzania was performed in 1997 and has shown a worsening epidemiological situation whereby the epidemic has rapidly spread into rural areas thereby increasing the previously low rural prevalence to more than 10% in some areas. Mother-to-child transmission appears to be on the increase, as more and more women continue to become infected and pregnant.

The youth and the women have been the most affected groups because of economic, social-cultural, biological and anatomical reasons. Hence, poverty, which reflects the country s economy, is an important determinant. Mobile population groups have also been categorised as vulnerable to HIV infection as their occupation forces them into high-risk sexual behaviour. The mobile population groups include commercial sex workers, petty traders, migrant workers, military personnel and long distance truck drivers.

Determinants of the epidemic have been identified and grouped into societal, behavioural and biological ones. The HIV/AIDS epidemic has had a serious impact on the country s economy. It has affected agricultural and industrial production as well as affected socio-demographic parameters such as life expectancy. AIDS orphans have been increasing in number while families, communities and the Government cannot cope with the needed resources to cater for their needs.

As regards the country s response to the epidemic there have been various national efforts to control the spread of HIV. While the initial efforts were mainly implemented by the MOH, overtime, there has been gradual involvement of other public sectors, NGOs and community-based organizations. This multi-sectoral response to the HIV/AIDS/STDs

problem has involved, among others, IEC activities for the prevention of HIV transmission, care for AIDS patients in hospitals and at home, family life education, Government budgetary allocation for AIDS activities, condom procurement and distribution and STD management activities. Encompassing all the above responses is the development of a National Policy on HIV/AIDS/STDs to widen and strengthen the national response against the epidemic.

Most unfortunately however, the situation analysis has shown lack of a strong political will and commitment on the part of the Government. As a consequence, policy and sensitization of HIV/AIDS issues at all levels of the political structure have been inadequate. Efforts to curb the HIV/AIDS epidemic have largely depended on external resources indicating that the situation will worsen when such external resources become unavailable.

The Strategic framework of MTP-III

Taping from the experiences of previous Medium Term Plans (MTP-I and MTP-II) and their corresponding programme reviews, it has become necessary that the current plan (MTP-III 1998-2002) must be thorough. Its main characteristics are those of a national expanded response which is multi-sectoral and addressing both risk factors for, and vulnerability to HIV/AIDS/STDs. The response will also attempt to cover more geographical areas in its activities and facilitate access to more prevention and care than ever before. Consequently, a strategic planning process was adopted in a workshop held in June 4-9, 1998. The workshop took into account many sources of information but the most crucial ones were the following:

1. Report of a situation analysis workshop held in August 1997.
2. Review report of MTP-II of November 1997.
3. Medium Term Plan (MTP-II) documents.
4. Consultancy Report on Review Structure of the NACP.
5. UNAIDS Strategic Planning Guide - Module 3.
6. MTP-III draft document.
7. Comments from government ministries, donor agencies and religions and other institutions on the MTP-III draft document.

The workshop followed a process of ranking potential determinants of the HIV/AIDS/ STDs epidemic, first, by order of importance in fuelling the epidemic. Next, the feasibility of each priority area was evaluated and finally, the resulting objectives, assigned to each priority area, were prioritized taking into account both the importance of the determinant and the feasibility of the response.

Each of the priority areas were further scrutinized in terms of what was done during MTP-II, what obstacles the Programme may face, and the opportunities to be taken advantage of during MTP-III. For each resulting objective, a list of strategies with corresponding steps, key actors as well as inputs was made in order to facilitate its implementation. With this arrangement it is envisaged that key actors will take initiatives in the implementation process by addressing the strategies and steps using available resources.

Programme Management Mechanism

An efficient programme management mechanism is critical for the successful implementation of MTP-III during its five-year span. The management mechanism of MTP-II had some serious constraints that must be avoided during MTP-III. The most important of these was that the NACP lacked the expected leadership of the National AIDS Committee on which it so depended in co-ordinating and mobilizing multi-sectoral initiatives in curbing the epidemic. The National AIDS committee was, in turn, weakened by the general lack of political commitment towards the Programme, making key actors in the government, including its sectors to give low priority and preference to HIV/AIDS control activities. The planned Programme Management mechanism for MTP-III intended to meet the expanded multi-sectoral response and lay emphasis on decentralized programme implementation to be focused at district and lower levels. The key actors in the implementation of programme activities will include central government ministries, district local governments, non-governmental organizations and the private sector, each with its own budget for HIV/AIDS activities and implementation schedule.

The management structure of MTP-III will therefore have the NAC as highest policy formulating body and will be responsible to the Cabinet. The Committee will be served by a secretariat, which will also be responsible for co-ordination of implementation of NACP activities. The main players in the implementation of HIV/AIDS activities will therefore be the public and private sectors, districts, NGOs, CBOs, religious organizations and PLHAs.

Implementation mechanism

For a successful implementation of MTP-III it will be necessary to strengthen the management and technical capacity of national, district and sectoral institutions including local NGOs and other voluntary agencies to undertake HIV/AIDS/STD prevention and control activities. The focus will be on resource mobilization, financial management, information management, disease surveillance, research and strengthening of multi-sector collaboration and district planning.

1.0 Introduction

The third Medium Term Plan (MTP-III) of the United Republic of Tanzania defines the national expanded response to the HIV epidemic in Mainland Tanzania for 1998 through 2002. This response is contained in a strategic plan that will be implemented by many sectors (multi-sectoral) and will address both risk factors for, and vulnerability to HIV/ AIDS/STDs. The response will also attempt to cover more geographical areas in its activities and facilitate access to more prevention and care than ever before.

During the last sixteen years, Tanzania has undertaken many different approaches in attempting to slow the spread of HIV and minimise its impact on individuals, families, and the society in general. Successful national responses have been identified during this intense period of battling with the epidemic in Tanzania. The most effective responses have been those touching on the major determinants of the epidemic, addressing priority areas that make people vulnerable to HIV infection and taking into consideration the unique constraints and opportunities of its people and institutions.

The Strategic plan for MTP-III that follows is the framework for implementing a multi-sectoral response based on what we know about the HIV/AIDS/STD epidemic in Tanzania, what has been done about it, where and how Tanzania will focus its response in the future. This document provides the basis for which subsequent formulation of operational of the Programme will be undertaken. The operational plans will be solicited from the central and the district levels in line with evolving roles of these levels as provided for in the Health Sector and local government reforms. The district will be given the most prominent focus because this is the level where most activities will take place.

This document is the product of many workshops, discussions, reviews and comments on the first draft MTP-III document by Government ministries, donors, NGOs, UNAIDS and United Nations co-sponsors, and partners in the Private Sector. Previous workshops were conducted, one in August 1997 to analyse the HIV/AIDS situation, another in October 1997 to review the second Medium Term Plan and yet another in November 1997 to draft the third Medium Term Plan. After a wide circulation of the MTP-III document to interested parties for comments and after receiving a substantial number of responses, a national workshop was held in June 1998 to finalize the draft into a Strategic Plan for the period 1998-2002.

2. Situation Analysis of HIV/AIDS/STDs in Tanzania and the Country s Response

2.1 *Epidemiological Situation of HIV/AIDS/STDs in Tanzania*

In Tanzania, transmission of HIV occurs mainly through heterosexual contact beginning in the early teen years and peaking before the age of 30. Since 1983, when the first three AIDS cases in Tanzania were reported, the HIV epidemic has progressed differently in various population groups. Early in the epidemic, urban populations and communities located along highways were most affected. According to the NACP HIV/AIDS/STD Surveillance Report No.11, 1996, the epidemic has rapidly spread to rural communities and in 1997, more than 10% of women attending antenatal clinics situated in some rural areas have been found to be HIV infected.

The cumulative AIDS cases as reported from surveillance reports collected by the National AIDS Control Programme (NACP) in Tanzania mainland, rose from 25,503 at the end of 1990 to 88,667 in 1996. Over 80% of the reported AIDS cases were in the age group 20 - 44 years.

Mortality data from Kagera, Dar es Salaam, Hai and Morogoro districts indicate that less than 40% of all adult deaths occur in hospitals while some AIDS patients are not reported because they die before diagnosis is made. Consequently, NACP estimates the true number of AIDS cases in Tanzania to be 4 to 6 times of that reported. Therefore, the cumulative number of AIDS cases by the end of 1996 could have been well over 450,000.

Since AIDS is a late consequence of HIV infection, the long incubation period of between 5 and 10 years and the absence of significant symptoms at the early stages of infection, make it impossible to know the exact number of HIV infections in the country. The only reliable data available is that from blood donors and the few sero-prevalence studies in selected regions. In 1986, 6.8% of adult male donors and 8.2% females were HIV positive (average from population studies 7%). Extrapolation from these figures in an estimated population of 15,500,000 adults in mainland Tanzania results in at least 1,350,000 HIV positives which is 8.7% of the adult population. At least 5% of the infected population could develop to full-blown AIDS, giving approximately 68,00 AIDS cases per year.

According to the blood donor data of 1996, HIV prevalence was high among young adults in the age groups 20 - 24, 25 - 29 and 30 - 34. Infection rates in these groups ranged from 5.9% to 7.9% among males, and from 9.3% to 10.1% among females, the latter being affected at earlier ages than the former.

Although it is estimated that the prevalence of HIV infection among adults blood donors is 8.7%, the range varies from 5% to 20%. Regions mostly affected are Kagera, Iringa and Mbeya with a prevalence range of 15% to 20%, Dar es Salaam, Rukwa, Shinyanga and Mwanza with a prevalence range of 10% to 15% while Ruvuma, Kilimanjaro and Mtwara are in the prevalence range of 5% to 10%.

Vertical transmission of HIV from mother to child is also considerable in Tanzania. In 1996 this accounted for about 4% of all reported AIDS cases. The problem seems to be on the rise as more women continue to become infected and pregnant. Data from sentinel surveys in antenatal clinics show sero-prevalence rates of 5.5% to 23%, and assuming a 30% prenatal transmission rate, the proportion of new-borns expected to be infected could reach 7 per cent.

HIV/AIDS is increasingly becoming the major underlying factor for hospital admissions and deaths. Many diseases, which seemed to have been controlled ten years ago, have returned to previous levels due to HIV/AIDS. For example the prevalence of HIV infection among 128 newly detected tuberculosis patients in Mbeya in 1995 was 52%, whereas that proportion in Bukoba hospital in 1992 was 57.4%. Studies conducted in Dar es Salaam, Hai and Morogoro showed that HIV/AIDS is the leading cause of adult mortality especially among women.

Population groups mostly affected

From the above observations it can be seen that two groups emerge as the most affected. These are the youth and the women. Several reasons can be advanced to explain this observation. Early marriage and early initiation of sex among women, young girls having sex with older men, peer pressure for high-risk behaviour, biological and anatomical predisposition are some of the most important reasons. In addition, failure of women to protect themselves from HIV infections due to economic hardships, repressive customary laws, beliefs and polygamy could all contribute to this state of affairs.

A third group mostly affected is the poor. This group is most likely illiterate and unemployed, as a result; it might use sex as a means of earning a living. Again, women are more likely to get involved than are men, for lack of alternative means of survival.

A fourth group of those mostly affected is the so-called mobile populations which consists of those who work and stay away from home for varied lengths of time during a year. These include commercial sex workers (CSW), petty traders, migrant workers, military personnel and long distance truck drivers. Their inability to negotiate for safer sex with their clients puts them at a high risk. Another group of workers in risky occupations is that of health workers who may inadvertently handle infected material in the course of their work. These often lack the necessary protective gear and education to prevent them from coming into contact with infected materials.

2. 2 Determinants of the Epidemic

From the situation analysis of HIV/AIDS in Tanzania, several determinants of the Epidemic were identified. The main groups are societal, behavioural and biological. These singly or in combination provide opportunities for HIV infection to occur to an individual.

Social determinants

1. Commercial sex workers form a group that potentially increases the sexual transmission rate of HIV infection. Studies by AMREF along the major truck stops and towns have shown this group to have a high HIV prevalence of up to 60%. A

study conducted by MUTAN in the Moshi municipality showed that bar workers had HIV infection prevalence rate of 32%, while a study in Dar es Salaam showed that 50% of the bar workers were HIV positive.

2. Stigma and discrimination against people living with HIV/AIDS is quite common in Tanzania. Studies done in communities in Magu, Mwanza by TANESA showed the level of stigma and denial for AIDS and HIV to be very high. Many people would not admit that their sick relative could be suffering from HIV/AIDS but believe instead in witchcraft as the cause of their sickness. This situation makes it difficult to convince people with wife-inheritance traditions not to marry women whose husbands may have died from AIDS.

3. A large proportion of the population with very low and/or irregular income is an important social determinant. Over 50% of Tanzanians live below the poverty line and females are worse than males. In addition, low and or irregular income creates an environment that encourages labour migration. Women in such situations may be easily tempted to exchange sex for money and this puts them and their spouses at risk for HIV. People with low income have less access to medical care including that for STDs and HIV/ AIDS.

4. Social isolation for long periods and peer pressures for high-risk behaviour among the military form other social determinants. In Tanzania when one is enrolled in the army, one is confined in a camp and barred from getting married for six years. This makes one vulnerable to high-risk behaviour and hence to HIV infection especially when the army has no proper programs for HIV/AIDS prevention like the promotion of condom use and provision of IEC for HIV prevention.

5. Cultural norms, beliefs and practices that subjugate/subordinate women are important determinants These include cultural practices like wife inheritance, polygamy and female circumcision which are common among many tribes in Tanzania. Obligatory sex in marital situations is condoned even by religion, and women cannot divorce in some faiths. Furthermore, in some cultures multiple sex partners for men is tolerated and may even be encouraged.

6. Young people leave home and school environments to become independent without a source of income. In Tanzania every year about 300,000 pupils leave primary education quite early (age 13 - 17yrs) and a significant proportion migrates to large towns like Dar es Salaam in search of employment. These youth and especially the female, become very vulnerable because they end up getting employment, which is poorly paid and in turn have to supplement their meagre income through unsafe sexual practices. Although there have been attempts to introduce sex education in schools, these have not adequately prepared those leaving school to confront sexual issues.

7. Illiteracy and lack of formal education is on the rise in Tanzania. In the eighties the level of literacy in the country was around 80%. At that time many people could read and understand messages meant for their well being. Today, the literacy rate has gone down to less than 60%, this means less people can understand written messages. This has been contributed by the fact that many young people are not being enrolled into

schools and these are unfortunate because it has been shown that the prevalence of HIV infection in educated women is lower than in those who were not educated. The other contributing factor to the declining literacy rate is that the post-independence adult education campaigns are currently so poorly managed for lack of resources that there is little or no output.

Behavioural determinants:

8. Unprotected sexual behaviour among mobile population groups with multiple partners makes them vulnerable to HIV infection. The groups include long distance truck drivers who have been found to have unprotected sexual intercourse with HIV sero-positivity of up to 50%. This is because they have multiple sexual partners available in all major truck stops. Migrant or seasonal workers are also vulnerable. It has been found that farm and plantation workers in Iringa and Morogoro for example, have HIV prevalence of about 30%, which is very high compared to the general population.

9. Reduced Social discipline for making good decisions about social and sexual behaviour. Long before the eighties when the AIDS epidemic became apparent Tanzanians were a disciplined society where traditional values and norms were cherished. But recently, social discipline has been eroded. This is so because of several factors such as failure of parents to institute traditional values and discipline to their children for lack of time. Sudden mushrooming of television programmes and other mass media have also contributed negatively to social discipline.

Biological determinants

10. STDs Infections (especially gonorrhoea and other genital discharges) are among the top-ten causes of disease in mainland Tanzania. Studies have found that patients with STDs are 2 to 9 times more likely to be infected with HIV. However because HIV and other STDs are both highly associated with high-risk sexual behaviour it is difficult to show the extent to which STD alone enhance infection of HIV. Nevertheless, studies in Mwanza have shown that STD management within the existing PHC system can reduce the incidence of HIV infection by about 40%.

11. Unsafe blood transfusion is a major determinant of HIV transmission. The HIV transmission rate through transfusion of contaminated blood is almost 100%. For this reason, in Tanzania all centres rendering this service are equipped with facilities to ensure safe blood transfusion. However, due to lack of regular supplies of reagents and equipment as well as lack of reliable power supply in some centres there is some risk of transfusing contaminated blood. This situation therefore calls for improved blood transfusion services in the whole country.

2.3 *Impact of the HIV/AIDS epidemic*

Given that the HIV/AIDS epidemic has progressed with different rates in various population groups in Tanzania, the impact has varied from being minor to being

profound depending on the time the infection was introduced in the area, rate of spread and the proportion of the population affected.

Experiences from several parts of the country indicate that HIV infected persons, on average, die about 4 to 12 months after falling ill with one or more of the major manifestations of AIDS. During this period a member of the family often has to stay at home or hospital with the patient to provide care especially during the terminal stages of the disease. The medical, emotional and social costs on the patient and indeed the family are frequently high. More socio-economic difficulties arise when the patient is the main bread earner. When death finally comes the traditional family structures, already stressed by poor health, increased burden of care and poverty, are in many cases at breaking points. Funeral costs have been estimated to exceed US $100 for every adult death in Kagera. Available data from severely affected communities show that AIDS often leads to social and economic disruption of affected individuals, families and communities. The poorest households are least able to cope with the impact of adult deaths due to AIDS and are frequently unable to obtain even the most basic needs in the short term. Child nutrition, education, health and living standards for the survivors may be severely affected.

Hospital based data indicate that up to 50% of beds are occupied by patients with HIV/AIDS related illness. Consequently the demand for care and hospital supplies is enormous and by-and-large government health facilities are at a breaking point if not broken already due to inadequate funding and manpower. It is estimated that in Tanzania the ideal life-time and nursing-care costs for HIV/AIDS is US $ 290 for adults and US$ 195 for children. Gains made during 1980 s in TB control have been lost due to HIV/AIDS. TB case rates had been declining steadily up to 1982 but since then there has been a sharp increase the number of reported TB cases and in most urban areas these have more than doubled.

Since agriculture is the backbone of the Tanzanian economy, and most agricultural workers are in the age group 15-45 who are mostly affected by the epidemic, the impact of HIV/AIDS is gradually becoming noticeable as the epidemic spreads to rural communities. Production of food and cash crops is bound to suffer as the labour force gets sick and dies from AIDS.

The World Bank estimates that because of the AIDS epidemic, life expectancy by 2010 will revert to 47 years instead of the projected 56 years in the absence of AIDS. The Bank further predicts that the mean age of the working population (labour force) will decline from 31.5 to 29 years between 1992 and 2010. The overall younger work force will have less education, less training and less experience. In addition the number of children orphaned by AIDS was estimated to be increasing from between 260,000 to 360,000 in 1995 to between 490,000 and 680,000 by the year 2000. Families, communities and the government will be required to generate resources to cater for the needs of these children. The Bank further estimates that, AIDS will reduce average real GDP growth rate in the period 1985-2010 from 3.9% without AIDS to between 2.8 and 3.3% with

AIDS. These factors will certainly have a negative impact on the overall economic performance of the country and its living standards.

2.4 Advocacy and Policies for HIV/AIDS

Government involvement and leadership are crucial for HIV/AIDS prevention and control activities. Governments have the mandate and means to finance public services necessary for the monitoring and control of diseases. Furthermore governments have the responsibility to create political and social environments that reduce high-risk behaviour in general. For example, government policies on provision of social services, maintaining law and order, poverty reduction, protection of the poor and weak are important in preventing HIV transmission and coping with its impact.

The situation analysis of the HIV/AIDS in Tanzania has shown lack of strong political will and commitment on the part of the government. As a consequence, policy and sensitization on HIV/AIDS issues at all levels of the political structure have been inadequate. Funding and other resources for HIV/AIDS activities in Tanzania have largely depended on external resources. Consequently efforts to curb the HIV/AIDS will stop if and when such funding stops forthcoming.

In spite of available data, including that from the World Bank, HIV/AIDS issues are yet to be adequately integrated into the macroeconomics and sectoral policies. To date most people including policy makers consider HIV/AIDS to be a health issue. Hence multi-sectoral response has been minimal. Legal and human rights issues related to community protection, protection of people living with AIDS and their families, widows and orphans have not been adequately addressed by the various sectors of the population. A draft HIV/AIDS policy document produced in 1995 that attempts to give guidance to some of these issues is yet to receive approval from appropriate government authorities.

The lack of a firm advocacy in the government machinery creates an environment that does not promote appropriate individual, community or national response to the HIV/AIDS epidemic. It is of interest to note that whenever there is strong advocacy from the government for a cause (e.g. cholera outbreaks) the communities are readily mobilized and effective measures put in place at all levels. However, when the AIDS problem continues to devastate our economy the response has not been serious. For example, the NAC which is the highest government body in AIDS control activities, has met only twice (instead of quarterly) during a period of 2 years indicating the low level of priority given to HIV/AIDS issues in the government system.

3.0 The Medium Term Plan Formulation Process

3.1 Guiding Principles for the response to the HIV epidemic in Tanzania

The implementation of MTP-III for Tanzania will be guided by elements in the Constitution, the Health Policy for Tanzania, and the proposed HIV-AIDS policy document currently being finalized for adoption. The following twelve principles were extracted from these documents to guide the Government in its response to the HIV epidemic:

1. Respect for basic human rights and equal protection for all persons is ensured irrespective of age, sex, race, political orientation or religion.
2. Promote the health and well being of all Tanzanians with a focus on those most at-risk.
3. Increase health system responsiveness to the needs of people in Tanzania
4. Ensure that health services are available and accessible to all in urban and rural areas.
5. Ensure that all health cadres shall strive to be self-sufficient at all levels from village to national.
6. Ensure that communities are sensitized on common preventable health problems and empowered to assess, analyze problems and to design appropriate action through genuine community involvement.
7. Awareness by Government and the community at large that health problems can only be adequately solved through a multi-sectoral co-operation involving public, private as well as Non-government sectors and religious groups.
8. Responsibility for one s health rests squarely with the able-bodied individual as an integral part of the family.
9. Transmission of HIV is preventable through change in individual behaviour, while education and prevention programmes are necessary to bring about changes.
10. Each person must accept responsibility for prevention of HIV transmission through sexual intercourse or sharing of infected needles; and provide care and support for those infected and affected by HIV.
11. The community as a whole has the right to correct information on HIV/ AIDS and therefore to appropriate protection against HIV infection.
12. The law should complement and assist education and public health measures in the prevention of HIV transmission.

3.2 Strategic Plan Formulation Process

Six Tanzania nationals and three international facilitators led the process used for formulation of this strategic plan, with relative global and national expertise, among a cross-section of partners responding to the epidemic.

During a workshop from 4th to 9th June 1998, they took into account the conclusions of the situation and response analyses summarised above, to rank the epidemic s determinants, priority areas and strategies in order of importance, and to develop a

strategic framework for HIV/AIDS prevention and control in Tanzania. This prioritization process was done in three successive steps:

(a) Ranking the determinants by order of importance in fuelling the epidemic
(b) Evaluating the feasibility of each priority area
(c) Prioritizing the objectives assigned to the priority areas, taking into account both the importance of the determinant and the feasibility of the response.

(a) Ranking the determinants

The process undertaken for focusing government response was first to identify the determinants of the HIV epidemic in Tanzania. Determinants were identified through a workshop in August 1997 analyzing the HIV/AIDS situation in Tanzania. During the June 1998 workshop, these determinants were ranked according to their relative importance on the basis of four criteria. These criteria were discussed in relation to each determinant employing a Likert scale for weighting relative importance and came up with a ranking scale of 1-4 (1=Very low, 2=Low, 3=High, 4=Very high). National experts guided the discussions among six groups of 5 - 6 participants and comprizing a cross-section of NGOs, government ministries, various sectors including those of religion, district representatives and donors. The four criteria for this analysis included: 1) the size of the affected group, (a very small size of the affected group was given a score of 1 while a big size was given a score of 3 and so on 2) the proportion of group members practising at-risk behaviour, 3) the efficiency of HIV transmission, within the group and 4) the estimated frequency of exposure to high risk behaviour. The resulting scores from each group were collated and resulted in the following ranked order of determinants starting from the most important:

1. High STD infection rate favouring transmission of HIV
2. Spread of HIV through commercial sex work
3. Unprotected sex behaviour among mobile population groups with multiple sex partners
4. Stigma and discrimination against people living with HIV/AIDS
5. Large proportion of the population with very low and/or irregular income
6. Condoning of multiple sex partners among men
7. Social isolation for long periods, peer pressure for high risk behaviour among the military
8. Cultural norms, beliefs, practices, and religious beliefs that subjugate/subordinate women
9. Young people who leave home and school environments to become independent without a source of income
10. Reduced social discipline for making good decisions about social and sexual behaviour
11. Unsafe blood transfusion
12. Increasing illiteracy and lack of formal education in the general population

(b) Evaluating the feasibility of priority areas

Each of these determinants then led to the definition of priority areas with the understanding that in order to tackle a determinant it was necessary to define a priority area for action. For example under determinant number 9 (Young people who leave

home and school environments to become independent without a source of income) it was decided to define and address the entire youth population in, as well as out of school as an important priority area. These priority areas were also subsequently ranked using the same process and scores as above but with the following eight criteria for evaluating feasibility: 1) is there a felt need for intervention in the community, 2) are resources for intervention available, 3) are target groups accessible for intervention, 4) are key partners committed, 5) will intervention produce quick results, 6) is cost related to major benefit, 7) are tools for intervention available, and 8) is intervention in the priority area feasible at district level. This process eventually established the following order of decreasing intervention feasibility for the priority areas:

1. Maintain safe blood transfusion services
2. Prevent unprotected sexual activity among the military
3. Reduce vulnerability of youth to HIV/AIDS/STD
4. Provide appropriate STD case management services
5. Reduce unsafe sexual behaviour among highly mobile population groups
6. Improve educational opportunities especially for girls
7. Reduce HIV transmission among commercial sex workers
8. Reduce poverty leading to sexual survival strategies
9. Reduce vulnerability of women in adverse cultural environments
10. Reduce widespread unprotected sexual intercourse among men with multiple-sex partners
11. Promote acceptance of persons living with HIV/AIDS
12. Reduce breakdown of cultural norms and values.

(c) Prioritizing the objectives

Once the priority areas were identified and ranked according to feasibility of implementation, an objective was formulated for each priority area to identify the concrete situation, the specific area and target which the plan would like to reach during a specified time period. Since these objectives were defined from the priority areas, which were ranked according to feasibility, they did not benefit from the ranking by importance to the epidemic, which was done for the respective determinants. This meant that in some cases, where the determinant was considered very important to the epidemic in Tanzania and hence ranked high, but in which the corresponding priority area is relatively difficult to implement interventions (and hence ranked low by feasibility), it was necessary to adjust the ranking for the resulting objective to lower it by combining importance and feasibility scores. As an example, commercial sex work was defined as the second most important determinant to the epidemic in Tanzania but the feasibility for implementing intervention programmes with them was considered very difficult and therefore ranked seventh. To adjust for this, a final process of combining the importance of determinants with the feasibility of corresponding priority areas was employed to prioritize objectives. The result of combining importance and feasibility for commercial sex work resulted in the ranking of its objective as the third most important. Similar adjustments were made for each determinant as well as the corresponding priority area to produce the prioritized and ranked objectives.

The objective for priority area number 9 (Reduce vulnerability of women in adverse cultural environment) was seen as redundant and therefore omitted because objective number 10

(Promote secondary and higher education especially for girls to reach 50% of the total enrolment by year 2002) and objective number 11 (Promote the cultural norms in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters) both address the issue of women s vulnerability in adverse cultural environments.

The final version of the prioritized and ranked objectives for responding to the HIV epidemic in Tanzania is as follows:

1. To reduce STD cases by 25% by the year 2002 with emphasis on the hard hit districts.
2. To obtain behaviour change for safer sex among 30-50% of mobile population groups in Tanzania by 2002.
3. To reduce STD and HIV transmission among Commercial Sex Workers by 25% by the year 2002.
4. To reduce unprotected sexual behaviour among the armed and security forces (Civil Military Alliance) by 75% before end of 2002.
5. To reduce vulnerability to HIV/AIDS/STD among in-school and out-of-school youth by at least 50% before the end of year 2002.
6. To ensure that safe blood is available in all blood transfusion sites by 2002.
7. To reduce the number of persons in poverty who earn money from sex work by 25% before the end of 2002.
8. To improve the well being of persons living with HIV/AIDS (PLHAs).
9. To reduce the percentage of men practising unsafe sex through multi-sex partnerships by 25% before the end of 2002.
10. To promote secondary and higher education especially for girls to reach 50% of the total enrolment by year 2002.
11. To promote the cultural norms in the Tanzanian society which encourage positive attitudes and decision-making about sexual matters.

Having formulated and rank-ordered the objectives according to priority, they were then established for possible implementation during MTP-III. The next step was then to formulate and identify strategies, steps, indicators, inputs as well as key actors. To do this, the same six working groups were asked to formulate strategies on the basis of what worked well in their experience, and on the basis of the failures and successes as defined in the review of MTP-II. Strategies were further refined by taking into consideration potential obstacles and opportunities. Following this, the working groups were asked to identify indicators for monitoring or for assessing achievement, inputs for budgeting purposes, and key partners/actors for managing activities. Further discussion about strategies and steps capturing the work of these groups is given in section 4.0 of this plan.

4.0 Priority areas, Objectives, Strategies, Steps, Inputs and Key Actors

On the basis of key determinants of the HIV epidemic in Tanzania, 11 priority areas were identified and formulated into corresponding objectives, strategies, steps, inputs and key actors for implementation during MTP-III.

4.1 Priority area: Provide Appropriate STD Case Management Services

The prevalence of STDs is high in Tanzania. Discharge syndromes are the most common STDs with gonorrhoea prevalence ranging from 2% to 10% among antenatal women. The patterns of genital discharge and genital ulcer diseases vary over the country with a higher prevalence of genital ulcers in the Mbeya/Iringa area and the Lake region than elsewhere. Syphilis prevalence in the same group varies between 5 and 15%. Of the genital ulcer diseases, syphilis is the most common causative agent, but there is a relatively high prevalence of chancroid, particularly in the Mbeya area. There are no reliable data for STD incidence in the country but if extrapolation from a small study area in Mwanza is made, it can be estimated that between 1 and 1.5 million symptomatic STD cases occur each year.

STD control in Tanzania, which previously included screening of antenatal women for syphilis, started getting special support through the European Union (EU) since 1989. The results of the Mwanza-based trial (1994) showed that an STD treatment programme designed to be replicable and sustainable within the existing PHC services of a developing country such as Tanzania, can reduce the incidence of HIV infection by a significant level (42%) in a rural population. These results were received with great interest by the NACP, which has subsequently supported implementation of its results on a wider scale by soliciting for donor support. The European Union is providing the first of such support. This support, with a budget of about 3.7 million ECU for three years, is directed mainly to the government sectors and aims at establishing PHC integrated nation-wide STD control activities. It mainly consists of support to training, purchase of STD drugs and diagnostic materials. So far STD control has been launched in eleven out of the twenty regions, all of which will be fully operational by the end of 1998. Drugs to cover program needs for at least two years have recently arrived in the country.

The EU support is supplemented by that given to NGOs and private sectors mostly by USAID with a budget of approximately 6.0 million USD per year. This support is channelled through the Family Health International (FHI) formally known as the Tanzania AIDS Project and mainly consists of management support to NGO clusters in ten regions to improve care-seeking behaviour through IEC strategies directed to the general public. The support also provides training to private practitioners in syndromic management of STDs.

(a) What was done in MPT-II

During the MTP-II some STD treatment centres were initiated in the Mbeya, Mwanza, Iringa, Shinyanga and Dar es Salaam regions. About 20 health facilities in 11 regions providing STD treatment in the country received drugs and other supplies from NACP. Some health staff were also trained by NGOs like TAP, AMREF and GTZ on STD control activities. Sex partner notification showed some success in most of the clinics. Also, the syndromic treatment guidelines were in place in most clinics. However, health seeking behaviour to STD clinics was inadequate because of the perceived stigma resulting to reluctance of some patients not directing their sex partners to health facilities for treatment. Condom use was still hindered by some religious beliefs.

(b) Obstacles for MTP-III

The presence of a high prevalence of asymptomatic infections in the general population particularly among women, was a major obstacle. This was compounded by the poor partner notification rate seen in most clinics due to the accompanying stigma. Other major obstacles met during MTP-II were the irregularity in the supply and distribution of relevant equipment, STD drugs and the total lack of female condoms, which would probably be more acceptable than the male condom. Furthermore, general lack of trained personnel, inadequate STD management training manuals for health care workers and the unwillingness of the prevalence sector to create conducive environments for proper STD management were important obstacles for consideration during MTP-III.

(c) Opportunities for MTP-III

To mitigate the impact of the above obstacles during MTP-III implementation, some existing opportunities need to be utilised. There is an incomplete draft for the STD curriculum that could be finalised. Different manuals (for TOT, health workers etc) that could be harmonised and used for teaching are in place. There are NGOs in some communities (AMREF for instance) that operate in the area of STD management. These should be consulted to provide their experiences. Availability of health facilities and the presence of DHMTs could be taken as a good environment for implementing the strategy. In the districts there are other programmes, which supply condoms, an integration with them could be an added advantage.

Objective: To reduce STD cases by 25% by the year 2002 with emphasis on hard-hit districts

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. Establish appropriate environments for management of STD cases in hard-hit districts.

The steps to accomplish this strategy are to modify the existing syndromic approach to STD management and care for use by district level health care workers. This would involve the hiring of experts from STD management and district staff to define needs and gaps in the current STD management. Next, identify training needs, determine the need to revive prophylaxis and treatment for neonatal conjunctivitis, determine whether partner notification and

counselling services need to be re-established, draft training materials, design a training of trainers course and implement STD management activities at the district level. The next step is to conduct a thorough analysis of the required facilities and supplies needed at the district level to maintain quality health care delivery, identify storage needs and current capacity, obtain materials including STD drugs and condoms and distribute through the Medical Stores Department. The District Health Management Team should be involved in overseeing programme implementation Another important step to accomplish this strategy is to incorporate STD drugs and supplies into the Essential Drug Programme kits, and to integrate STD services into the PHC structure. The key actor for this strategy is the Ministry of Health with support from the DHMTs. The major inputs are resource persons including those from NGOs, supply of STD drugs, condoms, training materials, storage facilities, test kits for syphilis and transport for distribution and supervision.

Strategy 2. *Strengthen and expand sentinel surveillance sites.*
The first step is to establish a comprehensive surveillance system for STDs. This would involve designating the responsibility of formulating such a system to a national expert. Once a system is in place, sentinel sites should be formed in areas where essential information will be needed and can be provided regularly. The next step is to identify training needs of health workers, procure essential test kits and carry out necessary training, monitoring, distribution and evaluation. The key actor is the Ministry of Health. The major inputs are syphilis test-kits, reagents, and relevant, well-trained human resources.

Strategy 3. *Strengthen management and co-ordination capacity at all levels.*
The major steps involved include an analysis of management needs, identifying terms of reference for addressing training needs, identify a national training facilitator, providing training for District Health Management Teams, and establishing key documentation centres for personnel to update their knowledge and skills in the care and management of STDs. The key actor is the Ministry of Health. The major inputs needed are training materials, transport, venue for training and staff for the documentation centres.

Strategy 4 *Promote reproductive health education in hard-hit districts.*
The steps for accomplishing this strategy are to promote reproductive health education in selected districts by identifying a national expert to develop IEC materials on STDs and reproductive health for women at the district level, and to conduct awareness seminars to district leaders and the communities including schools. The expert should also recommend appropriate methods for reaching the target population. The key actors are the Ministry of Health and the District Health Management Teams. The major inputs are human resources, materials for developing IEC messages and transport.

Strategy 5 *Promote health-care seeking behaviour.*
Steps for promoting health care seeking behaviour are to conduct a RAP to

determine patterns of health care seeking behaviour, Assessment study, develop and distribute IEC materials for promotion of health care seeking behaviour, to sensitize health care workers to the needs of STD patients and to prevent stigmatization through appropriate counselling. The key actors are the Ministry of Health and the District Health Management Team. The major inputs are human resources, to conduct RAP and develop appropriate IEC materials. Trainers of health care workers and transport.

4.2 *Priority Area: Reduce Unsafe Sexual Behaviour among Highly Mobile Population Groups*

Unprotected multiple sexual behaviour has been identified as a major determinant fuelling the epidemic in Tanzania. In particular, mobile population groups are well known for their frequent risk behaviour of acquiring multiple sex partners while they are away from home. Most sexual activity among them is unprotected. For this reason, reduction of sexual risk behaviour among these groups will be a major activity during MTP-III. Mobile populations include long distance truck drivers, seasonal farm workers, petty traders and small-scale miners.

(a) What was done in MTP-II:

During MTP-II, NACP co-ordinated different research and instructional activities that were mostly carried out by NGOs like AMREF. Of the main mobile population groups in Tanzania (Truck drivers, petty traders, minors and seasonal workers), only truck drivers were provided with some service involving promotion of sexual behaviour change among them. Truck drivers were a special group that was mainly accessed using the major truck stops in the country. In some areas, counsellors were trained, condoms distributed among truck drivers and STDs treated. However, the MTP-II did not spell out specific objective and strategies that were designed to approach this group and achieve the set objectives..

(b) *Obstacles for MTP-III:*

In order to implement successfully the strategies to promote sexual behaviour change among highly mobile groups, obstacles identified during situation and response analysis of MTP-II must be addressed. It is difficult to identify and access some of the highly mobile groups, which are not homogeneous, making it difficult to provide them with the necessary

(c) Opportunities for MTP-III:

The existence of NGOs experienced in working with highly mobile groups and who have financial and material support for the relevant strategies is a great opportunity into accessing this group. Such NGOs have already developed some educational materials that could be used by other actors to reach some groups. Mobile population groups are said to frequent entertainment areas. These centres could also be used as focal points for information on HIV prevention.

Objective: *To obtain sexual behaviour change among 30-50% of mobile population groups in Tanzania by 2002.*

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. *Create opportunities and environments for decision about sexual issues.*
The major steps were identified as follows: to identify peer educators for highly mobile populations using the AMREF experience; to produce peer educative materials in collaboration with AMREF and PSI; to train additional peer educators using other peer educators; and to produce a one page summary quarterly report on activities undertaken. AMREF will be the key actor for this strategy. Other actors can also join hands to address this strategy. Major inputs will be resource persons to train peer educators, materials for peer education and management support to NGOs.

Strategy 2. *Reach highly mobile groups in their respective areas*
Major steps identified were: to conduct a needs assessment for condom use among highly mobile groups outside AMREF s target groups; to develop IEC materials in a united effort among selected partners who are already working with some target groups; to procure and distribute condoms; to distribute relevant IEC materials in strategic areas; and to sensitise/orient health workers to the needs of relevant highly mobile populations in selected areas. The key actors are NGOs with assistance from AMREF. Key inputs include experts to conduct needs assessment for condoms, development of IEC materials, transport for distribution of materials and for supervision.

Strategy 3. *Make use of available entertainment areas and facilities.*
Major steps identified were: to identify and sensitise owners of entertainment facilities in HIV/AIDS/STD prevention among vulnerable and highly mobile populations; and to identify and orient contact persons in entertainment facilities on HIV/AIDS/STD prevention. The key actors are NGOs e.g. AMREF. Key inputs are resource persons to sensitise owners of entertainment facilities and to orient contact persons in these facilities. Resources will also be needed to develop IEC material and condoms. Also transport for distribution of relevant materials is essential.

Strategy 4. *Use existing religious institutions.*
Religious leaders and institutions already working with highly mobile population groups for dissemination of information on HIV/AIDS/STD prevention will be identified and supported. For example; Father Joinet s Fleet of Hope / Three-Boats concept of abstinence, fidelity and use of technology (condoms) and the Ugandan experience. The key actors are religious organisations such as the Christian Council of Tanzania and the BAKWATA (Baraza Kuu la Waislamu Tanzania- The Muslim Council of

Tanzania). Key inputs include IEC materials and transport for their distribution. Resource persons, educators, preachers etc. may also be required to disseminate the required information.

4.3 *Priority Area: Reduce HIV Transmission among Commercial Sex Workers*

The area of Commercial Sex Work (CSW) ranks very high among priority areas in HIV/AIDS prevention because commercial sex work is not only an important determinant driving the epidemic, but also has relatively effective interventions to reduce unprotected sexual behaviour among its clients

(a) What was done in MTP-II:

Commercial sex workers are not a group officially recognised by the government of Tanzania. However, because the group is crucial in HIV/AIDS transmission, different NGOs in Dar es Salaam and Morogoro have been implementing different activities with the groups ranging from condom distribution to income generating activities. In Tanga region GTZ has been working with prostitutes using peer educators. Other organisations have worked with CSWs in truck stops. They have been recruited as peer educators, condom distributors and to some extent, counsellors. However, there are no accurate data on the dynamics of this group and hence success in HIV/AIDS control activities involving them has been difficult to measure.

(b) Obstacles for MTP-III

In Tanzania the Government has difficulties in recognizing the reality of commercial sex work, and thereby making it difficult to approach this population group for education, condom promotion and distribution. This lack of recognition further leads to increased stigmatization, and hinders the provision of appropriate and adapted STD services. There has not been enough information on the dynamics of CSW s. For that reason, it becomes difficult to identify different group needs for intervention. Most of them do not have a permanent place for their sex work, making condom distribution a difficult endeavour. Because CSWs do their activities in darkness , it could be dif ficult to identify the needs for the peer educators, and even to design proper messages targeted to them. The health seeking behaviour of CSWs especially with regard to STD treatment is not known, hence it will be necessary to find innovative ways to provide them with care without stigmatising them.

(c) Opportunities for MTP-III

STD management clinics are available in 11 regions in the country namely; Mwanza, Mbeya, Iringa, Shinyanga, Mara, Kigoma, Dodoma, Dar es Salaam, Arusha, Morogoro and Tanga. Where such clinics do not exist, CSWs can be advised to utilise private and other public health facilities for treatment of STDs. Already, there are NGOs which are working with and treating CSWs for STDs in different parts of the country that could be used as opportunities for addressing this priority area. Existence of guest-houses and hotels where CSWs meet their clients is a

good opportunity for utilizing them as condom distribution places. Furthermore, the existence of women groups that engage in income generating activities provides an opportunity for creating focal points for the attraction of CSWs to join and hence acquire alternative means of income. Examples include the Young Women Economic Groups (YMEGs) being supported by UNDP.

Objective: To reduce STD and HIV Transmission among CSWs By 25% By the Year 2002.

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. To Promote Health Care Seeking Behaviour among CSWs

Important steps to implement this strategy are:
to collate and analyze available information on CSWs, identify different groups of CSWs and their focal points and develop and implement IEC interventions including peer education and counselling targeted towards CSWs. In view of the above-mentioned obstacle of the Government not recognising the existence of CSWs, NGOs are the key actors for this strategy. The Key inputs are resource persons and materials needed to collect and to analyse available information on CSWs, to train peer educators and counsellors and to develop of IEC materials for CSWs.

Strategy 2. To Improve and expand access to STD services for CSWs.

This strategy will need 2 essential steps, namely: To ensure availability of STD services, including drugs for CSWs and to promote non-discriminating attitudes among health care provides. The limited Government capacity to ensure a regular drug supply may remain a constraint to this strategy. The ongoing EU support for STD control is a great opportunity for this strategy. The MOH is a key actor and key in-puts will include human and other resources for running STD clinics either separately or integrated into routine services. Continuing educational materials and resource persons for sensitising health care providers will be needed.

Strategy 3. To promote the use of condoms among CSWs

Free condom distribution for all is already being implemented by the NACP, but there is no guarantee that they reach the CSWs as a group. Therefore, an important step for this strategy is to develop further the condom distribution system and to conduct social marketing for condoms, targeting CSWs. The total number of condoms distributed or sold will be a good indicator for monitoring this strategy. Respectively the MOH and the private sector will be key actors. Key inputs include resources to evaluate the existing condom distribution system and to recommend ways of improving it to include CSWs. Resources will be needed for conducting social marketing for condoms and for monitoring and evaluating condom distribution and use among CSWs.

Strategy 4. To promote income generating activities among CSWs

Promoting income-generating activities amongst CSWs empowers them to negotiate for safer sex. A better economic status of CSWs may not only encourage some of them to withdraw from CSW all together, but also empowers them to adopt the attitude of No condom, no sex! An obstacle to consistent condom use by CSWs is the lack of acceptance of condoms by their clients. Many CSWs clients prefer to have sex without condoms and therefore they do not hesitate to offer higher prices if the CSWs so demand.

Steps for the implementation of this strategy are: to identify partners interested in running and supporting income generating programmes for women and to create awareness among CSWs of existing credit schemes and negotiate with the schemes to give preferential treatment to CSWs in approving credits. The key actor will be the MCDWAC. The key inputs will include resource persons to identify partners interested in supporting income generating activities and resource persons and materials for creating awareness about credit schemes and for negotiating with them.

4.4 Priority Area: Prevent Unprotected Sexual Activity Among the Military.

Studies show that military recruits are at a higher risk of HIV infection and STDs than the general population. This is partly due to the fact that they are highly sexually active and mobile and yet they are subjected to military regulations which bar them from getting married while in service for at least six years. Being socially isolated for long periods they develop high-risk behaviour that is fuelled by peer pressure to engage in unprotected sexual activity.

(a) What was done in MTP-II:

During MTP-II, a civil military alliance, bringing together the police force, the armed forces and the civilian security forces, was formulated as a joint effort to fight HIV/AIDS among them. Screening for HIV and treatment of STDs were done in most places within the alliance. However, a proper research to establish the HIV prevalence among numbers of the alliance as a group has not taken place.

(b). Obstacles for MTP-III:

The military as a group is sparsely distributed in the country and so, if needs assessment to cover the whole country has to be done, then financial resources are likely to be an obstacle. It may be difficult for relevant civilian NGOs to operate within the military but this can be negotiated whenever it becomes necessary.

(c). Opportunities for MTP-III:

The existence of the civil military alliance is an opportunity for joint implementation of the intended activities.

The alliance increases the chance of availability of resource persons from within the alliance to be utilised in performing the different activities within the alliance. Furthermore, the military are expected to be highly disciplined and hence control programmes among them are expected to be well received. The fact that a large number of soldiers live in barracks, it makes accessibility and implementation of HIV/AIDS/STDs activities and control easier than outside the barracks.

Objective: To reduce unprotected sexual behaviour among the armed and security forces (Civil Military Alliance) by 75% before the end of 2002

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1 To establish base-line data on condom use among the armed and security forces

The important steps to implement this strategy are: to prepare terms of reference for a base-line study to establish the level of condom use among the military; to assign a military consultant to conduct the study; report the results of such a study to the relevant forum. These steps will provide the needed information on condom use. The main actor is the Civil Military Alliance. The main inputs will be the cost of the base-line study.

Strategy 2 To promote and provide condoms

Steps to address this strategy are: to prepare, pre-test, print and distribute IEC materials on condom use; identify proper storage facilities and transport for condoms; identify appropriate sources and procure condoms. The key actor is the Civil Military Alliance. The main inputs are IEC personnel and materials, condom storage facilities and transport

Strategy 3 To establish regular voluntary HIV screening and counselling services

Steps for achieving this strategy include identification and establishment of centres for voluntary HIV screening and counselling; identify and procure appropriate HIV test kits; identify appropriate storage facilities and transport for distribution of the test kits; train and re-train laboratory technicians for HIV testing; for the services. The key actors are the Civil Military Alliance and the MOH. The main inputs will be training and re-training of laboratory technicians and counsellors, regular supply of HIV testing kits, training materials, transport and resource persons with supervision skills.

Strategy 4 To provide STD case management services

Steps towards achieving this strategy include training of trainers on STD management; preparation of training materials; procurement of laboratory equipment and reagents; procurement of STD drugs and treatment algorithms. The key actors will be the Civil Military Alliance and the main inputs will be trainers, training and service materials and cost of STD drugs, laboratory equipment and reagents.

Strategy 5 *To promote positive sexual behavioural change*

Steps include identification and training of peer educators on positive sexual behavioural change among the armed forces. The peer educators should then train their peers on positive sexual behaviour change with regular supervision by informed resource persons. The number of educative sessions and the number attending will measure achievement. The key actors will be the Civil Military Alliance and the main inputs will be training of peer educators, training materials and transport.

4.5 Priority Area: Reduce Vulnerability of Youth to HIV/AIDS/STD

In Tanzania, about 65% of the total population are below the age of 25 years. This group constitutes youths and children, the former being the majority. The in-school youth are potentially vulnerable to many risks including STD and HIV infection through early sexual intercourse combined with lack of knowledge on inherent risks and preventive measures. This situation gets worse when many of them drop out of school at relatively early age, and loose the school s protective environment.

The out-of-school youth are the most vital and economically active group. Yet, they are increasingly being acknowledged as a serious development issue following rapid rural urban migration, youth unemployment, drug addiction and the relationship between youth sexuality and HIV/AIDS/STD. Government as well as NGOs and CBOs are already running a range of youth development programmes. Some of these programmes incorporate HIV/AIDS activities. The youth programmes under the Ministry of Labour and Youth Development, which incorporate HIV/AIDS action and which UNDP will support are:
(a) Youth economic groups (YEGs),
(b) Young mothers economic groups (YMEGs) and
(c) The youth guidance and counselling programme.

YEGs are being created through the initiative of the youth themselves at the village level. They address youth unemployment as the root problem that gives rise to other youth problems, including susceptibility to HIV infection. This priority area will therefore have two components in its objective: one for the out-of-school, and the other for the in-school youth.

(a) What was done in MTP-II

In some districts, there are NGOs that focus on out of school youth group. In MTP-II, this group was also accessed indirectly in STD management, counselling and condom distribution activities. This group was also reached by educational messages, which were disseminated to the general public. Also reached this group. Concerts aimed at behaviour change were conducted in four out of twenty regions of mainland Tanzania and also, some videocassettes were shown to this group. However, funds for production of IEC materials and for implementation of the planned activities at district level were not enough. Furthermore, there was no evaluation done on the content and impact of the materials used.

MTP-II did not have a direct focus on youths in school and as a consequence, the MTP-II Review Document does not mention any activity done in this group. However, some teachers in primary schools were sensitised on HIV/AIDS/STDs knowledge. Some learning materials were also prepared and incorporated in the primary school syllabus. However, there has been a lot of friction as to whether HIV/AIDS/STDs should be taught in primary schools.

(b) Obstacles for MTP-III

Youth out-of-school is a fragile group. It is difficult to reach them. Most of them are very mobile, hence not easily traced. Furthermore, they are in most cases not an organised group.

Parents and teachers are an important group to be incorporated in this struggle but, the willingness of some parents and teachers to participate in informing the children is also another obstacle. Drama and debate groups need to be used but there are not enough skilled teachers in those areas. Most of schools lack libraries making it difficult to make the necessary HIV/AIDS/STDs materials available.

(c) Opportunities for MTP-III

Youth centres are places that could be used to access the youth. Such centres exist in some communities, districts and urban areas. Examples are the Youth Economic Groups (YEGs) established under the Ministry of Labour and Youth Development and supported by UNDP. Also, there are NGOs that work with such groups in some communities. Their experiences could be taped and used to design ways to reach the group successfully.

Other opportunities include teachers as resource persons who are available in each school. Apart from that, all schools have committees and boards in place. The existence of theatre and drama groups in schools is good opportunities to be utilised. Schools that have libraries provide a good opportunity for dissemination of the required information.

Objective (a): To reduce vulnerability to HIV/AIDS/STD among in-school and out-of-school youth by at least 50% before the year 2002.

In order to address the above objective, the following strategy, its corresponding steps, key actors and inputs were identified:

The strategy: *to take advantage of existing youth meeting points in the communities in order to reach the out-of-school youth.*

The corresponding steps are:
To conduct needs assessment research at youth meeting points/centres, to identify peer educators among the cultural and economic groups, to train these peer educators on HIV/AIDS/STD prevention, to strengthen existing youth economic generating groups for maintaining health status, e.g. HIV prevention, improving vocational skills for securing employment, etc. and to encourage young people to start new youth social and economic groups.

The key actor in this area is the Ministry of Labour and Youth Development (MLYD) which should seek the collaboration of various NGOs with working skills among youth. Key inputs include resource persons for conducting needs assessment research in youth centres and for identifying and training peer educators. Other inputs include resources for strengthening existing youth economic groups.

Objective (b): To provide HIV/AIDS education for in-school youth at primary, secondary and post secondary levels.

Achieving behaviour change, especially among young people is not just a matter of providing them with the appropriate information. It requires various strategies to influence them through different channels that convey messages leading to the same objective. Hence, in order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: *To incorporate HIV/AIDS/STD education in school curriculum.*
The following steps will lead to the accomplishment of this strategy:
Conducting a needs assessment concerning the teaching of HIV/AIDS/STD in schools, preparing training manuals and education materials for teachers and students respectively and identifying and training teachers to provide HIV/AIDS/STD education in schools. The key actor here as in the other strategies to follow will be the MOEC.

Strategy 2: *To involve parents in HIV/AIDS/STD prevention efforts in schools.*
The strategy comprises the following steps:
To establish school committees where they do not exist, to arrange meetings of chairpersons of school committees to sensitize them on HIV/AIDS/STD education, to convene school committee meetings to discuss HIV/AIDS/STD related issues and to sensitize parents through parents meetings.

Strategy 3: *To promote HIV/AIDS/STD education in school extra curricular activities. such extra-curricular activities could include:*
The strategy comprises the following steps:
Participatory theatre groups and debating clubs, developing and conducting plays to promote prevention of HIV/AIDS/STD, identifying and training of peer educators and establishing or strengthening counselling services in schools.

Strategy 4: To Strengthen and promote the use of school libraries.

In existing school libraries, relevant educational materials on HIV/AIDS/ STD will be identified, or otherwise provided to them from other sources such as UNICEF or NGOs working in this area.

Strategy 5: To use peer educators in influencing behaviour change at post-secondary school level.

The steps to implement this strategy include:

The establishment of committees in the various institutions, identifying and recruiting a consultant with appropriate terms of reference for the development of guidelines for peer educators training, conducting the training of selected peer educators and supporting and supervising peer educators on a regular basis. The key actor is this area is the MOEC, which should utilize school committees, boards, parents, teachers and the students. Key inputs include development of guidelines for peer educators, training of peer educators, development of self-sufficient educational materials for the students and encouragement and training of teachers to participate fully in HIV prevention work

4.6 Priority Area: Maintain Safe Blood Transfusion Services

By maintaining safe blood transfusion services throughout all transfusion centres in the country all HIV transmission due to blood transfusion or its products can be eliminated. This is a key responsibility of the health care delivery system of the MOH. Among the 182 blood transfusion sites throughout the country, the four national and seventeen regional sites are operating well. The remaining 161 transfusion sites are not working well due to various logistic problems. Problems associated with these sites include inadequate provision of basic supplies and equipment, lack of assurance that supplies are being used properly, lack of cold chain facilities, and lack of standardized quality control for blood transfusion.

(a) What was done in MTP-II

During MTP-II, most donated blood was screened for HIV anti-bodies using the simple rapid tests (HIV CHECK or CAPPILLUS) in all centres providing blood transfusion services. In addition, relevant data on screened blood donors were kept and maintained at these centres. However, due to interrupted power supply in some regional hospitals they were forced to use HIV CHECK instead of the recommended ELISA test. Furthermore, no quality assurance arrangements were made by NACP, and there were no adequate supervisory visits conducted by NACP to these centres due to shortage of transport and funds.

(b) Obstacles for MTP-III

In MTP-III donated blood is more likely to be HIV sero-positive than previously and hence be discarded. For this reason, more blood donors will be needed to satisfy the demand for safe blood transfusion. Furthermore, the pool of blood donors is likely to decrease due to increasing fear of sero-positivity among

potential donors. However with intensive intervention activities in other priority areas of MTP-III this problem is likely to be minimized.

(c) Opportunities for MTP-III

The existing guidelines on blood transfusion could be used to train and retrain the staff in health facilities. Furthermore, the existing laboratory services in each transfusion centre, need to be used more efficiently.

Objective: To ensure that safe blood is available in all blood transfusion sites at all times by 2002

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1. *Update status of blood transfusion in all health units where blood transfusion is performed.*

The steps identified to accomplish this strategy include the undertaking of a research project to identify the needs and actions that must be taken to upgrade the existing transfusion sites. The first step is to prepare terms of reference, identify a consultant who is familiar with the blood safety issues in Tanzania and conduct the research. The key actor will be the MOH. The major inputs are human resources and funds for conducting the research.

Strategy 2. Develop a National Blood Transfusion Service.

The standardization and quality control of the district blood transfusion services need to be established, understood, and practised by all managers. This will require an investigation of whether the quality and standards already in place are adequate to meet demand and whether these standards are practised in the districts. A blood safety consultant is proposed to investigate the situation and make recommendations in collaboration with a national blood safety team. The recommendations should result into formulation of a National Blood Transfusion Service whose main responsibility will be to monitor the standards and quality of district blood transfusion.

The key actor will be the MOH while the main inputs will be human resources and funds for the consultancy tasks and the required investigations..

Strategy 3. Provision of materials.

The action required to provide materials on a sustaining basis is to establish a responsive monitoring system that will anticipate the need for materials, storage, and transport logistics.

The key actor will be the MOH and the main inputs will be the cost of supplying on a regular basis, the needed basic supplies and equipment for safe blood

transfusion services and the monitoring and quality control aspects of the programme.

Strategy 4. Training

The first step is to identify the training needs among the staff responsible for blood safety in the respective transfusion sites. This should also establish the manpower needs in each of these sites, their job description-responsibilities for managing a unit and any employment factors that may impede their management responsibilities. The next step is to identify a resource person who can carry out a training programme based on the needs identified among staff. The terms of reference of the training manager and the number of facilitators required will depend on the extent of training needs identified and the number of staff to receive training. Human resource opportunities probably exist among the National and Regional transfusion sites that are in good working order.

The key actor will be the MOH and the main inputs will be a resource person to identify manpower and training needs, facilitators to train existing staff and funds for regular retraining workshops.

4.7 Priority Area: Reduce Poverty Leading to Sexual Survival Strategies

It is a well-known fact that poverty reduces access to basic needs such as food and shelter as well as social services such as health education and employment. These circumstances by themselves increase the vulnerability of the poor to diseases like STD and HIV/AIDS, and often create the vicious circle of poverty, ill health and poor economic status. In addition, the temptation is high for poor people to get out of this vicious circle through all kinds of more or less marginalized activities including sex for money or other favours.

While poverty alleviation is far beyond the scope of health planning in general, and of a national HIV/AIDS plan in particular, it remains that sex for money or other goods, especially by young women and girls, is a major determinant fuelling the HIV epidemic, and hence it is justifiable to address it during MTP-III.

(a) What was done in MTP-II

During MTP-II, a poverty alleviation programme financed by UNDP was started. However, the programme does not focus on poverty as a factor that may lead to sexual survival strategies thereby increasing HIV transmission. Although there are other community based programmes in different areas of the country that mobilise women and provide them with soft loans, there is no active integration with activities aimed at reduction of sex for money.

(b) Obstacles for MTP-III

The difficulty of identifying low-income women who engage in sex for money is an obstacle. Lack of awareness among women on the availability of credit facilities and the negative attitude of some men towards women interpreneurship, are some of the hindrances that need to be addressed

(c) Opportunities for MTP-III

Different NGOs dealing with income generating activities exist in some communities and should be used as an opportunity for implementing the strategies. Other opportunities include; the existence of a poverty alleviation policy, existence of donors as potential partners, existence of women groups, existence of government sectors involved in women development, existence of mass media, existence of credit facilities, legal rights for women, existence of vocational training centres and women willing and able to take loans and pay back.

Objective: To reduce the number of persons in poverty who earn money for sex, by 25% before the end of 2002.

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: To initiate income-generating activities for low-income women who earn money from sex.

After identifying such women in the community and conducting a needs assessment, the next steps will be to train, encourage and assist them to obtain soft loans for initiating small businesses as income generating activities. The MCDWAC will be the key actor and NGOs already working in this area such as TGNP, TAMWA, TAHEA, etc. will be the key partners. The Key inputs will be resource persons for identifying low-income women groups in the community earning money for sex and conducting a needs assessment to determine their needs. Resource persons and materials will also be needed for their training in management of small-scale income generating activities and assistance in obtaining soft loans.

Strategy 2: To promote the rights of women.

As a first step, any law that would implicitly infringe women s rights should be identified and every effort made to change it in the legal frameworks which are now under consideration, particularly those of HSR and decentralization.

A complementary step is to sensitize women about their rights, and support and empower them to stand up for these rights. The NGOs already mentioned here above will be critical partners in helping the MJCA, which will be the key actor, to materialize this important strategy. The key inputs will be resource persons to identify laws that infringe women s rights and to recommend their appropriate amendments. Resource persons and materials will also be needed to sensitize women about their rights.

Strategy 3: To provide girls with opportunities to have access to vocational training.

Several successive steps will be needed to build up this strategy, in which relatively little has been done so far.

* Needs assessment for the demand for vocational training among girls.
* Identify existing vocational training centres and assess training opportunities for girls.

* Encourage the local government and community to establish vocational training centres for girls with accommodation facilities.
* Promote educational opportunities for girls in vocational training centres to be the same as for boys, if not more.

Sensitize parents and the society in general regarding the importance of vocational training for girls. The key actors in this process will be the local government, the MLYD and the MCDWAC. Key inputs will be resource persons to conduct a needs assessment for the demand for vocational training among girls. Resource persons will also be needed to identify existing vocational training centres and assess training opportunities for girls. Resource persons and materials will in addition, be needed for sensitising parents and the society regarding the importance of vocational training for girls.

4.8 Priority Area: Promote Acceptance of Persons Living with HIV/AIDS

Stigma, discrimination and non-respect of the basic rights of persons living with HIV or AIDS (PLHAs) not only are determinants for driving the epidemic - through having PLHAs conceal their HIV status to their partners if they know it, or discouraging them from testing, and hence contributing to the invisibility of the epidemic - but also constitute unacceptable breaches of these persons human rights on the basis of their mere health status. An important role of PLHAs is not to be passive but to be responsible and to participate fully in HIV/AIDS control activities.

(a) What was done in MTP-II

During MTP-II, the NACP supported some NGOs to implement community based counselling. Pre-and Post-test - counselling was implemented for those seeking voluntary HIV testing such as pre-marital couples and the worried well. A similar service was also provided for population-based surveys requiring HIV testing. Home-Based Care activities were carried out by different organisations like WAMATA, PASADA, UPENDO, TANESA and other several organisations dealing directly with PLHAs. Also, NACP conducted a baseline survey on Home-Based Care (HBC) and conducted training for home caregivers in two pilot regions, Rukwa and Coast. During MTP-II NACP trained 73 hospital-based counsellors in 59 hospitals to implement the counselling service.

However, there was little documentation on the counselling process, hence it is difficult to assess the quality of the service given. It was also noted that the existing guidelines for counselling are mostly hospital-based. It was also noted that privacy of counselling seemed to be lacking in most institutions. Also, family and couple counselling were not addressed in the MTP-II. The MTP-II review also noted that HBC services were not adequately addressed. The current hospital discharge plan does not include any aspect of HBC, and HBC service providers are not well motivated. Furthermore, NGOs dealing with HBC were not evaluated to measure the impact of HBCs on the welfare of PLHAs.

(b) Obstacles for MTP-III

Lack of a strong political commitment may be an important obstacle in this area. Shortage of drugs in most places where PHLAs go for treatment of their opportunistic infections is very frustrating. Lack of enough qualified counsellors could be a hindrance to PHLAs to come in public for necessary care and social support. Lack of awareness of legal rights hinder PHLAs to expose themselves to the public. Fear of HCWs to contract the disease from patients also makes the management of opportunistic infections of PLHAs difficult.

(c) Opportunities for MTP-III

The existing of NGOs dealing directly with PHLAs is an opportunity that could be used to address this area. The existing HIV counselling and testing services in hospitals is another opportunity. Government health facilities have personnel who could be trained to be good and confident counsellors. The existing user-fee policy (in public health facilities) that require PLHAs to be treated free is also an opportunity to be taken advantage of during MTP-III. Existence of working guiding principles, documents and teaching manuals on the transmission of the disease could be used as opportunities for proper management.

Objective: To improve the well being of persons living with HIV/AIDS (PLHAs).

In order to address the above objective, the following strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: To encourage and support counselling and voluntary HIV testing for communities and to improve access to care for PLHAs

This can be done in the following steps:
Training of 2 counsellors as trainers per region who should then train in their respective regions 25% of health staff in care and counselling services to be extended to district hospitals, developing a code of ethics for counsellors, incorporating counselling training into the curricula of doctors, clinical officers and nurses, updating on a regular basis the policies on care and counselling services for PLHAs and encouraging and supporting the formation and running of voluntary HIV counselling and testing centres at district level.

The percentage of health care staff trained in the care and counselling of PLHAs, the incorporation of a code of ethics into the AIDS policy document, and the number of health related curricula with counselling incorporated will be indicators for the effective implementation of this strategy. The MOH and the constituent medical institutions are key actors for this area.
Key inputs are as follows:

i. Resource persons, funds and materials for training 2 counsellors per region as trainers.
ii. Funds for training 25% of health care staff in the care and counselling skills for HIV/AIDS.

iii. Resources persons and materials for developing a code of ethics for counsellors.
iv. Resource persons, funds and materials to incorporate counselling aspects into the curricula of doctors, clinical officers and nurses.
v. Resource persons, funds and materials to review and update policies on care and counselling services for PLHAs.
vi. Resource persons, funds and materials to support the formation and running of voluntary HIV counselling and testing centres at district level.

Strategy 2: The Government to regulate and create a favourable environment to ensure availability of relevant and effective drugs at affordable cost.

Once the list of necessary essential/drugs has been established, the appropriate government sector will negotiate affordable prices for them, and review pharmaceutical laws accordingly. UNAIDS and WHO will be key partners to the MOH which is the key actor. The Pharmacy Board and the MSD will assist the MOH in addressing this issue. The key inputs are resource persons to develop a list of necessary/essential drugs for the management of HIV/AIDS. The Pharmacy Board to review pharmaceutical laws and MSD to negotiate for affordable prices.

Strategy 3: To expand and improve HBC services, focusing on districts with high HIV prevalence.

The steps leading to the accomplishment of this strategy are:
Identify training needs of HBC services in districts with high HIV prevalence, prepare and ensure availability of manuals and guidelines on HBC, recruit and train HBC providers and develop a clear discharge plan that links hospital based services to HBC.

While the different steps can be monitored through the respective outcome indicators, the final success of the strategy will be measured by the proportion of hospital-based AIDS patients referred to HBC and given effective and appropriate home-based care. The MOH will be the key actor for this strategy. The DHMT and interested NGOs will be partners to the MOH.
The key inputs are:

i) Resource persons to identify training needs of HBC services in districts with high HIV prevalence.
ii) Resource persons, funds and materials to prepare and ensure availability of manuals and guidelines on HBC.
iii) Resource persons, funds and materials to train HBC providers at district level in high HIV prevalence areas.
iv) Resource persons to develop a patient discharge plan that links hospital-based services to HBC.

Strategy 4: To address stigma within the community and health facilities.

The creation of public awareness on ethics and human rights in relation to HIV/AIDS will be achieved through the following policy and advocacy steps:

a) Conduct a study to find out why the level of stigma is still very high in the community and health facilities despite high levels of HIV/AIDS awareness.
b) Promoting mass media information programmes on misconceptions, cultural norms, beliefs, customs and taboos on HIV/AIDS.
c) Sensitise mass media journalists in HIV/AIDS related issues.
d) Enforcing laws on (basic) constitutional human rights and promoting legal aid groups.
e) Finalizing the National HIV/AIDS/STD policy document and submitting it for ratification.
f) Conduct advocacy activities on HIV/AIDS related issues by sensitising the community at grass-roots level.

Ratification and wide dissemination of the National HIV/AIDS Policy will be a good indicator for progress made in this area, and will greatly contribute to reducing stigma and discrimination against PLHAs and their relatives and immediate environment. The key actor will be the MOH and the MJCA will be a major partner. The key inputs are:

i) consultant/resource persons and funds to conduct a study to find out why stigma persists in communities and health facilities despite high level of HIV/AIDS awareness.
ii) Resource persons, funds and materials to sensitise mass media journalists and to promote mass media information on misconceptions regarding HIV/AIDS.
iii) Resource persons and funds to finalize the National HIV/AIDS/STD policy document.
iv) Resource persons, funds and materials to conduct advocacy activities on HIV/AIDS by sensitising communities at grassroots level.

4.9 Priority Area: Reduce Unprotected Sex among Men with Multiple Sex Partners.

This priority area focuses on the reduction of widespread unprotected sexual intercourse among men with multiple sex partners. Although men and women are equally involved in unprotected multiple sexual intercourse, men have generally been responsible for initiating such risk behaviour. As such intervention among men should result in a significant reduction in HIV transmission.

(a) What was done in MTP-II

The only men s group that was specifically targeted during MTP-II was the highly mobile population group of truck drivers. IEC activities were conducted by different NGOs in the major truck routes and condoms distributed in these areas. For the other male population groups, owners of guesthouses and hotels were encouraged to make condoms available in their guesthouses and hotel rooms. TV and radio programmes (messages) targeting high-risk behaviour were designed and produced. A set of IEC materials (newsletters and calendars) were produced and distributed by different communication channels. Different NGOs were also used to reach the

general public in trying to advocate for safer sex. However, the limited community involvement in planning, implementing and producing IEC materials acted as an obstacle against more achievements. Furthermore, the impact of these materials was not evaluated.

(b) Obstacles for MTP-III

TV and radio as a means for communicating messages do not reach each and every targeted group, because not all of them have TVs or radios. Some cultures allow men to have more than one wife, but this relationship is not considered to be multiple sex partnership unless one or more of the partners engage in extra-marital sex relationship. Although multiple sex partnership in Tanzania is rampant, identifying situations of multiple-sex partnership is difficult and may constitute an obstacle for MTP-III. However, reducing the widespread unprotected sexual intercourse among men with multiple sex partners will be the best option for MTP-III to reduce HIV transmission.

(c) Opportunities for MTP-III

Guest houses and hotels where these men spend their time with their partners should be used as condom distribution points by making sure that each room is regularly provided with condoms. Religious groups do exist in the society, and should be used to disseminate information on responsible sexual behaviour. Since most men can read and write, IEC materials and messages should continue to be distributed and the existing distribution points should be effectively utilized.

Objective: To reduce the percentage of men practising unsafe sex through multiple sex partnerships by 25% before the year 2002

In order to address the above objective, the following strategy, corresponding steps, key actors and inputs were identified:

The strategy identified is to promote safer sex through scaling up of the strategy of Father Joinet s Three-Boats concept of abstinence, fidelity and use of technology (condoms). Major steps identified are to provide awareness education on HIV/ AIDS through IEC materials, public meetings, radio and TV programmes; to develop IEC materials, and to disseminate the IEC materials to the target population. The key actors are religious organizations, NGOs, PSI and MOH. The key inputs are: Resource persons, funds and materials to develop, test and disseminate IEC materials using appropriate means e.g. posters, leaflets, booklets, public meetings, TV and radio.

4.10 Priority Area: Improve Educational Opportunities Especially for Girls.

Many studies have shown that women in many African cultures are subjugated and are powerless economically and socially. Hence their power to negotiate for safer sex is limited. Women marry earlier than men and acquisition of knowledge about factors affecting their health is delayed. School attendance is poor among women while dropout rates among those in school are higher than among boys. For these reasons, education for girls is a priority area that should be addressed during MTP-III. Education will equip them with the necessary tools to negotiate for safer sex and will further delay early marriage, which puts most of them at risk.

(a) What was done in MTP-II

During MTP-II, secondary and higher education girls were not prioritized as a vulnerable group. The group was being reached by the information targeted to the general population using IEC materials, listening to radio, meetings, drama etc. School enrolment in favour of girls was not discussed during MTP-II because it was a matter to be taken up by the MOEC and the private school system.

(b) Obstacles for MTP-III

A major obstacle in this area is the lack of enough qualified girls to fill positions in secondary and higher learning institutions because of high dropouts and failure to pass the relevant examinations. A negative attitude towards girl s education by some cultures is likely to be an obstacle in getting more girls in higher education. Some parents would like to have their girls married early and hence never proceed to higher education. The inclusion of educational aspects of culture and life skills in secondary and higher education school curricula is a process that is likely to take some time before it happens. Private schools are likely not to allow girls of low pass marks to join their schools just as a favour.

(c) Opportunities for MTP-III

Curriculum review is a common practise in the Ministry of Education and Culture and other ministries concerned with post secondary training. Hence, this opportunity could be used to incorporate cultural aspects into the curriculum. Furthermore, schools have teachers in place who could teach the required life skills/cultural materials. Because some criteria exists and have been used before to allocate more places to girls in secondary schools and universities, the same criteria could be modified and used in favouring more girls to join higher education.

Objective: To promote secondary and higher education for girls to reach 50% of total enrolment by 2002

In order to address the above objective, the following four strategies, their corresponding steps, key actors and inputs were identified:

Strategy 1: *to expand secondary and higher education opportunities for girls to reach 50% of available total enrolment capacity in secondary and higher education facilities.*

The major steps were identified as follows: to negotiate with education providers (public, religious, private and NGOs) for them to purposely expand enrolment for girls in their facilities; allocate more places in favour of girls in all secondary schools and higher education facilities. Key actors were identified as the MOEC and the MSTHE.

The key inputs are:

Resource persons and funds to make contacts with the relevant authorities in the MOEC and MSTHE to negotiate for expansion of enrolment for girls and their facilities. Negotiations should lead into allocation of more places in secondary/higher educational institutions in favour of girls.

Strategy 2: *To incorporate life skill education in school carricula with emphasis on cultural norms and values that help to reduce HIV/AIDS.*

The major steps were identified as follows: to draw the terms of reference for identification of positive norms and values; to engage a consultant who will identify positive cultural norms and values; to review secondary and higher education curricula and incorporate life skills education with positive norms and values; to orient teachers on the newly incorporated features of the curriculum. Key actors were identified as the MOEC and the MSTHE. The key inputs are consultants/resource persons to identify positive cultural norms and values, to review secondary/higher education curricula and incorporate life skill education and to orient teachers on the newly incorporated features of the curricula.

Strategy 3: *To provide economic assistance to girls in need to have access to secondary and higher education*

The major steps identified were: to develop criteria for identification of girls in need for economic assistance; to employ the criteria to identify candidates and to solicit for assistance; to provide assistance to the needy girls. Key actors were identified as the Ministry of Education and Culture, the Ministry of Science, Technology and Higher Education, Ministry of Rural Development, Women Affairs and Children, NGOs dealing with women affairs and UNICEF. Resource persons to develop criteria for identification of girls in need for economic assistance, to employ the criteria to identify candidates and to propose a means to solicit for economic assistance. Funds will also be needed from charitable organisations to provide assistance to needy girls.

4.11 Priority area: Reduce vulnerability of women in adverse cultural environments

The situation analysis done in 1997 for MTP-II already mentioned the erosion of cultural norms and beliefs, and the general decline in morality in the Tanzanian society as a factor that could adversely affect the HIV/AIDS situation.

It is well known that individual behaviour can ultimately influence a person s susceptibility to become infected with HIV. However, individuals belong to a society and undergo cultural influences from that society, even in their most intimate behaviour such as sex.

(a) What was done in MTP-II

During the MTP-II, members of parliament were sensitised on the issue of the rights of women, and it ended up with enacting a law that safeguards the interests of women in sexual matters. Different NGOs dealing with human rights have passed messages to the community on the rights of persons to make decisions on sexual matters. Televisions, newspapers, meetings and radios were used during MTP-II to pass messages on sexual rights to different population groups.

(b) Obstacles for MTP-III

In a country as vast as Tanzania it is somehow difficult to reach consensus on what positive norms and values should be adopted. Furthermore, certain groups may be reluctant to give information about positive norms and values. There are taboos and beliefs that could make people consider negative values and norms as positive. Different societies have issues that cannot be discussed with people of different age groups in a gathering. Ignorance of the law and illiteracy could deny some people information about their sexual rights.

(c) Opportunities for MTP-III

There is a whole body of knowledge on cultural issues of different tribes that could be used to design appropriate messages, and create a conducive environment to approaching the community. Where there is no such information, elderly people could be approached to provide information on positive values in their communities. NGOs, radios, existing government structures, a common national language, choir groups, newsletters and existence of different community associations, are some of the opportunities that could be taken advantage of. The existing laws and regulations are also instruments that could be used in the implementation of the strategies. there are teachers in schools and other places of learning, who could be used for the exercise. In addition, a curriculum for family life education also exists.

Objective: To promote the cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters

In order to address the above objective, the following strategy, its corresponding steps, key actors and inputs were identified:

The strategy: to revive cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters.

Major steps identified were:

a) To develop terms of reference for a consultant to design a study on identification of cultural norms and values in the Tanzanian society that encourage positive attitudes and decision-making about sexual matters and to suggest ways of reviving them
b) To identify and recruit the consultant to conduct the study to identify positive cultural norms and values
c) To identify peer educators and mass communication media at all levels of the society
d) To train peer educators and use mass communication media to sensitise, educate and inform the society about the positive cultural norms and values
e) To sensitise, educate and inform the society to internalise positive cultural norms and values through various interventions and communication channels

Key actors are NGOs dealing with identification of positive norms and values such as TAMWA Mass Media, MOH, DHMT, MOEC, MSTHE, UNICEF, private sectors and religious organizations.

The key inputs are:
Resource persons, funds and materials to conduct a study to identify positive cultural norms and values and train peer educators on mass communication media at various levels of the society. The peer educators together with mass media should train, educate and inform the community and society at large about the positive cultural norms and values.

5.0 Programme Management Mechanism and Resource Mobilization

5.1 Background

The achievement of the objectives of MTP-III, as is the case with any other programme, critically depends on the existence of an appropriate and efficient programme management mechanism. This is because the role of management mechanism is to facilitate the implementation of the programme through its co-ordination and follow-up functions. It is, therefore, important that MTP-III is provided with the requisite co-ordination and follow-up mechanism to meet the programme s challenges. Since 1985 various programmes and institutional arrangements have been put in place to respond to the HIV/AIDS epidemic. However, the response analysis indicated that weak institutional capacity and poor co-ordination of programme activities have been responsible for poor performance of previous programmes.

The management mechanism of MTP-II consisted of the National AIDS Committee (NAC) and the secretariat of the National AIDS Control Programme. Activities in sectors, which participated in the implementation of MTP-II, were managed and co-ordinated by the respective sector Technical AIDS Committees (TACs). However, the major problem with the NAC was its inability to meet according to schedule. This problem made it difficult to play its leadership role in the programme. With regard to the NACP secretariat its effectiveness was constrained due to lack of leadership by the NAC and was therefore not effective in co-ordinating and mobilizing multi-sectoral initiatives. This outcome is a reflection of the general lack of political commitment towards the programme, making key actors in the Government, including its sectors, to give low priority and preference to the NACP activities as reflected in the passiveness of NAC and sectoral TACs.

The experience of MTP-II also shows that the problem of lack of political commitments was compounded by shortage of resources. This shortage manifested itself in the problems of inadequate management and low technical capacity to implement programme activities. Shortage of financial resources was another major obstacle to achieve the objectives of MTP-II. During this phase only 20 percent of the programme budgeted funds were mobilised. Thus, MTP-III will take cognisance of these obstacles.

5.2 MTP-III Management Mechanism

The MTP-III management mechanism is intended to avoid the institutional problems identified above and also to meet the co-ordination demands of and expanded multi-sectoral response, including emphasis on decentralized programme implementation to be focused at district and lower levels. The key actors in the implementation of this programme will include central government ministries, district local governments, non-government organizations, and the private sector. The working principle in the MTP-III, multi-sectoral and multi-actor response is that all players will have their own budgets for AIDS activities, complimented by resources mobilized through other mechanisms. All in all, like in the previous phases of this

programme, the viability of this management mechanism still depends very much on the political will and commitment of and efficiency of every player at all levels of central and local governments.

The Institutional Structure

The National AIDS Committee will be the highest programme management body with respect to the implementation of MTP-III, and will be responsible to the Cabinet through its parent ministry. The committee will be served by a secretariat, which will also be responsible for the co-ordination of implementation of the NACP activities. Individual central government sectors including parastatal, districts, NGOs in the private sector enterprises will be considered autonomous and connected to the secretariat directly through technical AIDS committees and indirectly through the normal working system of the Government and other agencies. This approach considers that activities of all key actors i.e. the central government, parastatals, districts, NGOs and the private sector are spread out all over the sectors.

(a) The Role of the National AIDS Committee (NAC)

The roles of the National AIDS Committee in the implementation of MTP-III will be as follows:-

- To advise the government on HIV/AIDS/STDs policy.
- To solicit political and religious commitment at the highest level
- To provide overall guidance on the implementation of the NACP
- To submit half yearly reports to the government on the progress of the programme
- To approve plans and budgets for the NACP
- To guide and approve strategies to mobilize and allocate resources
- To appraise the government on the trends of the epidemic (yearly)
- To create and strengthen partnership for an expanded national response among government agencies, NGOs, donors, UN Agencies, the private sectors and people living with HIV/AIDS.
- To initiate collaboration and co-ordination of HIV/AIDS/STDs activities within the region and globally.
- To promote substantial multi-sectoral communication.

(b) The Role of the NAC/NACP Secretariat

In order to avoid the unfavourable experiences of MTP-II the secretariat will be located in a Government institution where the chairperson of the NAC is stationed. The secretariat will relinquish one of its roles played during MTP-II, of implementing programme activities for the Ministry of Health. Hence it will remain only with the co-ordination role in addition to being the secretariat of NAC. In order to meet the challenges of multi-sectoral and multi-actor responses, the composition of the secretariat will have to be inter-disciplinary. The functions of the secretariat, therefore, will be as follows:-

- To serve as a secretariat to the NAC
- To initiate and harmonize HIV/AIDS/STDs activities for a national multi-sectoral response.
- To initiate and co-ordinate planning for HIV/AIDS/STDs prevention and control.
- To identify sources of funding and mobilize resources
- To advise NAC on allocation and utilization of resources
- To provide information and technical advice to sectors.
- To co-ordinate the compilation of half yearly programme implementation reports.
- To co-ordinate research activities on HIV/AIDS/STDs.
- To maintain a database on HIV/AIDS/STDs.
- To monitor and evaluate the overall implementation of the programme.
- To advocate for the NACP and its activities
- To advice on availability of supplies and materials for HIV/AIDS/STDs prevention and control activities.
- To facilitate inter-sectoral and inter-actors collaboration.
- To convene and chair quarterly meeting of representatives of TACs. The fourth quarter meeting will serve as an annual forum.
- To organise annual forums for all TACs, to review their contribution to the NACP
- To advise the NAC on the trend of the epidemic.

(c) The Role of Sectors

MTP-III provides a framework for developing plans of action by participating government, non-government and private sectors. These plans will be based on the comparative advantage in implementing the planned activities within a priority area. The sectors are encouraged to establish technical AIDS committees, which will be responsible for advocating for, managing and co-ordinating, the implementation of AIDS control activities within their sectors. The TACs will also have the role of monitoring AIDS control activities, and liaising with other sectors and the NACP secretariat for co-ordination. The roles of the sectors will be as follows:-

- To formulate, sectoral action plans and to budget for their implementation.
- To allocate and/or mobilise resources
- To monitor and evaluate planned activities
- To establish operational and management mechanisms including Management Information Systems (MIS) and ensure that sectoral technical AIDS Committees (TACs) are functional.
- To identify key actors and collaborators and define their roles.
- To prepare and submit quarterly progress reports to the NACP Secretariat to be shared with other sectors.

(d) The Role of Districts

MTP-III sees districts and their local governments as a very important set of players in its implementation. Districts and their local governments are closer to the people than the central government. They are better placed to mobilize people in the response to the epidemic and can easily identify epidemic s determinants and areas

for priority action specific to the districts. It is also expected that emphasis on community involvement in the response to the epidemic will be their key strategy. The following are some of the functions of the district local governments in the implementation of MTP-III:-

i. To identify determinants of the spread of HIV/AIDS/ STDs, specific to the district.
ii. To identify obstacles to the response of the epidemic from a locality point of view.
iii. To plan for and facilitate a multi-sectoral and multi-actor response to the epidemic.
iv. To establish and facilitate community interventions and involvement in the response to the epidemic.
v. To work closely with all actors in the districts response to the epidemic.
vi. To integrate HIV/AIDS/STDs activities in the district development plans.
vii. To mobilize and allocate resources for HIV/AIDS/STDs programme activities.
viii To monitor and evaluate the implementation of MTP-III activities in the district.
ix. To work with the central government in the HIV/AIDS/STDs surveillance.

These functions will from time to time, be refined in line with the health and local government reforms.

5.3 Human Resource Development

(a) An Overview

One of the important tasks in the implementation of MTP-III will be to strengthen the management and technical capacity of national, district and sectoral institution, including local NGOs and other voluntary agencies, to undertake HIV/AIDS/STDs prevention and control activities. At the national level emphasis will be put on ensuring the establishment of the required support system, which will facilitate programme implementation at the district level.

At the same time there is need to strengthen institutional capacity for programme management and co-ordination at all levels. The focus will be on mobilising of resources, strengthening of multi-sectoral collaboration and strengthening of district planning.

(b) Capacity Building at the National Level

Capacity building at the national level will take the following forms:-

i. Harmonising the chairmanship and the location of the secretariat. The aim is to ensure that the chairman has interest and concerns on the day to day functioning of the NACP secretariat. This interest and concern will be enhanced if the function of the organ the chairman is heading has some relationships with the roles of the NACP.
ii. Establishing departments and units, which will enhance the NACP co-ordination, programme management, resource mobilization and management and programme advocacy.

iii. Recruitment and assortment of inter- disciplinary personnel to be deployed in the new secretariat structure.
iv. Training to sharpen skills and to make them appropriate to the needs of the NACP.

(c) Capacity Building at the District Level.

Capacity building at this level will be concentrated in the following areas:-

i. Integrating HIV/AIDS/STDs information system into the District Health Management Information System (DHMIS).
ii. Continue training of district staff on management of the District Health Management System.
iii. Establish proper logistics for service delivery and ensuring availability of transport for monitoring and supervision.
iv. Train local government personnel to acquire skills for integrating HIV/ AIDS/STDs issues and development plans.
v. Train members of the PHCC and DMCs to integrate non-health issues into HIV/AIDS/STDs activities.
vi. Impart skills to members of the DHMTs for policy analysis and reporting.

(d) Capacity Building within Sectors

In this area, capacity building will involve:-
Setting up Technical AIDS Committees.
Establishment of Management Information Systems for HIV/AIDS/STDs activities within the sector.
Training of members of TACs in programme management, monitoring and evaluation.

5.4 Resource Mobilization

(a) An Overview

The MTP-III will take cognisance of the scarcity of resources, including financial and material resources. For this reason the Programme will focus on strategic priority areas of action and on strategies which are not financial resource-intensive. This includes putting emphasis on mobilization and full involvement of the civil society through participatory approaches. Sectors incorporating MTP-III activities within their functions will ease the burden of overhead costs of a vertical programme.

However, despite these approaches, the implementation of the expanded response against the epidemic in MTP-III requires increased financial, human and material resources. All available and possible resource mobilization channels will be explored

(b) Sources of financial resources:

The Government will be pressurised to increase its budget towards the implementation of MTP-III in order to increase the programme momentum against HIV/AIDS epidemic. Government budgetary sources will include direct funds to the program and budgets of sectors. However, the government expects to enlist the civil society to be the major source of funding through participatory community involvement, material contribution, community mobilized funds and cost sharing for the services provided by the programme.

Other sources of funding will include local government funding through integration of MTP-III activities in their development plans and the private sector contribution through provision of services and availing commodities through the commercial system.

Donor support is expected to continue and probably expand. Nevertheless this support is seen to supplement national sources of funding.

5.5 Financial Management

All available HIV/AIDS/STDs related resources will be utilized to implement the MTP-III, and all efforts will be directed towards efficient use of resource and their co-ordination. Control on the utilization of available funds will be enhanced through ensuring that financial reports are attached to the periodic reports sent by the NACP Secretariat to the NAC.

In order to ensure financial accountability at all levels, personnel handling funds will be trained in financial management skills where it will not be possible to recruit a professional finance manager. Financial procedures will be put in place for purposes of ensuring that funds are handled properly.

5.6 Management Information System

One of the requirements for appropriate programme management is the establishment of Management Information Systems at national, district and sector levels, including training of MIS operators.

In order to operationalize the MIS, the NACP will establish an MIS unit in one of its departments which will in turn create and maintain a database on HIV/AIDS/ STDs To facilitate and support co-ordination, monitoring and evaluation of MTP-III, the MIS data-base will also include programme implementation information as a necessary component. The MIS unit within NACP will be expected to assist sectors and districts to establish their own management information systems. In order to avoid duplication of work on health information system in the country, the MIS in the NACP should liase and work closely with the MTUHA system of the MOH to improve on what they already have on HIV/AIDS.

5.7 Disease Surveillance

Disease surveillance is indispensable in the efforts to control the HIV/AIDS epidemic and hence it is will be an integral part of the MTP-III.

The annual surveillance reports produced by the NACP Secretariat relay to the various stake holders information which is received from health workers in the regions. On the part of these peripheral workers, interest and efforts among them in providing the necessary data are critical. This normally consists of properly filling the appropriate forms, compiling routinely collected data and submitting promptly for analysis, compilation and subsequently report writing.

Problems experienced in the HIV/AIDS surveillance system include incomplete reporting by hospitals. The more critical problem in the system is the fact that the cases reported by hospitals are estimated to be only one fifth to one quarter of the probable actual number, due to many cases not reaching health facilities. More reliable information about HIV/AIDS cases can be obtained through surveys.

MTP-III will improve this situation through implementation of recommendations from the MTP-II review. These recommendations include:-

i. Undertaking social behaviour research to assess changes in sexual behaviour.
ii. Undertaking HIV sero-surveys in areas where such studies have not been undertaken such as in the south, west and central parts of the country.
iii. Improving epidemiological data collection, analysis and interpretation.

5.8 Monitoring and Evaluation

(a). MTP-III Monitoring Framework

Monitoring is an important management activity during the implementation and operation of programmes or projects. Its purpose is to ensure that activities are being implemented according to the plan and desired outputs are being produced in anticipated quantity and quality. When anticipated quantities and quality deviate beyond acceptable limits, corrective actions should be taken.

The monitoring system under MTP-III will monitor inputs (funds, equipment, time and personnel), outputs and physical implementation of each activity. All institutions involved in the implementation of the programme and projects will also be responsible for their monitoring.

The following is the distribution of tasks for the NACP, TACs and UNAIDS or other donor agencies:-

The NACP will be the overall co-ordinator of the entire programme. As a central institution, it will be irresponsible for overseeing timely physical implementation of activities by relevant agencies at sectoral, district and project levels. It will ensure that activities/projects implemented have their action plans adhered to. NACP will report programme implementation and progress to relevant bodies.

Technical AIDS Committees (TACs) will monitor implementation of activities at project level. They will continuously monitor and periodically report to NACP the actual progress during implementation and key problems affecting projects.

UNADS and Donors will support programme activities in accordance with proposed action plans in the MTP-III document. Donor agencies have a vested interest in the manner in which funds and technical assistance they commit to a program are utilized. Their interest rests at timely expenditure and attainment of outputs. They will take part in the monitoring process through receiving reports from the NACP and participating in monitoring visits. Projects under MTP-III will not report directly to UNAIDS or donor agencies.

(i) Information flow among the involved parties

Monitoring agencies will require information about issues to be monitored. Managerial functions which will facilitate information flow, includes gathering of information from programme implementation, relaying information to decision makers, relaying decisions to implementers and storing information for reference.

Gathering and relaying implementation information will be done through reports, observations and interviews. Written reports will however be preferred to interviews as they are easily retrieved as records. Simplified reporting formats need to be designed. Information from TACs and districts will be relayed to NACP in accordance with a reporting timetable. For effective and timely feed-back NACP will communicate information/decisions to implementers.

Information will be stored in computer memories and record files. In both cases only information that managers can retrieve easily will be stored. A simple project/ programme profile data sheet will be designed and used to build a database essential for programme management.

(ii) Monitoring information

Monitoring report formats that will be used to facilitate monitoring of the programme. The monitoring report formats will be designed to cover Action Plan Reports (Physical and Financial), Progress Review Reports (Physical and Financial), and Problem Monitoring Reports.

The Action Plan Reports will involve level action plan reports, namely; programme action plan, and sector/district action plan. Each action plan will have physical and financial targets. The action plan reports for the programme sectors/districts will be completed once in five years while those for the individual projects will be completed once every year.

Progress Review Reports, like in the case of action plan reports, will have two levels. These are the programme level and the sectors level, indicating physical and financial performance. The progress report for the programme will be completed twice a year. while reports for the sectors/districts will be completed quarterly.

Problem Monitoring Reports will involve a list of implementation problems and corrective measures taken to solve them. A simple reporting format will be used during inspection to monitor such problems. The problem monitoring reports will assess physical and financial performance, and propose actions to solve identified problems.

Site visits will be conducted to supplement quarterly progress reports. Such visits will be done twice a year for selected projects. Site visits will be used as a means to compare received reports and actual situation as collaborated with visual inspection on the site. NACP in collaboration with sectors/districts will perform physical site visits upon receiving reports from implementers. Problem monitoring forms (see annex 3.2) will be used. Dully completed problem monitoring reports will later be computerised and translated to sector/district and programme reports.

Deviation in any operation may signal a problem. To determine the magnitude of deviations, implementing agencies have to determine a range of acceptable deviations from the plan in order to determine the seriousness of deviation. It is proposed that the Range of Acceptable Deviation (RAD) should not exceed 25% below the planned target.

(b). MTP-III Evaluation Framework

Evaluation is a process which attempts to determine as systematically and as objectively as possible the relevance, effectiveness and impact of activities in the light of their objectives. The process includes an analysis of the relevance of project/ programme design. The purpose of impact evaluation is to measure, interpret, and judge the attainment of a programme. Feedback about achievements is important during a programme cycle and at its conclusion, and impact evaluation should often be extended to assess long term effects, including intended and unintended effects and positive and negative outcomes.

Two major evaluation exercises are envisaged for MTP-III.

The first evaluation will involve program review to be conducted in 1999 at national and district level involving all sectors. It will provide an appraisal of programs, and catalytic projects put in place for each priority area identified in MTP-III. It will also highlight the extent to which AIDS activities have been integrated into sectoral and district plans.

The second and final evaluation will be done in the year 2002 to examine the success and the impact of the expanded response during MTP-III. It will examine available human, material and financial resource and the extent the priority areas have been addressed and been able to minimize the impact of the epidemic on the individual, the community and the society at large.

Evaluation/Review Mechanism

A situation assessment is to be conducted before the MTP-III evaluation. The evaluation of MTP-III is supposed to be the central piece of the response analysis,

which will lead to further planning at the end of MTP-III for the period beyond 2002.

NACP will be responsible to organize the evaluation/review process. External reviewers from outside the programme including some international participants should do the review. The review will be beneficial to the Tanzanian society as it will provide a critical examination of the national response. All sectors and partners will also benefit from the evaluation.

5.9 Research

(a) An Overview

Knowledge and information to support national response against HIV/AIDS/STDs is very crucial as it facilitates the identification and understanding of determinants of HIV/spread. Knowledge and information also facilitates the identification and solution to problems associated with HIV/AIDS. Acquisition of the needed information on HIV/AIDS is through undertaking multi-disciplinary research.

(b) Research Objectives

The purpose of research in HIV/AIDS work should include:-
i. To develop means of preventing infection with the HIV
ii. To develop better diagnostic and treatment methods for HIV/AIDS.
iii. To better define risk factors and to develop interventions against HIV/AIDS.
iv. To monitor the spread of HIV and to determine the impact of interventions.
v. To evolve and develop innovative methods of mobilizing and involving individuals and communities in HIV/AIDS/STDs control.

(c). Research Priorities

During MTP-III research priority areas will include:
i. Social, cultural, behaviour and risk factors
ii. Psychological and emotional problems of patients, relatives and health care workers to evolve coping mechanisms.
iii. Epidemiology
iv. Diagnostics for HIV/STDs/TB/Others.
v. Health systems research (research in the delivery of health care).

(d) Funding of Research

(i) At the national level, mobilization of research funds will use the same strategies adopted for the whole MTP-III. Research specific to a government sector will be funded through the budget of the sector itself, supplemented by MTP-III resources and/or direct donor assistance (local or external).

5.10 Operationalizing the strategic plan (MTP-III)

Once finalized, the National Strategic plan of MTP-III, will be endorsed by the Government through the issuance of a Presidential Circular on the Programme and its official launching by the President.

The approved document will be circulated to all the sectors that have participated in developing the plan. Copies will be sent to all partners in development, other potential partners who, by their participation, will contribute to the national response. These should include:

a) Ministries and departments in all social, economic and development sectors.
b) Academic institutions and groups already working in the response.
c) Communities affected by HIV.
d) Local and international development organization.
e) Local and international donors.
f) Selected private sector companies and organizations.

These groups should use the national plan to guide their contribution to the response, to help them identify priority areas to which they can best contribute, to give them idea about partnership and to help them match resources to needs. Also underline that NACP should play a leadership role in orienting contributions to the highest priority areas, assisted by that NAC and by the UN Theme Group on HIV/AIDS.

The critical objective of the strategic plan is to create space for both public and private initiatives, guiding both towards a clear goal that will do most to change the situations that make people vulnerable to HIV/AIDS and its impact.

BUDGET

I Programme Budget (In US $)

OBJECTIVE/OUTPUT	STRATEGY/ACTIVITIES	INPUT	1989/99	1999/2000	2000/2001	2001/2002
1. Reduce STD cases by 25% by the year 2000	1.Establish appropriate environment for management of STD cases	.Consultant	10,000	-	-	-
		.Expert in STD management	7,000	7,000	7,000	7,000
		.Training materials	15,000	5,000	-	-
		.Resource persons	10,000	10,000	10, 000	-
	2.Strengthen and expand sentinel surveillance sites	.Trainers and workshops	15,000	10,000	8,000	6,000
		.STD drugs	2,600,00	2,600,000	2,600,000	2,600,000
		.Condoms	0	200,000	200,000	200,000
		.Strengthening of storage facilities		10,000	10,000	-
		.National expert	200,000	-	-	-
		.Sentinel sites	-	7,000	7,000	7,000
		.Training	10,000	10,000	10,000	10,000
		.Transport	7,000	10,000	10,000	10,000
		.Training materials	10,000	-	-	-
		.Documentation centre and staff	10,000	15,000	15,000	15,000
		.Research on training needs & Consultant	-	-	-	-
			15,000			
			20,000			
	3.Strengthen management and co-ordination capacity at all levels	.Consultant + needs assessment	15,000	-	-	-
		.Training materials	3,000	-	-	-
		.Facilitators	10,000	6,000	4,000	-
		.Venues	2,000	2,000	2,000	-
		.Transport	3,500	3,000	3,000	-
	4.Promote reproductive health education	.National expert (trainer)	7,000	7,000	7,000	7,000
		.Training materials	3,000	3,000	3,000	3,000
		.Venues	2,000	2,000	2,000	2,000
		.Transport	3,000	3,000	3,000	3,000
	5.Promote health seeking Behaviour	.Consultant (RAP)	3,000	-	-	-
		.IEC materials	5,000	5,000	5,000	5,000
		.Counsellors	10,000	10,000	10,000	10,000
		.Trainers	5,000	5,000	-	-
		.Transport	3,000	3,000	3,000	3,000

2. Obtain sexual behaviour change among 30 - 50% of mobile population	1.Create opportunities and environment for decision about sexual issues	.Peer educators .Resource persons .Peer education materials (identification) .Training	10,000 10,000 3,000 15,000	10,000 10,000 3,000 10,000	10,000 - - 10,000	10,000 - - -
	2.Reach highly mobile groups in their respective areas	.Needs Assessor (consultant) .IEC materials .Condoms .Supervision .Transport	10,000 3,000 200,000 4,000 3,000	- 3,000 200,000 4,000 3,000	- 3,000 200,000 4,000 3,000	- - 200,000 4,000 3,000
	3.make use of available entertainment areas	.Resource persons .Condoms	2,000 100,000	2,000 100,000	2,000 100,000	2,000 100,000
	4.Use existing religious institutions	.IEC materials .Transport .Educators and Disseminators .Preachers	2,000 2,000 8,000 5,000	2,000 2,000 8,000 5,000	2,000 2,000 8,000 5,000	2,000 2,000 8,000 5,000
3. Reduce STD and HIV transmission among CSW by 25% by the year 2002	1.Promote health care seeking behaviour among CSWs	.Resource persons .Trainers .Counsellors	5,000 10,000 8,000	5,000 10,000 8,000	5,000 10,000 8,000	5,000 10,000 8,000
	2.Improve and expand access to STD services for CSWs	.Training materials .Resource persons	3,000 - " -	3,000 - " -	3,000 - " -	3,000
	3.Promote the use of condoms	.Resource persons .Evaluator	3,000 -	- 10,000	- -	- 10,000
	4.Promote income generating activities	.Promoters .Materials	5,000 5,000	5,000 3,000	5,000 -	5,000 -

4. Reduce sexal behaviour among the armed and security forces (Civil Military Alliance)	1.Establish baseline data	.Consultant	5,000	-	-	-
	2.Promote condom use	.Resource persons (IEC) .Materials .Condomss .Storage facilities .Transport (fuel)	10,000 10,000 100,000 20,000 15,000	- 100,000 - 15,000	- - 100,000 - 15,000	- - 100,000 - 15,000
	3.Establish regular voluntary HIV conselling and testing	.Test kits .Counsellors .Training (lab tech) .Transport (fuel)	200,000 10,000 6,000 12,000	200,000 8,000 4,000 12,000	200,000 4,000 - 12,000	200,000 - - 12,000
	4.Provide STD management services	.Training .Training materials .STD drugs & reagents .Facilitators	10,000 5,000 50,000 6,000	- - 50,000 -	- - 50,000 -	- - 50,000 -
	5.Promote positive sexual behaviour change	.Peer educators .Training	5,000 10,000	5,000 -	5,000 10,000	5,000 -
5. Reduce vulnerability to HIV/AIDS/STDs among in-school and out-of-school youths by at least 50% before the year 2002	1.Conduct needs assessment	.Consultant (research)	20,000	-	-	-
	2.Establish counselling	.Training teachers and counsellors	20,000	15,000	15,000	15,000
	3.Train peer educators	.Training (peers)	20,000	15,000	15,000	-
	4.Improve vocational skills	. Materials	10,000	7,000	7,000	7,000

	5.Encourage to start social and economic group	.Training (skills) .Resource persons	10,000 12,000	10,000 10,000	10,000 8,000	10,000 8,000
	6.Groups promote theatre and debating groups in schools	.Resource person (manuals)	10,000	10,000	10,000	10,000
	7.Incorporate HIV/AIDS/STD information in school curriculum	.Consultant (curriculum) .Books	5,000 20,000	- 20,000	- 20,000	- 20,000

	8. Penalize Training manuals	.Manuals	15,000	15,000	15,000	15,000
	9.Involve parent in HIV/AIDS/STD prevention efforts	.Seminars (Resource persons)	20,000	20,000	20,0000	20,000
	10.Promote discussion on HIV/AIDS/STD	.Resource persons	15,000	15,000	15,000	15,000
	11.Strengthen school libraries	.Materials	20,000	20,000	20,000	20,000
	12.Needs Assessment (schools)	.Consultant (research)	20,000	10,000	-	-
	13.Train teachers on HIV/STD	.Training	25,000	25,000	25,000	25,000
	14.Counselling services in schools	.Training .Counsellors	15,000 15,000	15,000 15,000	- 15,000	- 15,000
	15.Support supervision of peer educators	.Resource persons Transport	17,000 3,000	17,000 3,000	- -	- -
	16.Develop guidelines of peer educators in schools	.Consultant	6,000	-	-	-
6. Ensure availability of safe blood in all transfusion sites	1.Update status of Blood transfusion	.Consultant (research)	10,000	-	-	-
	2.Develop a National Blood Transfusion Service	.Consultant (establish situation) .Blood transfusion equipment (all districts)	10,000 50,000	- 50,000	- 50,000	- 50,000
	3.Provision of materials	.Supplies (reagents etc)	200,000	200,000	200,000	200,000
	4.Identify training needs of blood safety staff	.Resource person (consultant) .Re-training .Facilitators	10,000 20,000 5,000	- 15,000 5,000	- 10,000 5,000	- 10,000 5,000

7. Reduce those who earn money for sex, by 25% before 2002	1.Initiate income generating activities to low income women who earn money for sex	.Consultant (needs assessment) .Training (resource people) .Training materials	10,000 10,000 5,000	- 10,000 3,000	- 10,000 3,000	- 10,000 2,000
	2.Promote the rights of women	.Resource persons .Materials	10,000 15,000	10,000 10,000	10,000 8,000	10,000 5,000
	3.Promote girls with opportunities to have access to vocational training	.Resource persons (needs assessment) .Materials for sensitizing parents	10,000 8,000	- 8,000	- 8,000	- 8,000
8. Improve the well being of people living with HIV/AIDS (PLHAs)	1.Encourage and support counselling and voluntary HIV testing and improve access to care for PLHAs	.Training of counsellors .Code of ethics materials .HIV testing kits .Funds to run HIV testing centres .Resource persons	15,000 5,000 25,000 10,000 8,000	15,000 - 25,000 10,000 8,000	- - 20,000 10,000 8,000	- - 10,000 10,000 8,000
	2.Expand and improve HBC services in districts with high HIV prevalence	.Consultant (needs assessment) .Guidelines for HBC + distribution .Trainers .Workshop (update) .Resource persons (patient discharge plan)	10,000 10,000 7,000 10,000 5,000	- 8,000 7,000 10,000 -	- 8,000 7,000 10,000 -	- 8,000 7,000 10,000 -
	3.Regulate and create a favourable environment for availability of drugs	.Resource persons (develop essential drugs list .Resource persons (review laws)	2,000 2,000	- -	- -	- -
	4.Address stigma within the community and health facilities	.Consultant (research) .Training (mass media) .Resource persons (policy) .Advocacy materials	10,000 5,000 5,000 5,000	- 5,000 4,000 4,000	- 4,000 - -	- 3,000 - -
9. Reduce unprotected Among men with multiple sex partners	1.Promote safer sex	. IEC materials .Resource persons .Radio & TV programs .Condoms	8,000 6,000 10,000 150,000	8,000 6,000 10,000 150,000	8,000 6,000 10,000 150,000	8,000 6,000 10,000 150,000

10.Promote secondary and higher education for girls reach 50% of total enrolment by 2002	1.Expand secondary and higher education opportunities for girls	.Resource persons	10,000	10,000	10,000	-
	2.Incorporate life skills in school curricula	.Consultants .Training (teachers)	10,000 25,000	- 25,000	- 25,000	- 25,000
	3.Provide economic assistance to girls in need to have access to higher education	.Resource persons .Advocacy	10,000 10,000	10,000 10,000	- 10,000	- 10,000
11. Promote cultural norms and values and encourage positive attitudes and decision making about sexual matters	1.Revive cultural norms and values	.Consultant (research) .Peer educators .TV and radio programs .Training per educator .Training (mass media)	20,000 10,000 10,000 25,000 10,000	- 10,000 10,000 15,000 10,000	- 10,000 10,000 15,000 10,000	- 10,000 10,000 10,000 10,000
T O T A L			4,668,500	4,256,000	4,156,000	4,404,000

GRAND TOTAL - US$ 19,034,500
Exchange Rate Tshs 660 (Sept' 1998)

TOTAL in Tshs: 12,562,770,000/=

Budget Notes

1. Consultancy fees include the fieldwork cost
2. Condom estimations are based on sexual contact estimates in the population
3. Budget for most IEC materials is for printing and distribution; taking into consideration most of the materials exist.
4. Figures have been rounded to the nearest hundreds.

II. Budget for Programme management, monitoring and evaluation (PMME)

ITEM NO	ACTIVITY	1998/99	1999/2000	2000/2001	2001/2002
1	-Coordination Meetings & Technical Support	-	-	-	-
	- National AIDS Committee (NAC), National Steering Committee, Technical AIDS Committees IEC, Research, Health, Education, Agriculture, Youth Development, Women & Children Donor Committee	20,000	20,000	20,000	20,000
	- NGO strengthening - support the NGO Technical AIDS Committee	10,000	10,000	10,000	10,000
2.	Resource Mobilization e.g.- Update document on donor contributions to the Programme	5,000	-	5,000	-
	Meeting to obtain private sector contributions	15,000	10,000	10,000	10,000
	Organize fund-raising activities	5,000	5,000	5,000	5,000
3.	Management Strengthening e.g.-country wide workshops on AIDS/STD management training course of WHO, -overseas training course on planning & management of economic Impact of AIDS/STD, -computer training, -administration training, -management information technology	40,000	40,000	40,000	40,000
4.	Programme Planning & Budgeting	-	20,000	-	-
	Reprogramming for 2000	10,000	10,000	10,000	10,000
	Developing yearly work-plans & developing quarterly work plans & implementation reports.	5,000	5,000	5,000	5,000
5.	Strengthening of Management Information System (Central, Regional & District Levels Consultancy Services) e.g.- Improvement of the accounting system, Improvement of the supply system, Application of the STD Surveillance System, Application of the AIDS Impact Model (AIM), Maintain MIS officer	10,000	10,000	10,000	10,000
6.	Inter-sectoral Coordination e.g. field visits to project in all sectors	10,000	10,000	10,000	10,000
	-workshops on effective interventions/lessons learned	-	20,000	15,000	10,000
7.	Intra-regional collaboration. Involves study visits to neighbouring countries.	15,000	15,000	15,000	15,000
8.	Advocacy Activities e.g. seminar for parliamentarians, sensitization seminars for heads of non-health government departments, study tour of NAP Uganda & Zambia for top officials of the NAC, World Health Day activities, International Day of Women, National Trade Fair, Participation in International Conferences	70,000	70,000	70,000	70,000

9.	Policy Development e.g. Update and reproduce national AIDS policy document	15,000	-	-	-
10.	Operating Costs (vehicles)	6,000	6,000	6,000	6,000
11.	Technical Assistance - Full time External Advisor Management (Financial management & general managerial support).	15,000	15,000	15,000	15,000
12.	Operating Costs e.g. Security services, Cleaning Services, Condom logistics and quality assurance, Distribution of supplies and materials, Telephone Services, Electricity & Water, Rental of warehouse facility, Maintenance of Equipment & Supplies, Maintenance of building	30,000	30,000	30,000	30,000
13.	Staff Support e.g. National staff salary subsidy, Secretarial services, Librarian	15,000	15,000	15,000	15,000
14.	Supplies/Equipment; Overseas & local procurement which involves; cleaning supplies, office & stationery supplies, office equipment & data processing, vehicles	40,000	40,000	40,000	40,000
15.	Supervision of district level activities	25,000	25,000	25,000	25,000
16.	Programme Review - Internal Review of MTP-III 1998 –2002 1. Preparatory activities; contract to refine, pretest already developed instruments for district- level data collection 2. Printing of instruments, Contract to computerize, enter and analyze district data.	-	-	20,000 10,000	- -
17.	External review of MTP-III e.g.- pre & post-review workshops, field work report writing, etc. Travel and per diem for review from neighbouring NAP.	-	-	-	80,000
18.	Internal Review of yearly activities.	5,000	5,000	5,000	5,000
	SUB TOTAL	**356,000**	**381,000**	**391,000**	**421,000**

GRAND TOTAL FOR PMME: **US $ 1,549,000 FOR 4 YEARS (1998-2002)**

Exchange Rate = Tshs 660 per US$

Total in Tshs = Tshs 1,022,340,000

GRAND TOTAL FOR MTP III = US $ 20,583,500 or = Tshs 13,585,110,000

7.0 References

1. TANESA: Tanzania-Netherlands Project to Support AIDS Control in Mwanza Region Annual Report, 1997
2. Tanzania Bureau of Statistics and Planning Commission, DHS: Knowledge, Attitudes and Practices Survey 1994
3. Tanzania Bureau of Statistics and Planning Commission, DHS: Demographic and Health Survey 1996.
4. The United Republic of Tanzania, Ministry of Health: NACP Research Priorities on Human Immuno-deficiency Virus infection and AIDS in Tanzania. December 1991
5. The United Republic of Tanzania, Ministry of Health: The National AIDS Control Programme - National Policy of HIV/AIDS/STD, Draft 1.0 September, 1995
6. Mnyika KS: Epidemiology of HIV-I Infection in Northern Tanzania, 1996
7. World Bank. Tanzania AIDS Assessment and Planning study. Washington, DC. December 1992.
8. Isaack H, Kisesa A: Report of the Inventory of local Institutions/NGOs and Human Resources for HIV/AIDS/STDs Programmes in Tanzania. September 1997.
9. United Republic of Tanzania: The Impact of HIV and AIDS on Women and Children in Tanzania , November 1995.
10. The United Republic of Tanzania, Ministry of Education and Culture: Guidelines for HIV/AIDS/STDs Preventive Education for schools Version 1.0 October 1996.
11. TANESA: Planning of District HIV/AIDS Programmes October 1996
12. Van-Praag E: The TANESA story, Evaluation of the Tanzania - Netherlands support on AIDS, Feb - March 1998
13. Ngw eshemi JZL, Boerma JT Barongo L, et al : Changes in Male Sexual Behaviour in response to the AIDS epidemic. 1. Quantitative Evidence from a Cohort Study in Urban Tanzania. TANESA working paper No. 6. December 1995.
14. Mdalami R, Luhamba D, Bulashi E, et al : Survey of Economic Opportunities for women in fishing posts Magu district. TANESA Internal Report Series No.1 Tanzania-Netherlands Project to support HIV/AIDS Control in Mwanza region, Tanzania; TANESA, November 1994.
15. The United Republic of Tanzanian, Ministry of Health: Policy Implications of Adult Morbidity and Mortality. End of Phase One Report. August 1997.
16. Ng weshemi JZL, Boema T, Bennet J, et al : HIV prevention and AIDS Care in Africa. A district level approach. 1997
17. SAREC: Behavioural and Epidemiological Aspects of AIDS Research in Tanzania. Proceedings from a workshop held in Dar es Salaam, Tanzania, 6 - 8 December, 1989. Eds. JZJ Killewo, GK Lwihula, A Sandstrom and L Dahlgren.
18. The United Republic of Tanzania, Ministry of Health, National AIDS Control Programme : ParProso - Participatory Management in Coping with AIDS. 1994.
19. The United Republic of Tanzania, Ministry of Health, National AIDS Control Programme. HIV/AIDS/STDS Surveillance Reports, No. 1 -11 (1989 - 1996)
20. The United Republic of Tanzania, Ministry of Health: NACP & ZAP Review Report of MTP-II November, 1997.
21. The United Republic of Tanzania, Ministry of Health: NACP Situation Analysis Workshop Report, August 1997.

22. The United Republic of Tanzania, Ministry of Health: NACP Review Reports May 1989, September 1991 and 1995.
23. Medium Term Plan II Documents: Strategic Plan (Vol. I), Health Sector (Vol. III) and Non-Health Sector (Vol. IV), (1992 - 1996)
24. UNAIDS: Strategic Planning Guide - Module 3:
25. Consultancy Report on Review Structure of the NACP (Mainland and Zanzibar) 1993.
26. World Bank (1997), Confronting AIDS: Public Priorities in a Global Epidemic. Washington DC.
27. Over, M., Ainsworth, M., Mujinja, P. G. M. et al (1996) Coping with AIDS: The Economic Impact of Adult Mortality from AIDS and other causes on Households in Kagera, Tanzania. Draft Brochure.
28. Mujinja P. G. M. (1997) Households Income and Poverty in relation to HIV/ AIDS Control. A paper prepared for NACP Situational Analysis.