

**2<sup>ND</sup> JOINT TECHNICAL REVIEW OF THE NATIONAL HIV/AIDS  
MULTI-SECTORAL STRATEGIC FRAMEWORK (2003-2007)**



**MARCH 8<sup>th</sup> to 10<sup>th</sup> 2006 - DICC, DAR ES SALAAM  
TECHNICAL REVIEW MEETING  
PROCEEDINGS**

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## **LIST OF ABBREVIATIONS**

ABC	Abstain, Be Faithful, Condom use
ABCT	AIDS Business Coalition in Tanzania
AIDS	Acquired Immunodeficiency Syndrome
AMREF	African Medical Research Foundation
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARVs	Anti-Retroviral Drugs
ATE	Association of Tanzania Employers
BAKWATA	Baraza Kuu la Waislam Tanzaniaia (National Muslim Council)
BCC	Behaviour Change Communication
CARF	Community Action Response Fund
CBOs	Community Based Organizations
CCT	Christian Council of Tanzania
CDC	Centre for Diseases Control
CHAC	Council HIV/AIDS Coordinator
CHBC	Community Home Based Care
CMAC	Council Multisectoral AIDS Committee
CSOs	Civil Society Organizations
CSWs	Commercial Sex Workers
DACC	District AIDS Control Coordinator
DC	District Commissioner
DED	District Executive Director
DPG AIDS	Development Partners Group on HIV/AIDS
DPs	Development Partners
FBOs	Faith based Organizations
FHI	Family Health International
GBS-HIV	General Budget Support for HIV
GFATM	Global Fund on AIDS, Tuberculosis and Malaria
GFCCM	Global Fund Country Coordination Mechanism
GLIA	Great Lakes Initiative on HIV/AIDS
GoT	Government of Tanzania
GTZ	German Technical Cooperation
HAART	Highly Active Antiretroviral Therapy
HBC	Home Based Care
HE	His Excellence
HIV	Human immunodeficiency Virus
HSS	Health Sector Strategy
ICT	Information Communication Technology
IEC	Information, Education, Communication
ILO	International Labour Organization

JICA	Japanese International Cooperation Agency
LGAs	Local Government Authorities
M&E	Monitoring and Evaluation
MAS	Multisectoral AIDS Strategy
MDAs	Ministry's Department and Agencies
MDGs	Millennium Development Goals
MKUKUTA*	Mkakati wa Kukuza Uchumi na Kuondoa Umaskini
MoCDGC	Ministry of Community Development, Gender and Children
MoEVT	Ministry of Education and Vocational Training
MoF	Ministry of Finance
MoHEST	Ministry of Science and Technology & Higher Education,
MoHSW	Ministry of Health and Social Welfare
MoLYDS	Ministry of Labour, Youth Development and Sports
MoU	Memorandum of Understanding
MTEFs	Medium Term Expenditure Framework
MUCHS	Muhimbili University Collage of Health and Sciences
MVC	Most Vulnerable Children
NACP	National AIDS Control Programme
NGOs	Non-Governmental Organizations
NHACAS	National HIV/AIDS Communication and Advocacy Strategy
NMSF	National Multisectoral Strategy Framework
NMSP	National Multi Sectoral Plans
NPEs	National Poverty Eradication Strategy
O&OD	Obstacles and Opportunities in Development
ODA	Oversees Direct Assistance
OIs	Opportunistic Infections
OVCs	Orphans and Vulnerable Children
PEPFAR	US. Presidential Emergency Plan for AIDS Relief
PER	Public Expenditure Review
PLHAs	People Living with HIV/AIDS
PMO-RALG	Prime Minister's Office Regional Administration and Local Governments
PMTCT	Prevention of Mother to Child Transmission
PO-PSM	Presidents Office, Public Services Management
PR	Public Relations
PS	Private Sector
QSP	Quick Start Project
RAS	Regional Administrative Secretary
RFAs	Regional Facilitation Agencies

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\* Swahili acronym for the National Strategy on Growth and Reduction of Poverty (NSGRP)

RFE	Rapid Fund Envelop
RH	Reproductive Health
RNE	Royal Netherlands Embassy
RS	Regional Secretariat
SBAS	Strategic Budget Allocation System
SHDEPHA+	Services for Health and Development for People Living with HIV/AIDS
SIDA	Swedish International Development Agency
SPW	Students Partnership Worldwide
SRH	Sexual and Reproductive Health
STIs	Sexually Transmitted Infections
TACAIDS	Tanzania Commission for AIDS
TACs	Technical AIDS Committees
TAMWA	Tanzania Media Women Association
TANASO	Tanzania Network of AIDS Services Organizations
TB	Tuberculosis
TCRA	Tanzania Communication Regulatory Authority
THIS	Tanzania HIV/AIDS Indicator Survey
TMAP	Multi Country AIDS Programme for Tanzania (World Bank)
TNW+	Tanzania Network of Women Living with HIV
ToRs	Terms of Reference
TPHA	Tanzania Public Health Association
TUCTA	Tanzania Confederation of Trade Unions
UMASITA	UMOJA wa Matibabu wa Sekta Isiyo Rasmi Dar es salaam
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children' Fund
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VEO	Village Executive Officer
WAC	World AIDS Campaign
WAD	World AIDS Day
WAMAC	Ward Multisectoral AIDS Committee
WEO	Ward Executive Officer
WHO	World Health Organization
WPPs	Work Place Programmes

# **1. INTRODUCTION**

## **1.1. Background**

The 2nd technical review of the Tanzania National Multi-sectoral Strategic Framework was done between March 8<sup>th</sup> and 10<sup>th</sup> 2006 in Dar es Salaam. About 100 participants attended the three days meeting representing various organizations including Public and Private sectors: Civil Society Organizations, Faith Based Organizations, Associations, PLHA Networks, Bilateral and Multilateral Development Partners, Government Ministries as well as Local Government Authorities.

In 1999 HE President (rtd.) William Benjamin Mkapa declared HIV/AIDS a national disaster. This was followed by a development of a National HIV/AIDS Policy in 2001, the development of Tanzania AIDS Commission in 2002 under act no. 22 of 2001 and then development of a National Multisectoral Strategic Framework in 2003. The late was meant to operationalise the National HIV/AIDS Policy by providing strategic guidance for developing and implementing HIV/AIDS interventions by various partners between 2003 and 2007.

The national HIV/AIDS Multi-sectoral response is usually revised on annual basis as stipulated in the NMSF 2003-2007 section 6.4 under Monitoring and Evaluation and Article VII of the Memorandum of Understanding between the Government of Tanzania and Development Partners. To complement annual technical reviews, section 6.5 of the National Multisectoral Strategic Framework provides for an in depth evaluation that is to be done twice during the five-year period. In this light a Mid-Term evaluation was to be done in 2005 with the objective of assessing the achievements of the national response after two years of implementation. However, the Mid-Term review for 2005 was postponed until March 2006 due to a number of timing and operational reasons including originally planned dates falling within the national campaigns for 2005 general Elections. The 1<sup>st</sup> technical joint review was done in February 2004

## **1.2. Objective of the technical review**

The objective of the joint technical review was to assess the implementation status of the National HIV/AIDS Multisectoral Response. Reflecting on the milestones set for 2004/05 (*annex no.1*), the review meeting was to evaluate and establish what has been achieved so far, challenges as well as opportunities and based on the findings, agree on the best strategic way forward towards scaling up the national response to HIV/AIDS. The expected output of this joint technical review was a package of recommendations of strategies and milestones for the next period which will be presented to the joint TACAIDS and stakeholders conference due to take place between March 15<sup>th</sup> –16<sup>th</sup> 2006.

### **Specific objectives**

- ✓ Assess reasons for success or failure of specific aspects of the national response,
- ✓ Assess if the NMSF 2003-2007 is achieving its intended goals and objectives,
- ✓ Assess if the NMSF is still valid and appropriate to the challenges of the epidemic,
- ✓ Assess adequacy of resources, which had been available for the national response,
- ✓ Assess the performance and adequacy of the institutional framework especially the coordination mechanisms at national and local levels.

### **1.3. Meeting organization and facilitation methodology**

The technical review meeting was programmed for three days and it was organized by TACAIDS in collaboration with a Task Force composed of various key stakeholders as follows:

- |                             |                      |
|-----------------------------|----------------------|
| 1. Dr J Temba               | TACAIDS- Chairperson |
| 2. Ken Heise                | MSH                  |
| 3. Yosiah Bwatwa            | CONSULTANT           |
| 4. Eliazary D. E. Nyagwaru  | TACAIDS              |
| 5. Dr. Bergis Schmidt-Ehry  | GTZ                  |
| 6. Wilhelmina Balyagati     | TACAIDS              |
| 7. Dr. Peter S. Bujari      | HDT                  |
| 8. Dolores Candelaria       | TACAIDS              |
| 9. C.T. Mashauri            | TACAIDS              |
| 10. Richard K.S.Ngirrwa     | TACAIDS              |
| 11. Sophia Luhindi          | TACAIDS              |
| 12. B. Muhunzi              | TACAIDS              |
| 13. Gerwalda M. Henjewe     | TACAIDS              |
| 14. Bernadette Olowo-Freers | UNAIDS               |

Members of a Task Force together with a local consultant, Professor Yosia Bwatwa, facilitated all preparations for the meeting. Different facilitation methods were applied including opening addresses, review keynote presentations and discussions, thematic presentations and discussions, group work discussions and plenary sessions

The meeting was opened by TACAIDS Executive Chairman, Maj.Gen. (rtd) Herman Lupogo and closed by the Chairman of the Development Partners Group on HIV/AIDS, Dr Bergis Schmidt-Ehry from GTZ. Professor Yosia Bwatwa facilitated the meeting throughout the three days.

## **2. TECHNICAL REVIEW MEETING PROCEEDINGS**

### **2.1. Welcome remarks**

The TACAIDS Executive Chairman Major Gen. (rtd.) Herman Lupogo gave opening remarks and officiated the Technical Review. He sited that although TACAIDS was inaugurated in 2002; it became fully functional in 2003 and therefore what was to be presented and discussed covers the three years period between 2003 and 2005.

Commenting on the technical Review, the Executive Chairman informed participants that this was the 2nd review after the one carried out in 2004.

The opening remarks by the Executive Chairman emphasized the following key points:

- Reflecting on the linguistic meaning of the word “response”, it means so far the nation is responding to what is hitting it in Swahili “kujibu mapigo” He commented that given the escalating impacts of the epidemic, responding only is not enough. He urged all actors in the fight against HIV/AIDS including all Tanzanians to move ahead of the epidemic by thinking in broader terms and agreeing on the best way to scale up the national response.

- He cautioned participants that along the course of evaluating the progress of implementation of the national response, a useful approach would be to stop talking and complaining about TACAIDS but rather focus on evaluating how together we have been able to take care of the sick, elders and children in order to fulfill the fight against HIV/AIDS
- He requested participants to internalize the rationale of doing the review and urged them while they continue for the 3 days to review the progress made to date, they should reflect on the NMSF vision which is: *To have a Tanzania Society that is free from the threat of HIV and AIDS and that provides care and support for those who are infected and otherwise affected by the epidemic.*
- He challenged participants not be too polite, but interrogate themselves, be analytical and critical in measuring and agreeing on what have been achieved so far, what are the challenges as well as opportunities in order to be able to collectively agree on the best actionable way forward.
- He commented HIV/AIDS to be an illusive and complex matter compared to many other subjects, which are mechanical in nature. The national response to HIV/AIDS is looking for behavioral change of the people as an output of all interventions, which cannot be directly tied to the amount of resources spent in all interventions.
- Regarding condoms as an approach in HIV/AIDS prevention, the Executive Chairman called upon condom promoters and others preventive items, to analytically assess the impact made by condoms in reducing the spread of HIV/AIDS. If all the current approaches cannot make the difference then this evaluation phase should be made a turning point to overcome the spread of the epidemic.

The Executive Chairman ended his opening remarks by sharing his expected output of the three days technical review, which was to jointly come up with an implementable way forward on how best the national response can be scaled up and intensified.

## **2.2. Presentations**

A total of eight presentations were made from TACAIDS and selected\* sectors which in this report have been presented as follows:

### **Operations and Coordination**

TACAIDS progress report on Operations and Coordination (2003 –2005) by Dr. Temba J.

### **Thematic progress reports**

District & Community Response by Ms. Tembele R.

Advocacy by Burhan M.

### **Sector progress reports**

Education Sector by Dr. Sayi

Health Sector by Dr. Swai

OVC by Mr. Charwe

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\* Selected Sectors because not all sectors were present and made presentations.

## **Crosscutting progress reports**

Financial Management by Beng'ii

PER Highlights by Beng'ii Issa

PORALG by Mr. Mtei

### **2.2.1. Operations and Coordination**

#### **2.2.1.1. TACAIDS progress report on Operations and Coordination (2003 –2005) by Dr. Temba J.**

##### **TACAIDS Institutional building**

- Although TACAIDS was inaugurated in 2002, it became fully operational in 2003
- Commissioners in place since Feb 2002.
- Heads of departments were recruited in November 2002 and officers in March 2003.
- Orientation and team building exercise for heads of departments and officers was carried out
- To date TACAIDS has a total of 54 staff; 36 technical and 17 support staff. However following its growing, office space has become inadequate.
- TACAIDS is receiving technical support from MSH Resident Advisor on Management, Leadership and Sustainability.
- The process to establish a Technical Assistance Facility (TAF) is underway.

##### **Coordination and Leadership:**

- The National Multisectoral Strategic Framework on HIV/AIDS (2003-2007) translates the National policy on HIV/AIDS into implementation by outlining priority objectives, activities, targets and indicators in the national response.
- The 'Three Ones' principle is in place.
- The MoU between development partners (DP) and the Government that DPs will jointly support the implementation of the strategy in joint planning, resource mobilization and monitoring and evaluation is a very significant asset in the national response.
- The Tanzania National Coordinating Mechanism is another important multisectoral forum for sharing information and coordination of resources from various sources for HIV/AIDS, TB and Malaria, and any other health related emergency requiring multisectoral action and monitoring their implementation.
- TACAIDS strengthening its capacity to coordinate global, international and regional HIV/AIDS programmes, including Global Fund, Tanzania Multisectoral AIDS project (TMAP), President's Emergency Plan for AIDS Relief (PEPFAR), Southern African Development Coordination (SADC), Great Lakes Initiative on AIDS (GLIA) and East African Community (EAC) and Africa Region AIDS Care Capacity Network (ARCAN).

##### **Public sector response:**

- The process of mainstreaming HIV/AIDS in the Ministries, Departments and Agencies (MDAs) that was initiated in 2003 is ongoing. All MDAs have focal persons, technical AIDS committees, strategic plans and budgets in Medium Term Expenditure Framework (MTEF).
- The level of implementation varies but is generally not satisfactory in relation to the seriousness of the epidemic. All MDAs need long term technical assistance in developing

and implementing a well-designed and sustained programme on mainstreaming HIV/AIDS. Having a strategic plans and budget in MTEF is only the beginning.

- Private sector response “UMOJA wa Matibabu wa Sekta Isiyo Rasmi Dar es salaam” (UMASIDA)
- Response in the private sector is evolving well expanding to other urban centres,
- AIDS Business Coalition on HIV/AIDS (ABCT) is making good progress
- Formation of Tanzania Informal Sector Network on HIV/AIDS Initiative (TISNAI) is underway.

#### **Civil Society Organizations response:**

- The process of forming the Tanzania Network of AIDS Service Organizations (TANASO) and PLHAs national council is very slow.
- National level CSOs are forming a Forum for sharing information and advocacy on HIV/AIDS, poverty alleviation and gender.
- Faith Based Organizations are involved in the response
- **Monitoring and Evaluation**
- With support from World bank supported Global AIDS Monitoring and Evaluation Team, TACAIDS is rebuilding its M&E capacity and system
- TACAIDS is supporting MUCHS in research in traditional medicine

#### **HIV Indicator Survey**

- The findings from the Tanzania HIV Indicator Survey are being disseminated at different levels.
- The atlas and brochures on regional data are proving to be very popular among politicians in the regions.
- We need serious advocacy at all levels to internalize the seriousness of the epidemic

### **2.2.2 Thematic progress presentations**

#### **2.2.2.1. District & Community Response**

- Substantial investment has been put in initiating, monitoring and strengthening district and community response
- In 2003, TACAIDS in collaboration with PORALG developed guidelines to establish Council Multi-sectoral Committees (CMACs) at all levels of the LGA down to the sub village
- In 2004, all CMACs were established and trained.
- Training of the CMACs was outsourced to a team of facilitators and trainers.
- All Regional Secretariats were oriented on the establishment of the CMACs and their role on providing support supervision to them.
- The CMACs are new but they are legal entities of the LGAs and form part of the Standing Committees. They still need mentoring, coaching and support in order to be functional
- They are unique in the way they are constituted. They are multi-sectoral forums with wide representations

- Appointment of the Council HIV/AIDS Coordinators (CHACs) is to facilitate multi-sectoral coordination and community mobilization
- Regional facilitating Agencies (RFAs)
- After a lengthy international bidding process, 11 RFAs were recruited at different phases and are now operational
- The introduction of the RFAs is intended to further strengthen the capacity of the RS, LGAs and CSOs

### **Rationale of having Regional Facilitating Agencies**

- The development of the TMAP was participatory in nature; all partners and stakeholders including the Government and Development Partners
- The grant from the Bank required the operationalisation of the CARF be done through a Firm
- TACAIDS supports the idea of having the RFAs because they are their ‘ears’, ‘eyes’ and ‘hands’ to the regions in this initial phase of establishing the district and community response structures
- Many RFAs are performing well and a few need more support. A comprehensive evaluation will be done after one year, which will provide room for continuation or termination of the contract.
- More than 50 Civil Society Organizations were give grants amounting to Tshs. 1,140,432,874 specifically to provide services to Orphans and Vulnerable Children and PLHAs.
- With new institutional relationships and organizations being established, there has been slow progress.

It is expected that all partners will continue to support the organizational, financial and programmatic structures of the national response. District and Community Response is one area that will be intensified and accelerated to reach grass root communities in line with the principles of MKUKUTA

### **2.2.2.2 Advocacy**

#### **Introduction**

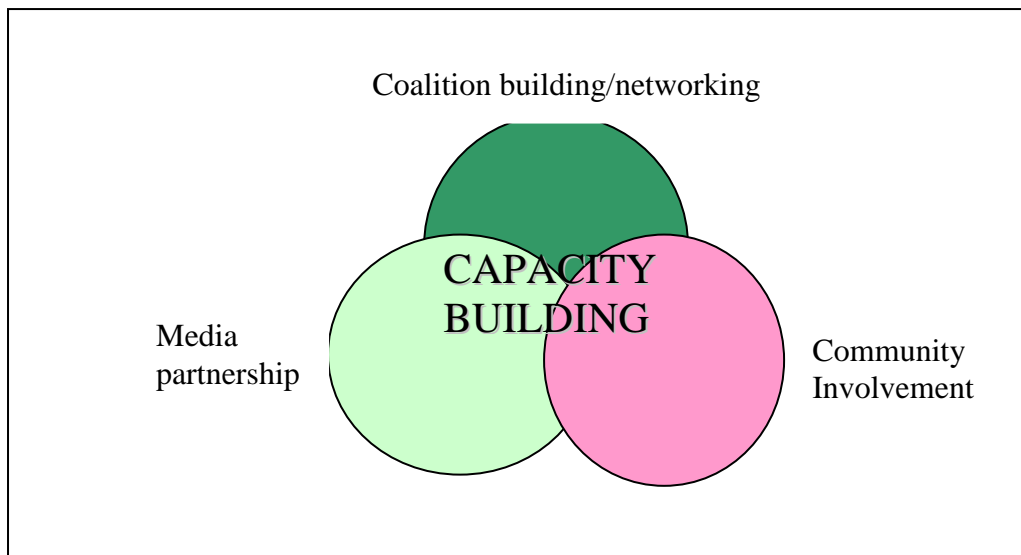
ADVOCACY is one of the nine goals of the National Multi-Sectoral strategic framework on HIV/AIDS- (2003-2007)

#### **Goal**

Political and government leaders consistently give high visibility to HIV/AIDS in their proceedings and public appearances

Indicator: The percentage of national funds spent by the government on HIV/AIDS

## Advocacy strategies for TACAIDS



**Why Advocacy:** Advocacy aims at creating AWARENESS (VISIBILITY), ATTENTION and ultimately lead to ACTION

### **BCC: Definition**

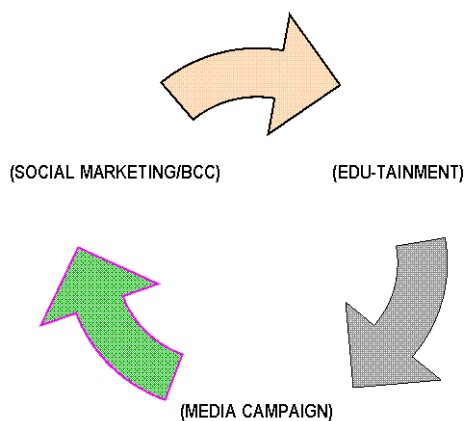
Behaviour Change Communication is an interactive process with the community to develop tailored messages and approaches

It uses a variety of communication channels to develop positive behaviours

It promotes and sustain individual, community and societal behaviour change; and maintain appropriate behaviours

### **IEC: Strategic Approach**

- Interpersonal communication and counseling
- Peer education & Enter-education
- Active community participation
- Community mobilization
- Mass Media campaigns
- Social marketing



## **BCC approach for TACAIDS**

### **Ongoing initiatives**

- Reaching the highest level government commitment on HIV/AIDS
- National Communication Strategy has been finalized and will be launched in April 2006
- Media Advocacy Strategy being developed
- Media Impact assessment study conducted
- A Training manual for media practitioners is being finalized
- Initiatives to scale up Youth programmes
- KABP Study underway
- Increased awareness on HIV/AIDS related issues

### **Challenges**

- Lack of a mechanism to ensure consistent supply of information of HIV/AIDS to every citizen
- Need for more advocacy on different issues for different decision makers (target audience)
- Need for increased knowledge to politicians, religious leaders and other key stakeholders in advocacy
- Need for increased HIV/AIDS knowledge to the general public (some stakeholders keep on repeating the same messages)
- Inadequate resources for implementing HIV/AIDS BCC

## **2.2.4. Sector response and progress reports**

### **2.2.4.1. Education sector progress**

#### **Introduction**

AIDS educational programs in schools in Tanzania began in 1988 five years after the diagnosis of AIDS in Tanzania in 1983. The MoH through the National AIDS Control program (NACP) collaborated with the Ministry of Education and Culture to design an Educational response that will reach children and youth in schools and teachers Colleges. The responses on AIDS were included in a series of 5 years Mid-Term Plans (MTP) under auspices of the NACP. These were the MTP1 1987-1991, MTP2 1992-1997, MTP3 1998-2002 and now the TACAIDS Multi Subsectoral Strategic plan 2003-2007.

#### **Education sector response -Ministry of Education and Vocational Training.**

The HIV/AIDS affect mainly the sexually active members of the population between the ages of 15-55 years. The youth segment is a higher risk of HIV/STI than other age group.

The education sub sector is seriously threatened by HIV/AIDS as it deals with the very population segment that is highly vulnerable to or mostly affected by epidemic. The ample evidence thus this trend is affecting pupils, students, teachers, attendance school, completion rates and taking toll and teaching force. There is therefore agent need to ensure the increasing trend is controlled through appropriate response.

## **Rationale for the sector response.**

### **General.**

Generally the reasons for response arise from the fact that the effects of HIV/AIDS are each and everyone's issue and also HIV/AIDS impede the social political and economical development of an individual, family and community at large.

### **Specific reasons**

The specific base in the Ministry of education rise from:

- The fact that the major mode of transmission of HIV in youth, is through unprotected and multipartnered sexual intercourse.
- The sexual environment in which children adolescence and young persons live, natural and biological changes, mind and feelings are strong enough to elastic curiosity, experimentation about their sexuality, hence infection of STIs including HIV/AIDS.
- The emerging issues resulting from AIDS impact like increase number of orphans and children made vulnerable by HIV/AIDS also forms the base for the ministry response as it increases the threat on the planning and management of education system.
- The mandate of ministry HIV/AIDS response guided by the education and training policy of 1995.

## **Vision, Mission, and Goal for Response in the Educational Programme**

The Vision, Mission and Goal for the response of AIDS Education programme is based on the overall MoE & culture vision-a well educated nation, sufficiently equipped with knowledge and skills needed to competently and competitively solve the development challenges that faces the nation.

### **Vision**

All members of education sub sector are sufficiently equipped with knowledge, skills and are aspiring to protect themselves and others against HIV and STI while providing care and support to infected and affected people, particularly young people.

### **Mission**

Provide life skills based education that will empower learners, teachers and other sub sector employees to cope with the HIV/AIDS/STI epidemic including prevention, care and support and impact mitigation, taking into account gender and vulnerable issues foremost

### **Goal**

To build capacity to respond to and reduce the spread of HIV and AIDS epidemic and its impact on the education sub-sector.

### **Target Population**

The target of the education sub-sector strategic plan on HIV/AIDS include:

- Pre-primary children
- Primary school pupils
- Secondary students
- Adult and non formal education participants/learners
- Teacher Trainees, at certificate and diploma levels

- Teachers, cultural officers, employees of the education sub-sector and its affiliated institutions.

### **Implementation Approaches**

The AIDS Education Programme response is effected through advocacy, mainstreaming and participatory approaches.

#### **Advocacy**

Advocacy is done to Education personnel at the following levels: National level, Regional level, District level, Ward level, Community level, i.e. School Boards, School committees.

#### **Mainstreaming**

The AIDS Education Programme response has been mainstreamed into the overall planning and development process, which means the Programme Activities automatically becomes components of the Ministry of Education and Culture. This implies that resource for HIV/AIDS, STI and Life-Skills related activities are included in the Ministry of Education and Culture.

#### **Participatory Approach**

Key people at all levels of the education system, faith leaders, students/pupils are involved in the development, implementation and monitoring of the Programme.

### **Organization and Management of the AIDS Education Programme Response**

#### **Policy Guidelines**

The Policy Guidelines were first developed in 1993 and revised in 2000 to help the education sub-sector and others to plan, to implement and evaluate their efforts better for efficient and effective sector and others to plan, to implement and evaluate their efforts better for efficient and effective management, administration and financing of the school HIV/AIDS and STI's Education Programme. These guidelines match and closely observe the principles of the Tanzania Education and Training Policy (1995) and those of the National Policy on HIV/AIDS (2000) as regards to preventive education and counseling intervention strategies. AIDS Education Programme response is mainstreamed in the sub-sector plans and operations.

#### **Coordinating Section and AIDS Committees**

The Ministry has established an AIDS Education Coordinating Section, which is composed of 4 personnel working full time to manage and coordinate the implementation of the Programme.

#### **The Ministry has in place:**

- The Technical AIDS Committee (TAC) composed of all Focal Persons from the Ministry departments and institutions. The role of the TAC is to plan, oversee, monitor, evaluate and advise on issues of the HIV/AIDS. TAC is chaired by the Chief Education Officer
- The AIDS Steering Committee (ASC) composed of directors and heads of institutions of the education sub-sector. This committee is chaired by the Permanent Secretary. The role of the committee is to advice on HIV/AIDS issues; solicit leadership will and commitment to provide overall guidance on the implementation of the HIV/AIDS and provide plans and budget.

## **The AIDS Education Intervention in Schools**

The AIDS Education in Schools has four pronged interventions complementing and supplementing each other. They are all teacher led as follows:

- The class teaching of life skilled based AIDS education topics through syllabi of carrier subjects. AIDS education is not a subject. A range of topics have been integrated in the Basic Science subject for Primary School, at Ordinary level Secondary Education into Biology and at the Advanced level Education and Teachers' Colleges in the Subjects of Civics and General Studies.
- Provide Counseling, Care and Support services to school youths. Its main task is to provide counseling, care and support to the infected and affected youths.
- Use of Peer Approach
- The purpose is to use peer strength within peers to support each other in learning including issues of healthy behaviour and acceptable peer norms.
- d. Use of School Counseling and AIDS Education Committee
- The role of the committee is to supervise and monitor implementation of HIV/AIDS intervention in schools, support and coordinator counselors in dealing with various issues in schools. School counseling services, peer education and AIDS Education Committee has started in a small scale.

## **HIV/AIDS Education Training**

### **a) Primary School teachers**

- First training for primary school teachers were conducted between 1994/5. There were about 12,000 Government primary schools in the country. The aim was to train 2 science subject teachers per school in all schools. 21,000 out of the expected 24,000 teachers in government primary schools were trained.
- Training of the primary school teachers resumed in May/June 2003. 1049 primary school teachers received training. However, the numbers are very small to make a difference and meet the demand still 38,000 need to be trained to have at least two teachers in each primary school to teach HIV/AIDS Education. The plan is to train all primary school teachers.

### **b) Secondary School teachers**

- Training for secondary school teachers is at present provided for teachers who teach subjects that contain HIV/AIDS topics. These subjects include Biology, Civics and General Studies. About 3000 teachers have been trained in HIV/AIDS Education.
- Training for Heads of Secondary Schools is in progress. 1,300 Heads of Schools have been trained during July 2004 and January 2005. Training is going on until all Heads of Schools in government and private schools have received HIV/AIDS education so that they could monitor effectively AIDS Education in schools.

### **c) Teacher Education**

There are 45 teacher colleges, 38 being public and 7 private. About 86 subject tutors in Civics and General Studies were trained in December 2002. First training was conducted in 2001 with a total of 90 tutors of the same subjects. In October 2005, UNESCO and UNICEF in collaboration with MoEC-Teacher Education trained all Principals of teachers colleges and two tutors from each college.

#### **d) Teachers for Visually and Hearing Impaired**

About 60 visually impaired teachers for primary and secondary schools have been trained in June and December 2003

Others trained include all 21 Regional Education Officers, 121 District Education Officers, 8 Chief Zonal Inspectors of the Schools and the school Inspectors of the schools based at zone offices.

#### **e) Instruction Materials**

Primary Education class teaching and materials for classes 5, 6 and 7 have been Revised, printed and distributed in 2003.

1. STD 5-60,000 copies
2. STD 6-62,500 copies
3. STD 7-94,565 copies

#### **f) Teachers guide for the three classes 28,000 copies**

- Peer education has new volumes for classes 5, 6 and 7 produced by the support of Government's. Books are not yet distributed as the Ministry of Education and Culture is supposed to buy the books and distribute them countrywide. Plan for buying the books is in the MoECSP for 2003/2007.
- There are teaching and learning materials for tutors and students in Certificate and Diploma in Education.

### **2.2.4.2. Health Sector response and progress report**

#### **The Health Sector HIV/AIDS Strategy: 2003-2006**

- A framework of health sector response to the HIV/AIDS epidemic
- Outlines the priority interventions of the Ministry of health and its stakeholders
- Interventions focus the areas of prevention, care support and treatment and cross cutting issues
- It derives guidance from the NMF, the Health Sector Strategy and National Policy on HIV/AIDS
- Formulation of HS HIV/AIDS Strategy

#### **Health Sector HIV/AIDS Strategy (2003-2006):**

- Situation and response analysis carried out by NACP in collaboration with national experts and presented to a stakeholder meeting for review
- 3 thematic groups (with NACP staff, national and international experts, stakeholders from NGO, FBO, PLHAs) were formed and formulated strategies for (1) Prevention, (2) Care and (3) Cross cutting issues
- The formulated strategies were shared with partners and reviewed in a broad stakeholder meeting
- Launched by Ministry of Health in March 2003

## **Components of the Health Sector**

- Public and private Health Services
- Institutions producing inputs for the health care system (pharmaceutical industry and teaching institutions)
- Health related NGOs and CBO
- Health Professional Associations.
- Traditional health providers.
- Communities that utilize the health services

The vision of the Health Sector HIV/AIDS Strategy: was adopted from that of the NMSF:

*Tanzania free from the threat of HIV/AIDS and which cares for and support all those who are infected and affected by HIV/AIDS*

## **Mission Statement of The Health Sector HIV/AIDS Strategy**

*Working in partnership with private sector and civil society play a leading role in the prevention of further spread of HIV/AIDS and mitigate its impacts by providing essential prevention interventions and quality care*

## **Goals of The Health Sector HIV/AIDS Strategy**

- To promote increased access and utilization of affordable and essential interventions and commodities for HIV/AIDS
- To scale up the health sector responses to HIV/AIDS and strengthen the health systems` capacity to support HIV/AIDS interventions
- To improve the provision of friendly HIV/AIDS interventions to the general public, PLHA, health care providers and other vulnerable populations

## **Content of the Health Sector HIV/AIDS Strategy**

There are three core interventions under the three thematic areas:

- 1) Prevention
- 2) Care, treatment and support.
- 3) Crosscutting issues.

### **Prevention Interventions:**

- 1) Treatment and prevention of STIs
- 2) PMTCT
- 3) Condom programming
- 4) Workplace programmes
- 5) Blood safety
- 6) Vulnerable groups
- 7) Youth

### **Care, treatment and Support Interventions:**

- Training
- Home based care
- Management of Opportunistic infections
- Antiretroviral treatment
- Nutritional support
- HIV/AIDS/TB interventions

### **Cross Cutting Interventions**

- Voluntary Counseling and Testing
- Stigma and discrimination
- Human resources
- Monitoring
- Laboratory services
- Research

### **Health Sector HIV/AIDS Strategy**

- Coverage of Core Health Sector Interventions...
- What services are available?

### **National Care and Treatment Plan 2003-2008**

- Initiated through high level consultations between Government of Tanzania and Clinton Foundation
- Developed by a Task Force of 30 Tanzanian experts (NACP, TACAIDS, clinicians, academicians) and 14 US experts
- Regular briefing and review by development partners and stakeholder from all constituencies (Government, NGO, FBO, PLHAs, private sector)
- Endorsed by Cabinet in October 2003

### **ART Needs in Tanzania**

1. By end of 2003, about 2 million Tanzanians living with HIV
2. About 400,000-500,000 are in need of ART
3. Some 1.2 million in need of drugs for OIs
4. Only about 2,000 Tanzanians were on ART in 2003.

### **Goals of the Care and Treatment Plan**

GOAL ONE: To provide quality, continuing care and treatment to as many HIV+ residents of the United Republic of Tanzania as possible.

GOAL TWO: To contribute to strengthening the health care structure of Tanzania, through expansion of health care personnel, facilities and equipment and comprehensive training in the care and treatment of PLWHA

**GOAL THREE:** To foster information, education and communication efforts focused on increasing public understanding of care and treatment alternatives, reducing the stigma associated with HIV/AIDS, and supporting ongoing prevention campaigns

**GOAL FOUR:** To contribute in strengthening social support for care and treatment of PLWHA in Tanzania, such as home-based care, local support groups, and treatment partners

### **Achievements: Care & Treatment**

- Rollout started October 2004 in 32 sites
- Currently 96 are providing ART
- From the 96 sites, 629 health care workers were trained on ART management
- In the second year of ART rollout, 104 new sites were identified. Already 689 HCW in 99 sites have been trained and drugs have been sent to 71 sites. By June 2006, 200 sites will be providing ART
- Between October 2004 and January 2006 about 52,085 PLHAs enrolled into care of whom 25,840 (2,473 children) are receiving ARV drugs
- To monitor PLHA on care and treatment all regional and consultant hospitals are equipped with CD4 Facs Count machines

### **Criteria used to identify the initial ART sites**

- Readiness to start treatment such as Competent human resources and adequate infrastructure (efficiency)
- Potential to serve as a learning centre for others
- Assurance of equitable geographical distribution
- Special considerations for the regions with the highest HIV/AIDS burden
- Other Developments on CT
- Care and Treatment Unit established in the NACP.
- Tools, Training Manuals & Guidelines for management and care of AIDS patients developed and in use.
- Resources mobilized from the Government of Tanzania and different partners including the Governments of Sweden, Norway, Netherlands, and Canada; Clinton Foundation, PEPFAR, TMAP, Global Fund and WHO.

### **CHBC Services**

#### **Target:**

- Provide HBC services to 5000 people by 2006.

#### **CHBC Achievements**

- HBC services increased from 28 districts in 2003 to 61 in 2006.
- More than 22,000 people were reached in 2005
- Guidelines and training materials have been developed and regularly reviewed
- The number partners and Home Based Care implementing organizations has increased from 6 to over 15

### **VCT Services**

#### **Targets:**

- By 2006 about 1,600 counselors trained or up-graded according to national standards. Eight hundred of these should have certificates of counselors specialization
- By 2006 establish six VCT facilities in each district

#### **Achievements of VCT Services**

- More than 1,800 counselors trained
- 43 National VCT trainers were trained
- 44 District VCT supervisors trained
- 240 counselors were retrained
- 60 District health managers oriented on managerial skills on the provision of VCT and other HIV/AIDS related interventions
- More than 570 VCT sites were established and least each district has a minimum of 3 VCT sites

#### **Development/reviewing of guidelines and training materials:**

- National training curriculum reviewed
- National VCT guidelines developed, disseminated and distributed to the districts and other partners

#### **STI Service**

Targets:

- By 2006, all Hospitals and Health centers and at least 50% of the dispensaries in the country offer quality STI services
- By, 2006, 70% of patients with STIs at 80% of health facilities are appropriately diagnosed, treated and counseled.

#### **Achievements of STI Services**

- All public hospitals including Referral, Regional, District hospitals and DDH provide STI services
- Similarly, all public health centers have been covered.
- 60% of the dispensaries in the whole country offer quality STI services
- 7,731 health care providers have been trained in STI syndromic case management
  - According to the study “Evaluation of STIs Service Delivery in Tanzania Mainland 2005”, 67.2% of service providers made correct choice of drugs, dosage and duration of treatment for their clients

#### **PMTCT Services**

PMTCT targets to increase access of PMTCT services in all regional and selected district hospitals by June 2006

#### **Achievements of PMTCT Services**

- PMTCT policy guidelines and training materials have been developed to standardize the provision of PMTCT services in the country
- PMTCT national monitoring framework has been developed
- PMTCT services expanded from 4 referral hospitals, to all 17 regional hospitals, 62 district hospitals, 66 other hospitals, 354 health centers and dispensaries

## Information Education and Communication

### Target: Health promotion to deal with:

- Safety and precautions in dealing with human beings, human fluids or blood products
- Promotion of HIV/AIDS services uptake
- General issues of good health e.g. substance abuse which affect responsible behaviour

### Summary of IEC materials produced and distributed

Year	W/calendars	Brochures	Newsletters	Posters
2003	60,000	351,000	90,000	100,000
2004	60,000	300,000	200,000	100,000
2005	60,000	500,000	4000	100,000
2006	100,000	* In process	* In process	100,000
<b>TOTAL</b>	<b>280,000</b>	<b>1,151,000</b>	<b>294,000</b>	<b>400,000</b>

### Condoms

Condom use has been promoted for those population groups that cannot adapt to other strategies like abstinence and sexual fidelity to one partner

### Condom promotion and distribution

#### Indicators and Targets

- Percentage of young people aged 15-24 reporting the use of a condom during sexual intercourse with a non-regular sexual partner
- Number of condoms per capita (total number distributed divided by total population)

### Condom consumption

MALE CONDOMS	2004	2005	TOTAL
MOH	17,311,500	11,300,000	28,611,500
PSI	38,900,000	54,443,000	93,343,000
T-MARC	0	0	0
<b>TOTAL</b>	<b>56,211,500</b>	<b>65,743,000</b>	<b>121,954,500</b>
<b>FEMALE CONDOMS</b>			
PSI	134,2800	0	134,280
T-MARC	0	376,480	376,480
<b>TOTAL</b>	<b>134.280</b>	<b>376.480</b>	<b>510.760</b>

**Achievements**

- According to the Tanzania HIV/AIDS Indicator Survey 2003-04, 41.7% of youth aged 15-24 years used condom at their last higher risk sex.

**Coverage Of Blood Safety Services**

- Blood safety assured in over 180 health facilities; in public, private and FBO
- In 2003, more than 147, 377 units of blood screened for HIV
- During 2003, overall HIV prevalence was 8.8%
- More than 12, 969 primary infections were avoided through blood screening

**Monitoring and Evaluation**

## Targets

- Effective outcome and impact monitoring system for all indicators
- Effective system and procedures for monitoring the implementation for all strategic interventions in health sector
- A mid term review and summative programme evaluation
- Operational research to obtain data for evidence-based decision making
- Dissemination M&E summary report

## **Challenges**

- Coverage of core interventions still decimal compared to needs due to financial constraints
- Severe shortage of skilled human resources to deliver the various interventions
- Poor health infrastructure fails to provide support services in the areas of laboratory, logistics, coordination and patient referral.
- Stigma and discrimination prevent uptake of available services
- Rolling out ART services to Health Centres and Dispensaries poses a major human resource as well as infrastructure challenge
- Public awareness on some of the core interventions still low and many myths and misconceptions persist

## **Conclusions**

- During the past three years, the Health Sector has made a very significant contribution to the National Response to HIV/AIDS
- The introduction of ART has galvanized the provision of all Health Sector HIV/AIDS interventions.
- Further scale up of current interventions is going to pose a major resource and capacity challenge
- Delivery of Health Sector interventions is heavily dependant on skilled human resources
- The human resources crisis facing Tanzania must be urgently addressed to allow for further scale up of Health Sector response to HIV/AIDS

### **2.2.3.3. Orphans And Vulnerable Children (OVC)**

#### **Developments in responding to the needs of orphans and vulnerable children**

- Tanzania has about 36 million people
- HIV/AIDS prevalence rate is 7%.
- 10-12% of all children are MVC
- Of these 42% are orphans (2002 National Census Report) result of HIV/AIDS,
- Other sources estimate that up to 4 million children are MVC

#### **Local Government Authorities And Community Response**

- The extended family has been the first line of response to MVC crisis
- Over 53% of all the MVC in Tanzania are cared for by the extended families and 12% by old siblings
- 6% of MVC have access to psychosocial and material support and 4% medical support and information
- MVC and vulnerable house holds identification and targeting has been realized in 21 councils
- MVC matching funds established in some the 21 councils
- Community Justice facilitation / paralegal provided to MVC
- Formation of MVC committees at village level realised in some villages in the 21 councils

## National efforts

- Initiated the identification and targeting MVC and vulnerable households
- Secured partners and Funds for rolling out the establishment and strengthening MVCC
  - UNICEF - 17 councils
  - Global Fund Round 4 - 24 councils
  - USAID/Pact \$240,000 - 21 councils
  - USAID/FHI - 19 councils
  - AXIOS Foundation - 4 councils
- Ministry of Health and Social Welfare is working with the PMO-RALGA to mainstream Social welfare services into LGA
- Data management system for M&E
- Costed OVC national plan of action
- Put in the Management and Coordination structure which stipulates the roles different actors including the line ministries, councils, faith based organizations, national and international organizations

## Management and coordination structure of MVC care and protection

Structure	Role
National steering committee	Policy, quality control of care and protection of MVC
National Technical Committee	-Technical issues of care and protection at national level -Overall decision-making on MVC care and support at national level -Technically implement policy, guideline and directives
District Coordinating Committee	-Oversee the implementation of policy, guidelines and directives on MVC care and protection at council level -Coordinate and supervise all MVC service providers including NGOs, FBOs, CBOs -Quality control of MVC care and protection -Contribution to MVC funds
Ward Coordinating committee	-Implementation of the council directives on care and protection of MVC -Provide technical support and coordination to village Coordinating committees and CBOs -Support training in CJF and data collection on MVC
Village Coordinating Committee	-Support MVCC to implement action plans for MVC -Deliberate MVC plans and budgets and forward to ward development committees -Support the MVCC in the process of MVC and vulnerable households identification and targeting -Contributing to the MVC funds

- The Ministry has reviewed the National guidelines and strategies for care and support of orphans of 1994, and has prepared the National guidelines for care and protection of Most vulnerable children, which emphasizes the community based approach
- The guidelines, therefore, proposes that CMAC/VMAC should be strengthened by incorporating MVCC members

### **Observations and suggestions**

- There is a rapid increase in number of OVC/MVC in our communities has over-stretched extended family to a point of breakdown
- OVC/MVC made vulnerable by HIV/AIDS belong to us all
- Each one of us is expected to put community-based MVC identification and support mechanisms
- If we are not putting this on our agendas as a priority we are sitting on a time bomb ready to explode
- To strengthen the government system of coordination and mapping of the most vulnerable children through Most vulnerable committees
- Strengthen the capacities of communities in order to play a proactive role in the care and protection of MVC
- To strengthen the working relationship between government and NGOs

### **2.2.4. Cross cutting presentations**

#### **2.2.5.1. Financial management and resource mobilization**

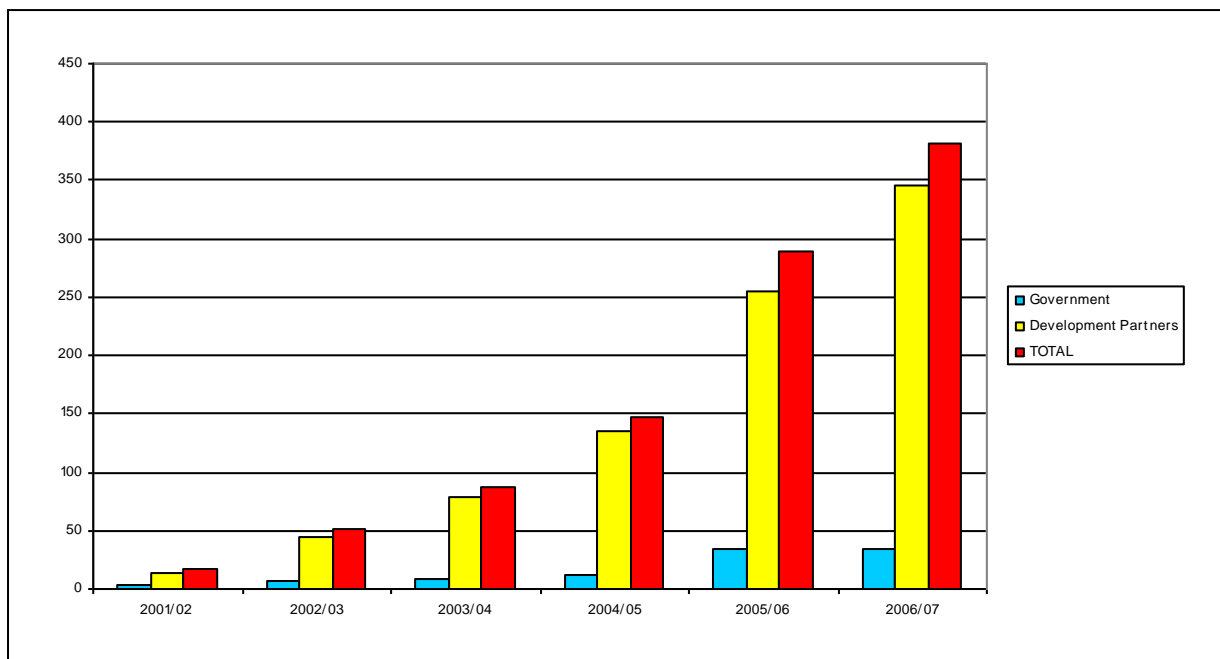
##### **Funding trends**

- Funds for HIV/AIDS into the country has increased tremendously since 2001/02
- In 2005/06 the funds for HIV/AIDS are estimated to be more than 10 times that of 2001/02
- Financing HIV/AIDS activities is estimated to cost more than Tshs. 350 bn p.a.

##### **Funding trends**

<b>SOURCE OF FUND</b>	<b>2001/02</b>	<b>2002/03</b>	<b>2003/04</b>	<b>2004/05</b>	<b>2005/06</b>	<b>2006/07</b>
<b>Government</b>	2.8	6.9	8.1	12.6	35.0	88.0
<b>Development Partners</b>	14.0	45.0	79.0	135.0	255.0	346.0
<b>TOTAL</b>	<b>16.8</b>	<b>51.9</b>	<b>87.1</b>	<b>147.6</b>	<b>290.0</b>	<b>381.0</b>

## HIV/AIDS funding trend



### Achievements

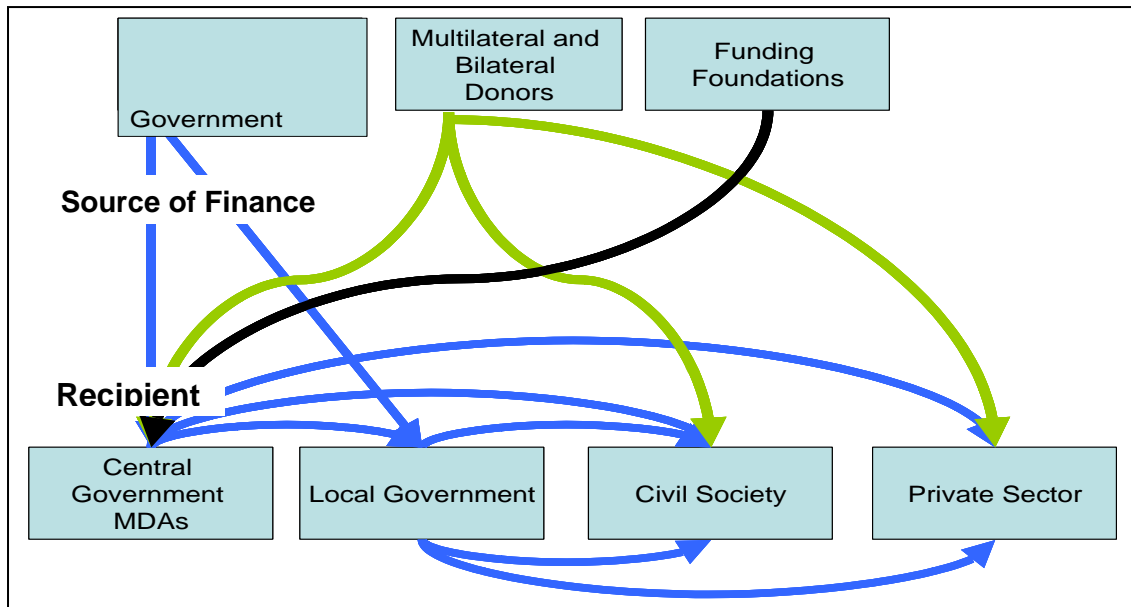
- Increase in funds for HIV/AIDS
- Mainstreaming of HIV/AIDS budget into the Government budget – remove project mind set
- Introduction of specific objective for HIV/AIDS in the Government budget, which has made tracking very easy.
- Project funds for different sectors flow through the Government exchequer system
- Introduction of the Budget Support for HIV/AIDS to operate within and outside the Government entities.
- Contribute to Government budget guidelines as a tool for all sectors in budgeting for HIV/AIDS activities.

### Funding modalities

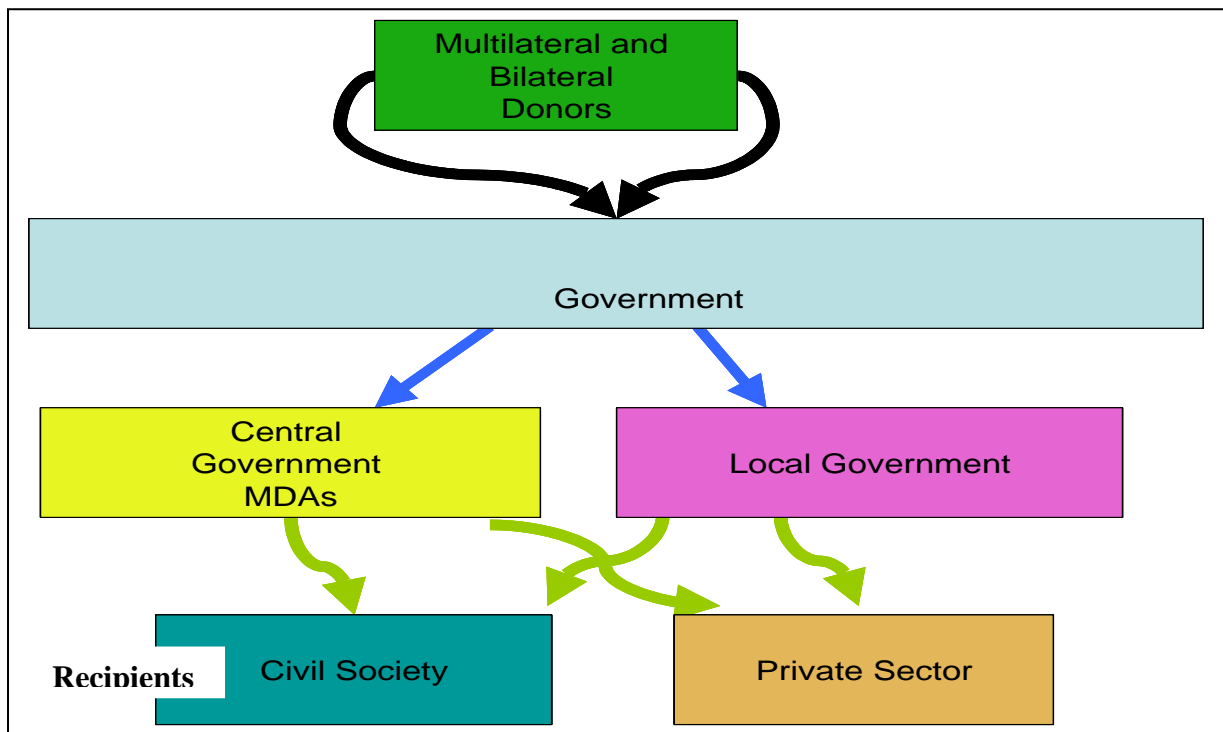
Currently the following are the funding modalities:

- Government to Ministries, Departments and Agencies
- Donors to Government to Ministries, Departments Agencies and Civil Society Organizations
- Donors to Civil Society Organizations and Private Sectors

**Adverse and complex system of financing stakeholders is developing**



**Envisaged modality as per budget support on HIV/AIDS**



## **Challenges**

- Only 44% of the assistance received for HIV/AIDS is captured by the Government systems.
- High transaction costs due to different funding modalities
- Quality programs (Value for money) on HIV/AIDS is a challenge
- Absorption of funds in the Public Sector is relatively slow:
  - Government Procurement systems is relatively new
  - Poor coordination within the Ministry is one of the reasons
  - Occupation of other duties by the Coordinator in the Ministries
  - Inadequate skills in mainstreaming
  - Most of the Coordinators are not in the position of decision making

## **Current developments**

- More MDAs are planning for HIV/AIDS in 2006/07
- Total of 88bn has been requested by MDAs through SBAS
- All these were requested from the GOVT budget
- 46 MDAs are going to budget for HIV/AIDS, including all new Ministries
- Major requests come from:
  - MoH – 61 bn
  - MoEV – 3 bn
  - MCDGC – 3 bn
- 15 Regions have also planned for HIV/AIDS

### **2.2.4.2. Public Expenditure Review (PER)**

#### **Overall trends**

- The Government of Tanzania has increased spending on HIV/AIDS from General Budget Support by more than 10 times since 2001/02
- The Government spending on HIV/AIDS represents about 10% of the total resources spent in the country
- Overall trends.
- Spending on HIV/AIDS is now absorbing 10% of the total external assistance.
- Per capita HIV/AIDS spending (including off-budget) is around \$8 per head.
- Analyses of resources committed to date indicate that are sufficient for the next 2 years including Care and Treatment.
- However, there is a need to disburse in time

#### **Achievements**

- The following are achieved since 2003/04 PER:
  - HIV preventive measures remained the top expenditure priority, reaching funding levels of more than Tshs 35 bn p.a.
  - TACAIDS focused its facilitation efforts with MDAs on finalisation of sector HIV plans all MDAs have produced sector plans with TACAIDS support and reflected in MTEFs,

- TACAIDS has worked with MDAs on improving their strategies and MTEFs,
- Initial arrangements were finalized to introduce budget support for HIV/AIDS from 2006/7
- The Z-code system for tracking HIV budget and expenditure was introduced and worked well in the first year, however, a new software (SBAS) interrupted the system in 2005/6, and it is now solved. (Objective A)

### **Government Expenditure On HIV/AIDS**

- Government disbursed 88% of the planned budget for HIV/AIDS in 2004/05
- Health, Defense, Education, PORALG and transfers to Regions and Local Government Authorities accounted for bulk actual expenditure in HIV/AIDS
- Few LGAs that were involved in the study showed expenditure per year on HIV/AIDS was around Tshs. 100 million
- Few Ministries under review showed that they were spending beyond levels compared to their strategies. i.e. Health, Education, PORALG, MCDGC, Labour, Energy and Minerals.
- Ministry for Community Development Gender and Children has a very important role in the District response and OVC
- PORALG has shown initiative in the budget to support LGAs
- Ministry of Education envisages for two counsellors per school, requiring a total of 14,000.
- There are currently 432. The new strategy envisages meeting half of the need by 2007.
- Significant preparatory work has been undertaken, training trainers at regional level, and preparing and distributing curriculum materials and teaching guides and pamphlets.
- Ministry of Health related expenditure on HIV/AIDS is constrained by shortage of human resources.
- It is estimated that HIV/AIDS account for 40% of staff time in Health Sector
- Care and Treatment program is well coordinated by the MOH, in terms of procurement and distribution of drugs, as well as tracing and monitoring patients.
- Nutrition support, funding of services and expensive drugs for treating opportunistic infections, and the numbers and incentives and support available to home-based carers remain problematic
- Ministry of Energy and Minerals has also shown initiative of supporting small-scale mining areas.
- Most of other MDAs are implementing workplace interventions.

### **Developments in Partners' Expenditure on HIV/AIDS**

- 90% HIV/AIDS activities expenditure in the country is financed by Development Partners
- The Development Partners have increased spending on HIV/AIDS for more than 20 times since 2001/02
- The share of support spent through the Government institutions is low and therefore not aligned with Govt. planning, budgeting, reporting cycles, uses different disbursement and accounting routes.

- 75% of the contribution from the Development Partners is done by the 3 big Donors i.e. GFATM, World Bank and USG
- The big 3 donors are working directly with the GOT, however, the USG part going through the GOT is only 2% of the total resources coming into the country.
- CIDA and SIDA are also big donors when joined together they make it 85% of the total contribution to HIV/AIDS

### **Budget Support For HIV/AIDS**

- This is a fund, which, allow different Donors to pool HIV resources together, and the GOT to have one prioritised plan for HIV/AIDS.
- The fund would help to take the pressure off the government budget frame by partly funding government HIV-AIDS expenditure, where spending commitments are rising very rapidly.
- It would allow HIV funding to be channelled to multiple government spending MDAs
- This Fund would be fully integrated into the budget frame, spent/accounted for through the standard government exchequer system.
- This modality offers lower transaction costs
- Disbursement rates would likely be higher than the other options
- The fund will promote an appropriate balance between prevention, care and impact mitigation
- The fund will start 1<sup>st</sup> July 2006
- Few donors have already committed to start
- It is very easy to start immediately with donors currently supporting the Government General Budget Support since modalities are the same
- Efforts are underway in the near future for the World Bank and GFATM to provide their support via General Budget Support.
- If achieved this would mean that donors representing 60% of existing support to HIV/AIDS would be providing their assistance via the budget, with USG the main funding source remaining outside.
- It will necessitate the coordinated plan and implementation of HIV/AIDS activities in the country.
- Bringing all funding within the same planning and budgeting structure does not mean Government replacing NGO programmes,
- But does mean that support delivered via NGOs needs to be coordinated with Government spending, to ensure that all priority needs are met and minimise wasteful duplication.
- Tracking of HIV/AIDS expenditure under this support will achieved through the Objective A in the IFMS (EPICOR)

### **District and Community Response**

- It is envisaged that LGAs be provided with guidance on what they should be doing to address HIV/AIDS,
- LGAs may own the HIV/AIDS programs in their areas when they are left with discretion to plan and manage their own budgets.
- There are gaps in the funding of the district and community response.

- PEPFAR and GFATM resources are not equitably distributed across the country, and have focused on few Districts mainly treatment-related programmes.
- The Rapid Funding Envelope does cover the country well since distribution of resources reflect the location of NGOs with the capacity to develop and present good projects.
- The LGAs tracking study that was conducted in 5 districts showed that some LGAs spent at least Tshs. 100 million on HIV/AIDS every year
- The source of funds for HIV in District comes from own revenue collected resources, Basket fund, GFATM, TMAP and GOT through TACAIDS
- District and Community Response is now been scaled up through the Community AIDS Response Fund (CARF)
- 7 RFAs have started to disburse funds to Communities. 13 Regions are now accessing CARF
- It is estimated that 560 Community groups will access HIV/AIDS funds in the next 2 months
- Estimated amount per year is Tshs.5 bn

### **Recommendations**

- All HIV/AIDS expenditure should be brought within the national planning and budget framework
- HIV/AIDS spending should be on the budget of the implementing Vote holder, not TACAIDS.
- MOF should require MDAs to include realistic assumptions regarding their need for external support in the outer years of the coming MTEF
- Government should identify funding gaps for the outer years of MTEF, and feed the information into the policy dialogue with donors to HIV/AIDS
- The funding gap identification is necessary especially at District level.
- TACAIDS should participate in the health sector review at Director level, to facilitate coordination with related activities to be taken forward by non health-sector partners – for example, the links to VCT promotion and to community support to PLWHA.
- TACAIDS needs to ensure that information on the fight against HIV/AIDS epidemic is systematically collected, stored, and disseminated far more widely both within TACAIDS and to outside groups.
- Effort is needed by both Government and donor partners to extend the pipeline of commitments for HIV/AIDS, bring more routine to the renewal and rolling forward of donor pledges, simplify the disbursement arrangements to enable funds to flow more easily, and minimise the risk of conditionality-related interruptions.
- reforming the approach to financing expenditure on HIV/AIDS, including launching budget support for HIV/AIDS, and on developing block grant funding for LGAs.
- Expenditure on HIV/AIDS needs to be managed in a decentralised way, and integrated within the overall budget (plan, budgets and implementation should be left to implementers).
- World Bank and TACAIDS should review the scope for simplifying and liberalising the TMAP financial management arrangements, which have proved a constraint to implementation.

- The proposed approach to monitoring and evaluation should be reviewed with external support.
- More emphasis should be on prevention, which remains under-resourced in several crucial areas: -
  - too few condoms being purchased,
  - need to further expand access to STI services;
  - inadequate focus on prevention in schools and in the ministry of defence;
  - need to expand the coverage and expenditure of the district and community response.
- The cost estimates for the Care and Treatment Plan should be updated. Different unit costs between centres in Tanzania
- The CARF should receive additional resources from the regular budget, to support CBOs
- RFAs should continue beyond the life of the TMAP project, with contract renewal by competitive tender, to ensure quality services are maintained.
- Financial support for LGA HIV/AIDS expenditure should be allocated on a largely non-discretionary formula driven basis,
- The RFE could be further expanded.
- LGAs should be encouraged to use expanded HIV/AIDS block grant funding for supporting NGOs.
- Introduce budget support.

### **2.2.4.3. Prime Ministers' Office, Regional Administration and Local Government (PMO-RALG)**

#### **Local Government HIV/AIDS Perspectives**

##### **Status of the HIV/AIDS epidemic in Tanzania**

- First three AIDS cases reported in 1983 in Kagera Region.
- By 1986 all regions had reported AIDS cases.
- Currently HIV prevalence in adult population is estimated at 7% affecting both sexes within age group 15 to 49 years.
- Infection rates differ between regions and it varies between 2% in Manyara and Kigoma Regions to 13.5% in Mbeya and Iringa Regions.

##### **Mode of Transmission**

- 80% heterosexual relationships,
- 5% mother to child transmission,
- 1% blood transfusion.

Recent implementation reviews show that there is Strong stigma against HIV/AIDS as only 12% of the people infected with HIV have tested and are aware of their HIV status.

##### **Mode of coordination of HIV/AIDS in the LGAs**

###### Structure of coordination

- National level - TACAIDS/PMO- RALG,
- District level - DAC and CMAC (focal person responsible for planning, monitoring and evaluation),

- Village level - Village Multisectoral AIDS Committees.(VMAC)

## **Resource allocation (MTEF 2006/7)**

### **Purpose of MTEF**

The government has introduced the MTEF as a resource management tool which aims at:

- Improving the predictability of budgets by enhancing domestic resource mobilization, integration of donor finance into the budget framework, ensuring consistency and compliance to agreed allocations based on priorities.
- Enhancing budget sustainability (costs meet targets),
- Shift of donor finance towards general budget support, thus enhancing flexibility of allocation,
- Strengthen output-oriented budget that focuses on service delivery.

### **Local Government HIV and AIDS Planning and MTEF**

- LGAs prepare Medium Term Strategic Plans and MTEF using the Medium Term Strategic Planning and Budgeting Manual (Nov. 2005).
- As a measure of improving the predictability of budgets under HIV/AIDS, the government has introduced block grant funding for HIV/AIDS activities in LGAs – (2006 – 2007 FY).
- LGAs will prepare their MTEF to budget for HIV/AIDS and use objective “A” for budgeting HIV/AIDS activities (MKUKUTA Cluster Approach).
- Under the Tanzania Mult Sectoral Planning Framework (TMAP), LGAs will target activities aimed at HIV/AIDS prevention, care and treatment or mitigating impact of HIV and AIDS.
  - Introduction of block grants to finance HIV and AIDS activities through MTEF will facilitate ownership and accountability of LGAs to HIV and AIDS services.
  - Budget guidelines 2006/07 will include the Block Grant for HIV and AIDS for LGAs.
  - CHALLENGES
  - Lack of capacity in planning and implementation of HIV and AIDS activities.
    - LGAs will need more orientation on MTEF and Budget Planning and preparation.
    - Get Guidelines “minimum package of interventions” to be able to incorporate activities of prevention, care and impact mitigation in their Strategic Plans.
    - Use of Participatory Methodologies (O & OD).

### **Way Forward**

- PMO – RALG support to LGAs on MTEF Budget Planning and Preparation,
- TACAIDS/PMO – RALG facilitate availability of guidelines (e.g. Minimum package of interventions) and how to include activities using the O & OD Approach,
- LGAs consult with the Health Sector on their Comprehensive Council Health Plans to ensure avoidance of duplication and overlaps of activities,
- Appropriate management of the HIV and AIDS Block grant through:
  - a) Abiding to all financial standards and budget procedures (LGAs).
  - b) LGAs abide to all technical and professional regulations.

- c) LGAs to set their performance objectives using their Comprehensive Council Development Plans and the National Multi sectoral Framework which takes consideration of national priorities, local conditions, local priorities, and the availability of Local Resources.
- d) LGAs adhere to the Joint Assistance Strategy (JAS), which is national medium – term framework for managing development cooperation between the Government of Tanzania and Development Partners.

### **3.KEY ISSUES RAISED DURING DISCUSSIONS ON PROGRESS PRESENTATIONS**

#### **A. RESOURCES AND FUNDING**

- ✓ Funding modalities for HIV/AIDS need to be further harmonized at all levels
- ✓ Under the new system of Block funds to be administered through LGAs, it is not clear how the CSOs and CBOs who are the actual implementers will be able to access funds.

#### **B. CAPACITY DEVELOPMENT AND TECHNICAL ASSISTANCE**

- ✓ Fund absorption capacity in the public sector especially is LGAs is relatively low compared to the private sector.
- ✓ There is low capacity in Monitoring and Evaluation especially in tracking implementation at District level. [e.g. it is being observed that while the flow of funds from Donors to Government, then from Government. to TACAIDS and LGAs seems to be fast; there is a slow return of fund expenditure reports from the implementers.
- ✓ Although CMACs and RFAs have been put in place as per the 2004/05 milestones some of them have not been able to effectively function and there is need for support in capacity building to enable them to fully and effectively function.
- ✓ Although MDAs have been able to develop HIV/AIDS strategies most of them have not been able to move on to implementation. TACAIDS called upon stakeholders to systematically offer Technical Assistance to MDAs so that they can be able to develop and implement comprehensive strategies and MTEFs
- ✓ Although MTEFs are being praised of including HIV/AIDS plans, the huge difference among sectors e.g. Health Sector spending 61billion and next closest being 3 billion in Education which is one of the key ministries indicates a serious problem that needs to be addressed.
- ✓ Human Resource issue is critical to Tanzania both in terms of skills and personnel.
- ✓ Government capacity to utilize funds is low
- ✓ Method of calculating condom demand per head/ year is not clear and also female condoms have to be scaled up. The use of historical method to identify projections was commented to be unpractical.
- ✓ Condoms accessibility and effective utilization is not tracked as so far there are no clear data on number of condoms used and effective use remains unattached hence it is not easy to establish what percentage does condoms account for in reducing infections and what percentage do other methods such as AB might be accounting for.

- ✓ How to accelerate care and treatment as far as national targets are concerned remains a challenge.
- ✓ The level of achievement in the Ministry of Education and Vocational Training to date is low e.g. Less than 3% Primary teachers trained; less than 10% of required counselors, only 10% of annual requirements of instructional materials produced. It was anticipated that the upcoming national HIV/AIDS Education conference could come up with some practical questions.
- ✓ Shortage of Human Resources in the Health sector issue is a crisis that needs immediate solutions. However it was not established how the government plans to reduce the problem both in terms of skills and personnel numbers.
- ✓ So far there is no central Blood Bank in Tanzania. Each Hospital manages itself and there is no collaboration between the public and private Health Sector. In view of this the Government cannot guarantee blood safety. However, it was mentioned that efforts to establish Zonal Blood Banks are underway: Mwanza, Arusha, Dar es Salaam and Mbeya.
- ✓ The method used to identify OVCs is not clear and it seems that the mapping exercise carried out by the MoHWF does not cover the whole country.
- ✓ Scaling up VCT especially to rural areas remains to be a challenge.

### **C. COORDINATION**

- ✓ As far as coordination is concerned under the roles and mandate of TACAIDS, it has been observed that the region has been left hanging with no clear focal people or structure responsible for HIV/AIDS at regional level. There is fear that when RFAs phase out regions will not be able to provide necessary back up to Councils.
- ✓ TACAIDS under the auspices of the Parliament act no. 22 of 2001 has been given legal responsibilities and not the legal authority and this is creating ownership problem in coordination and follow up of the response.
- ✓ Although Advocacy is one of the core roles of TACAIDS, there is need to refine each actor's level of involvement and type of activities to enhance a more coordinated response.
- ✓ There are no clear plans as of yet on how to harmonize HIV/AIDS M&E systems in Tanzania and also the linkage to the rest of indicators such as the MKUKUTA indicators.

### **D. ACCOUNTABILITY AND QUALITY ASSURANCE**

- ✓ Accountability and transparency is still a set back in effective programming and implementation of comprehensive HIV/AIDS Programmes especially at local Government level and below.
- ✓ The question of quality assurance for HIV/AIDS programmes was a concern. Members felt that measuring effectiveness by solely looking at the pace of flow of funds may lead to expenditure without outputs. It was suggested that TACAIDS and MDAs must set a mechanism to ensure programmes developed are of desired quality and output oriented and this includes reaching beneficiaries communities.

- ✓ There is lack of transparency and there is low capacity in resource tracking at all levels e.g.:
  - Only 44% of the External Assistance received for HIV/AIDS is captured by the government system.
  - Reports provided are not detailed in terms of activity expenditure, district and regional expenditures and it is not clearer how much reaches the primary beneficiaries at the community level
  - There is no clear feed back system in terms of HIV/AIDS resources utilization to Tanzanians as well as to donors and this may lead to donor fatigue and confusion when there is no clear linkage between billions of money flowing in, and very little impact made in the response. It was commented that LGAs are not transparent and the government is slow.
- ✓ O&OD is not comprehensive in itself in ensuring HIV/AIDS issues are captured effectively in District and village plans. It was suggested a combination of COMATAA and O&OD should be considered when facilitating preparation of HIV/AIDS plans.

#### **E. SUSTAINABILITY**

- ✓ On the issue of sustainability, Tanzania is being sited as a donor dependent Country in terms of funding [e.g. Over 90% of all HIV/AIDS funding comes from external support and in the General Budget, Tanzania covers only 44% of the total annual budget]. Participants were concerned and suggested that the government should come up with a plan to reduce the extent of dependence.

### **4. THE PROCESS OF DEVELOPING MILESTONES FOR 2006/07**

#### **4.1. Group presentations and discussions**

As part of the process to develop milestones for 2006/07, a group discussion methodology was employed. A total of 6 groups were formed and particular roles of the group were set as follows:

Based on the national Multisectoral HIV/AIDS response mid-term evaluation findings and the milestones for 2004/05 identify achievements made so far, challenges and opportunities. Finally groups were to identify key issues and recommend appropriate milestones for 2006/07. At the end of each presentation there was a discussion session to seek for clarifications, give recommendations, raise concerns or give additional points to be included in the presentation. Issues raised are documented at the end of each group section.

#### **GROUP I: FINANCE, BUDGET AND RESOURCE MOBILIZATION**

*Group members: Paul Smithson, Beng'I Issa, Rachel Smyth, Mayage E.W, Mtei O.P, Henjewe G.M, Colleen Wainwright, Alfred B.M. Musai*

#### **Presentations**

*[Note: Issues arrangement not by priority]*

#### **Issue**

- Improve accountability of CSOs.
- Ensure value for money of CSOs programs.

**Milestone:**

- Next PER should include a mini-study on;  
“Funding system for CSOs, how they evolve and recommending to streamline funding mechanisms and information dissemination”

**Issue**

- Identification of HIV/AIDS activities by MDAs.
- A lot of duplication and overlapping.
- NMSF is not specific and do not provide responsibilities.

**Milestones**

- A minimum package of intervention by MDA.
- NMSF should meet expectations.
- A stronger link between TACAIDS and priority sectors like MOEVT.

**Issue**

General budget support on HIV/AIDS-GBS-HIV.

**Milestones**

- In order to get more donors, the budget support on HIV/AIDS should be advocated.
- Next round of the global fund should design the GBS-HIV.
- Strategies on the monitoring and evaluation of the performance to be put in place.

**Issue**

Resource allocation and absorption capacity.

**Milestones**

- National care and treatment plan need to be re-costed.
- Placement of units and consideration for seniority of the coordinators at the MDAs.
- MOEVT be a quick win in the next 2 years.
- there should be a national campaign on HIV/AIDS.
- there should be clarity on social protections, so that it is scaled up.
- address human resources constraint of the health sector.
- harmonize approach to work place interventions and clear policy guidelines from PO-PSM.
- Hold a learning session to draw essential experiences from experienced LGAs, prepare a package to guide LGAs.

## Comments and discussions on group I

- To accelerate the national Multisectoral response to HIV/AIDS in the public sector, there is need for Technical Assistance especially on how to move beyond sector strategies to developing activities and implementing. It was suggested that in developing NMSF II there is need to consider going further than just a framework to developing a minimum package of guidelines to MDAs and sectors according to their mandates, roles and working environment.
- The funding gap for HRH should come from the government and not from donor funds.
- Participants were concerned that so far despite increasing inflow of funds for HIV/AIDS, the trickle down effect has not been realized. It was suggested that a study should be carried out to identify current sources, modalities and levels of funding. This study should come up with recommendations on how to harmonize the available funding systems without necessarily extinguishing any of them but enhance harmonization to reduce transaction costs and ensure easy tracking.
- It was agreed that there is need to advocate for budget support for HIV/AIDS:
  - a) It was suggested that in addition to donors who are already operating or interested to operate through Budget Support of HIV/AIDS advocacy should be done to attract more partners towards BS. It was recommended that wider consultations and information sharing should be made as the process for BS modalities takes off so that all interested partners get a chance to state their positions from the beginning.
  - b) Look into a possibility of GF funds, which have not been utilized so far to be directed towards BS. It was also recommended that GF round 6 would be negotiated for BS. Additionally other funds such as T-MAP public sector funds could be negotiated for be diverted towards BS.
- Recommended additional milestones were:
  1. ***Systematic resource tracking***
  2. **Timely disbursement of Funds to implementers**
- It was cautioned that concern for resource tracking should not only be on resource expenditure by LGAs but also on how best to ensure funds reach the people down at community level.
- Concerning the proposed milestone on re-costing/revising the national care and treatment plan to establish actual funding needs, it was suggested further discussions be held during the upcoming Health Sector Review due to take place between 21<sup>st</sup> – 24<sup>th</sup> March 2006

## GROUP II: POLICY AND PLANNING

*Group members: Pascal Mahyo, Hisairi Hishijima, Gavyole A. Bergis SE. Sachiko Arimitsu, Abdallah Jaffery, Temba J, Ngirwa R.*

### Issues and milestones for 2006/07

*[Note: Issues & priority milestones in descending order]*

#### Issue

Prevention- There is need focused and proactive interventions

#### Milestone

Develop Prevention interventions with more emphasis on youth and women.

### **Issue**

Coordination of TACAIDS to MDAs

### **Milestone**

- Ensure more responsibility and accountability by Management of MDAs in planning and implementing HIV/AIDS programmes in the sector
- Through PMO TACAIDS to ensure quality assurance of MDAs strategies and MTEFs
- TACAIDS to organize regular consultative meetings with key Ministries-e.g. Education and health.

### **Issue**

National HIV/AIDS Policy and registration not streamlined with recent developments incorporation of provision of ARV + other legal issues including prevention

### **Milestone**

Revise policies and legislations to incorporate recent sectoral and multisectoral developments

### **Issue**

Capacity within TACAIDS

### **Milestones**

- Reorganization of TACAIDS for more focused interventions including office space by end of 2006
- The Technical Assistance facility to be in place by end of 2006,
- Communicate roles of TACAIDS in relation with RFAs

### **Issue**

There are significant gaps between the MKUKUTA and NMSF

### **Milestone**

- Revise the NMSF in light of MKUKUTA -2006/2007
- Identify and implement interventions that will cover the gaps in accordance with the gaps study report.

### **Issue**

Improving relations between NACP (MoH &VT) and TACAIDS

### **Milestone**

Improve communication and working synergies by regular consultative meetings between NACP and TACAIDS.

## **Comments and discussions on group II**

- Suggestion of an additional milestone on: *Support to operationalisation of Sector Strategies*
- On the question of how to hold MDAs Management accountable for HIV/AIDS implementation in the Public sector a number of ways were suggested as follows:
  - a) Issuing a directive from the Prime Minister's Office (Disasters and HIV/AIDS) to all MDAs to include HIV/AIDS in their regular reports.
  - b) Ministers' Budget reports to the Parliament to include HIV/AIDS

- c) If possible request the President and Prime Minister to issue a directive on accountability through reports.
- d) Another complementally way would be through letting the public know exactly what is the expected role of every single actor in the response and that way the public would demand for outputs. However besides inadequate capacity within MDAs, lack of ownership was seen to be a key block to effective implementation of the national response.

### **GROUP III: DISTRICT AND COMMUNITY RESPONSE**

*Group members: Malangalila E, Madili M, Alhaj Ntaru, S. Winani, Lekule M.R, Mathew Cogan, Madubi M.A, Elisabethe Māgele*

#### **Recommended milestones for 2006-'07**

1. Establish regional steering committees in order to transfer responsibilities from RFA to regional government and ensure sustainability  
**[Learn from TANESA and Action Aid's experience; the composition of committee and ToR to be defined. TACAIDS to convene workshop for discussion/preparation.]**
2. End '06: 100% of WMACS trained and functional
3. CMAC guidelines to be revised by end '06
4. By end '07 *new* NMSF simplified & adapted for community use
5. By Sept. '06 all RFAs are disbursing funds to eligible CSOs
6. Improved communication mechanisms established between TACAIDS and RFAs
7. By March 2006 HIV&AIDS to be mainstreamed in to O&OD processes

#### **Comments and discussions on group III**

- The question of Comprehensiveness needs to be re-looked at more critically
- It was recommended that flow of funds should not be regarded as the solely indicator for "functionality" of programmes and systems but also consider quality and outcome aspects.
- It was suggested that TACAIDS utilize Regional Secretariats, which are already in place within the Government structures instead of establishing Regional Steering Committees as suggested by the group.
- It was recommended that instead of developing a milestone on Developing a NMSF popular version by end of 2006, plan to have developed a new NMSF and its popular version by end of fiscal year 2006/07
- It was recommended that while RFAs are currently assessing only CSOs they could also assess CMACs as well as NGOs within their areas of operation.
- It was observed that although almost all RFAs have been established, some of them were not effectively functioning due to a number of reasons including late starting and inadequate capacity. Partners were called upon to support RFAs to that they become more effective. The request was received with multiple reactions including questioning the rational for putting in more resources and time to build capacities of RFAs, which have been contracted to build capacities of CSOs and communities.
- Participants were concerned with the fact that most members of CMACs who were trained in the first phase were Members of Parliament and Councilors who in the 4<sup>th</sup>

Gov. might have not been re-elected that endangers the issues of continuity and sustainability of functioning of CMACs

- There is need for intensive capacity building of CHACs to enhance their roles as HIV/AIDS coordinators in the councils.
- It was suggested that the training of WMACs and VMACs should be done at the same time. He however TACAIDS should explore partnering with NGOs who might be interested to support financially.
- The O & OD methodology was commented to lack enough coverage on HIV/AIDS issues. It was suggested that a combination of COMATAA and O&OD would close up the gap in development of District, Wards and Village plans in order to strengthen HIV/AIDS components.

#### **GROUP IV: ADVOCACY**

Group members: *Massi, Muhuunzi, Egidio, Joan Chamungu, Ng'weshemi, Lujuo DJ, Dr. Peter Bujari*

#### **Cross-cutting milestones for 2006/ 07**

##### **Issue**

Knowledge of NMSF & TACAIDS roles

##### **Milestones**

- Simplify the NMSF and disseminate it to the wider spectrum of stakeholders with a minimum advocacy package (working toolkit)
- TACAIDS & other players, to disseminate the NMSF to the new leadership MDAs, MPs, Civic Leaders in order to win their support in programs implementation
- Publicize TACAIDS role as the sole national coordinator and leader in the fight against AIDS

##### **Issue**

Harmonization of plans (LGAs, CSOs with NMSF)

##### **Milestones**

- Use of the RFAs as the technical personnel for AIDS interventions in the regional multi-sectoral forums
- Presence of AIDS focal persons at all government departments.

##### **Issue**

Funds disbursement

- **Milestones**
- Advocacy for simpler procurement processes for disbursement of funds in an urgency manner i.e. Tender procedure
- Develop Information Kit on grants for funding HIV/AIDS interventions at various levels i.e. CARF, RFE, PEPFAR, Sector fund
- Evaluation performance reports and funds disbursement be publicize, i.e. Best & Poor performers

**Issue**

Regional Facilitating Agencies' operations

**Milestones**

- Popularise the Roles of RFA in providing services & grants in the Regions
- Advocating for the strengthening and coordination RFA, CMAC & Beneficiaries for quality service delivery and funds disbursement

**Issue**

Building capacities

**Milestones**

- Build capacity for other stakeholders and Players engaged in Advocacy and IEC in terms of technical & funding resources in partnership.
- Build stakeholders capacity in making use of results from THIS in developing AIEC materials according to the NMSF thematic areas.

**Issue**

Communication, Knowledge-based, documentation & dissemination.

**Milestones**

- Disseminate, popularize and implement the National HIV/AIDS Communication and Media Advocacy Strategies
- Intensify the use of various channels of communication, including electronic and print media, billboards, mobile cinemas
- Use of modern ICT tools like the Website, CDs and Video to inform and capture feedback from the public
- AIEC Stakeholders should emphasize the locally made (community-based) -IEC suiting the environment in question
- Documentation of best practices intervention and AIEC programs
- 6. Availability of AIEC materials at all levels and manner in quantity time and space.
- Disseminate, popularize and implement the National HIV/AIDS Communication and Media Advocacy Strategies

**Comments and discussions on group IV**

- The group was advised to go beyond just mainstreaming of HIV/AIDS to the particular role in getting messages to the people to ensure there is a right understanding about HIV/AIDS and its management.
- Issues such as cultural beliefs and practices that affect behavior change process should also be incorporated.
- It was suggested that Advocacy milestones for 2006/07 should focus on operationalising the newly developed national Advocacy and Communication.
- Advocacy milestones were commented to have missing links to schools of high education, military barracks and such sections which are most affected and these need to be closely examined on how they can be reached.
- There is need for specific strategies on how to recapture win-over strategies and develop information packages that will encounter the negative attitudes by extreme

traditionalists, faith and political based negative information that keep obstructing the response to reduce infection. [e.g. Those who remove condoms in places where they are set, destroy them or preach against them]

- Participants felt that the Advocacy group was to rework their recommendations on key issues and milestones. One additional member was added to the group so help to recast the recommendations and milestones. *Due to time constraints it was recommended that the DIRECTORATE go back and finalize the prioritization and unpacking of the strategy rather than the whole group going back to rework the presentation.*

## **GROUP V: MONITORING AND EVALUATION**

Group members: David Mulongo, Kasilima Yosh, Ken Heise, Sophia Luhindi, Hilde, Magrethe Mrema, Dolorosa, Nico Mraduma, Stigmata Tenga, Kimoi

### **Issues and milestones for 2006/07**

#### **Issue**

The Tanzania HIV/AIDS Indicators Survey (THIS) report dissemination has only been done at national level

#### **Milestones**

- The National indicators Survey (THIS) disseminated to stakeholders at all levels
- Simplified version in Swahili developed and disseminated by end of 2006
- Train CMACs in utilization of THIS data through RFAs
- Plan for THIS in 2007 in collaboration with the National Bureau of Statistics

#### **Issue**

M&E Framework operationalisation

#### **Milestones**

- UNGASS indicators incorporated in the national M&E framework
- Ensure consistency of NMSF, M&E tools and M&E Framework
- Develop the M&E Road Map for implementation

#### **Issues**

Data collection tools

#### **Milestones**

- Develop specific tools for: CSOs, CMACs, MDAs and Private sector.
- Coordinate with HMIS for health sector data
- Develop guidelines for use of M&E tools
- Surveys to be planned to collect data for UNGASS specific indicators from health, education and the private sector
- Utilize the ABCT to obtain data from the private sector

#### **Issue**

Training /capacity gaps

#### **Milestones**

- Need for training on the use of new tools and guidelines “on job training by RAFAs to CSOs and CMACs

- Use MDAs capacity needs assessment report to provide targeted training for MDAs

#### **Issue**

National database

#### **Milestones**

- Agree with partners on requirements for a national database to electronic data capturing
- Make web based accessible to the public

#### **Issue**

Feed back from TACAIDS to stakeholders

#### **Milestones**

- Periodic feed back from TACAIDS to stakeholders on reports and /data
- TACAIDS M&E Unit to coordinate to relevant directorates and local response to obtain data from RFAs, CMACs, MDAs and other partners

#### **Issue**

M&E technical working group

#### **Milestones**

- Ensure representation of RFAs in the TWG
- Regular meetings to core team and continuity

#### **Issue**

TACAIDS capacity in the Monitoring and Evaluation Unit

#### **Milestone**

Urgent staffing of TACAIDS M&E Unit by the end of 2006

#### **Comments on group V**

- It was commented that to ensure effective implementation, there is need to come up with specific indicators to track sectors implementation
- Through the support of GAMET (WB) and UNAIDS- manuals and the framework is being finalized, also the roadmap is being finalized, the indicators are being re-looked at in the MKUKUTA [UNGASS and nationally defined indicators. It was commented that TACAIDS is not supposed to develop tools for each sectors but to set guidelines and regarding sectors reporting to TACAIDS it was clarified that they are to do so in some areas but not everything.
- Need to have a set of indicators that cut across and there must be a link up of all indicators in different sectors [This advocates for harmonized national indicators]
- With regard to Contribution to MKUKUTA indicators members were informed that there is a National M&E Task force and they have started looking at the MKUKUTA indicators.
- *It is being suggested that the proper milestones will be set and prioritized by TACAIDS*
- Suggested Milestones for 2006/07:

**1. TACAIDS M&E UNIT to be functional by end 2006**

**2. The Roadmap to be developed and operational by end of 2007**

## **GROUP VI: Private sector (Formal and Informal sectors)**

Group members: *Dr. A. Kiwara, Mr. Jones Sikira and Mr. David Mulongo, Emmanuel M.*

### **Issues and milestones for 2006/07**

This sector constitutes of:

1. Formal (business and companies)
2. Informal (small-scale businesses)

#### **A) FORMAL (BUSINESS AND COMPANIES)**

##### **Issue**

More coverage is needed; currently the number of companies providing coverage is comparatively small.

##### **Milestone.**

Increase coverage by more companies attained.

##### **Issue**

Many companies still see HIV/AIDS as an individual and personal issue. They therefore have not taken on board HIV/AIDS prevention as a major issue at work place.

##### **Milestone.**

More companies mainstreaming HIV/AIDS control in their annual plans and implementing them.

##### **Issue**

Political will needed to ensure that the private sector protects human resources at work place and beyond the rapid growth of this sector should be reflected in investment in the control of epidemic.

##### **Milestone.**

Politician addressing the private sector directly and urging it to play a bigger role at work place and beyond.

##### **Issue**

Role of ABCT not appreciated. Some companies are doing it solo. They are willing to undertake activities at their work place, but don't appreciate ABCT.

##### **Milestone.**

Critical role of coalitions/associations recognized. Networking seen as a tool in complimenting each other in the control of epidemics.

##### **Issue**

Funding from companies and development partners inadequate. Companies are still at 30% and development partners 70%. At these levels SUSTAINABILITY in the event of TURBULENCE is not possible.

##### **Milestone.**

Increase funding from companies and development evident.

##### **Issue**

Quality (comprehensive) programs are needed. Currently many companies see the components as the program. For example a condom dispenser in the toilet is seen as a program.

**Milestone.**

What constitute a comprehensive work place program defined and well prepared is needed.

**Issue**

CAPACITY with the ABCT (finances, human resources and equipments) is inadequate.

**Milestone.**

Adequate capacity established and functioning.

**Issue**

Company status is an issue. Subsidiaries (Tanzania Breweries Limited, Tanzania Cigarette Company, Geita Gold Mining Company) have done better than non-subsidiary. Local companies like X, Y and Z regard HIV/AIDS as a sole responsibility of the Government.

**Milestone.**

Local companies improved performance in HIV/AIDS control (after being urged by the government)

**Issue**

People Living with HIV/AIDS (PLHAs) and their associations are not being used adequately in the fight against epidemic.

**Milestone.**

More PLHAs mobilized and participating in the epidemic control activities.

**b) INFORMAL SECTOR (SMALL-SCALE BUSINESSES)**

**Issue**

Economically and socially the main sector produces 60% of GDP, but in control of HIV/AIDS a reciprocative effort has not been evident.

**Milestone.**

More resources being channeled in to control of epidemic and its sequatae in the sector.

**Issue**

The sector is huge and without adequate structures for networking and joint activities.

**Milestone.**

Networking structures/umbrella organization established and functioning.

**Issue**

The organized component of the sector such as associations, retail markets, guilds; have performed well in control activities like (UCT, IEC, STI treatment and condom uptake). Funds and human resources are however the problem.

**Milestone.**

More financial and human resource channeled to manage the epidemic and its sequalae in the sector, and scale up what is known to work already.

**Issue**

Available classical IEC materials not easy to understand and seems alienative.

**Milestone.**

Appropriate IEC materials designed produced, disseminated and being used.

**Issue**

Capacity of the sector to participate in the fight against HIV/AIDS and own program is low.

**Milestone.**

Capacity in the sector should be built and supported on a continuous basis.

**Issue**

PLHAs are known to play effective role in the control activities. In the sector they have not being used/participated in the control activities.

**Milestone.**

PLHAs associations facilitated to play a needed role.

**Issue**

Actual sources of funds to support control in the sector are very few.

**Milestone.**

More sources of funds identified and mobilized.

**PRIVATE SECTOR PRIORITIES FOR 2006/07**

1. Political will and active support is needed from the highest to the lowest levels. This should canvassed for continuously for both the formal and informal sectors.
2. Comprehensive in work place programs such programs covers all the requisite components. This calls for development or adaptation of generic workplace policy for the formal and informal sector.
3. Seed funding made available to build capacity to the coalitions and members and those facilitating control activities in the formal and informal sector.
4. Scaling up and consolidating what works already in the informal sector.

**Comments and discussions for group IV**

- Concerning ways to scale up the already good work being done by the private sector the following comments were made:
  - a) Consider Positive/ stimulative partnership between the public and private sector
  - b) Build incentive approach to scale up HIV/AIDS considerations by various Companies.
  - c) Occupational Health and Safety mechanisms can be used as entry point
  - d) Encouraging leaders to be more involved in resource mobilization for HIV/AIDS especially in the private sector.
  - e) Need for an Awareness strategy to help the Companies understand how they can care for their people and protect them.
  - f) It was suggested that ABCT could be taken as a secretariat of HIV/AIDS within the Private sector while encouraging wider networks to join in.
  - g) Use of sanctions: Mandatory social responsibility in the community development would lead to more Companies involvement in the response against HIV/AIDS

- The 2004 labour act was commented to have gaps which needs to be addressed by revising it and other related legislations or ensure they are incorporated in the underway HIV/AIDS Bill.
- Although TMAP- CARF has a provision for financing the informal sector, however so far RFAs have been financing only CSOs. There is a great need of sharing information among all sectors and the public at large regarding available funds and how to access them so that eligible target groups can access them.
- Need to mainstream WPP in the CMACs especially in training tools
- There is need to incorporate gender mainstreaming in private and informal sector interventions.
- Condom accessibility by the private sector remains to be a challenge.
- Participants were informed that the ABCT newly developed business plan had components on 1. Coordinating Company's activities in HIV/AIDS and 2. Sponsoring the Public and Private forums on HIV/AIDS.

## **5. CLOSING AND WAY FORWARD**

### **5.1. Closing Remarks**

The meeting was closed on Friday after noon by Dr. Bergis from GTZ and Dr. Temba of TACAIDS. Dr. Bergis Commended the jointness spirit observed throughout the meeting by taking the common approach in that at no point one could see the Government side and partners' side. Also despite the unquestionable fact that there have been significant achievements through out the past 3 years of implementation, participants were also able to appreciate that there are weaknesses that need to be worked upon. However he commented that some work was being left to fine-tune the milestones, a task that remained with respective Directorates of TACAIDS in collaboration with some few people.

Summarizing main issues that came out of the technical review, he mentioned lack of accountability and ownership, slow implementation in the public sector as some of the challenges which need to be tackled by further revision and development of new comprehensive strategies that are outcome oriented. He called upon all stakeholders to think of moving ahead of the epidemic by getting to action rather than just talking, attending workshops, planning and developing policies and strategies.

On his side, Dr. Temba appreciated the work done during the technical review and further commended participants for their attentiveness and tremendous contributions.

He mentioned Advocacy as an area that still needed reworking on the issues and milestones and assured participants that the Directorate would finalize the fine-tuning.

Dr. Temba, reaffirmed TACAIDS position that the national response would be scaled up by increasing focus on rural area.

Finally he informed and invited participants to the upcoming stakeholders meeting on March 15<sup>th</sup> and 16<sup>th</sup> 2006 to finalize the 2<sup>nd</sup> review of the NMSF 2003-2007.

END

## **6. ANNEXES**

### **Annex 1**

#### **MILESTONES SET FOR 2004-05**

*“It is Time for Action!”*

##### ***Cross cutting milestones:***

- Advocacy to increase knowledge and awareness of NMSF and role of TACAIDS
- Harmonization of plans (LGAs, CSOs) with NMSF
- Funds are being disbursed as planned and in a timely manner
- Regional Facilitating Agencies operating, providing services and grants
- Build capacities
- Communication, knowledge base, documentation and dissemination
- Coordination strengthened

##### **Milestones to Specific Thematic Areas**

###### ***i. District and Community Response***

###### **2004**

- User-friendly version of NMSF ready and disseminated
- Assessment of interventions on HIV/AIDS in all districts (mapping, information from CMACS)
- All councils have functioning CMACS (indicator: flow of funds and number of councils that disbursed funds on HIV/AIDS)
- Transparent mechanisms of selected NGO and FBO representatives in CMACs
- RFAs in place
- Inventory of CSOs in all councils available
- List of criteria for selection of CSOs who want to be active in AIDS
- Transparent guidelines for CSOs to access funding in place
- Funding mechanism in place giving priority given to AIDS
- CARF functional in 21 regions
- T-MAP funds disbursed to LGAs

###### **2005**

- TACAIDS and RFAs have assessed the comprehensiveness of HIV/AIDS related services (VCT, condom supply, others)
- In all council plans HIV/AIDS activities are formulated according to NMSF (minimum package of interventions)
- (Over)-proportional increase of block grants earmarked for councils on AIDS compared to GOT expenditures
- In (%) of villages, plans HIV/AIDS activities are formulated according to the NMSF
- Coding of expenditures in LGAs

## **ii. Mainstreaming HIV/AIDS in the Public Sector**

- Mainstreaming HIV/AIDS in the public sector is done on the basis of the NMSF
- Each sector should be implementing its strategic plan and workplace AIDS program
- Key sectors (MOF, MOE&C, MOH, PO-CSD, MOLYDS, MOCDGC, MOSTHE, MODNS) assisted by multisectoral working groups
- Care and treatment plan is operational (MOH and TACAIDS) by 2004
- An operational strategy for local resource mobilization developed TACAIDS

## **iii. Civil Society Organizations**

- Civil society organizations include CBOs, NGOs, FBOs
- RFAs in place in all regions by 2004
- RFAs functions and delivering services by 2005 in all regions
- RFAs provide technical assistance to align CSO and national plans by 2005 (ongoing)
- CSOs advocate at community level to popularize, the NMSF and the HIV/AIDS Policy
- Underserved areas (as determined in mapping) have at least 5 CSOs active in each council by 2005
- CSOs agree on leadership, modalities, roles, responsibilities and accountability of national and district networks (including PLHA)
- Communication mechanism designed to improve knowledge base, documentation and dissemination on funding (i.e. GFATM), on programmes, on success stories and more finalized by 2004
- Communication mechanism in place by 2005
- Requirements for securing donor, foundation and government funds simplified for easier access by local CSOs

## **iv. Private sector**

- Formation of Business Coalition that will be charged with, inter alia, mobilizing resources (financial and human) to mainstream HIV/AIDS – 6 months
- Scaling up participation of the informal sector – 18 months
- Donors and government increase the resource base for Private Sector HIV/AIDS interventions – 18 months
- Government processes integrate HIV/AIDS programmes as precondition for investment opportunities, tenders
- XXX private sector enterprises have comprehensive workplace interventions based on audits and situational analysis

## **v. Orphans and Vulnerable Children**

- Complete process of participatory national situation analysis by September 2004
- Develop costed National Plan of Action by September 2004
- Develop a National Monitoring and Evaluation framework by 2004
- National coordination mechanisms immediate and ongoing
- Legal, Policy and Regulatory Framework

- Delivery of essential services to children based on action plan targets (immediate and ongoing)

vi. **Poverty Reduction Strategy**

- Integrate HIV/AIDS concerns in the new PRS
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**Annex II**

**JOINT TECHNICAL REVIEW 8 -10 MARCH 2006**  
**DAR ES SALAAM INTERNATIONAL CONFERENCE CENTRE**  
**DRAFT TIMETABLE**

<i>Wednesday 8<sup>th</sup> March 2006</i>				
<b>No</b>	<b>Time (hrs)</b>	<b>Session</b>	<b>Time Allocation</b>	<b>Responsible</b>
1	08.30-9.00	Registration	30	Secretariat
2	09.00-09.30	Self-Introduction	30	Participants
3	09.30-9.45	<b>Welcome Remarks</b>	15	Executive Chairman TACAIDS
4	09.45-10.00	Review of Timetable and House keeping	15	Facilitator
5	10.00-11.00	<b>TACAIDS progress report/ milestones</b>	60	TACAIDS
<b>6</b>	<b>11.00-11.30</b>	<b>TEA BREAK</b>	30	ALL
7	11.30-11.45	Comments /Clarification	15	ALL
8	11.45-12.15	<b>Education sector rector response to HIV/AIDS</b>	30	MOEC &VT
9	12.15-12.30	Comments/clarification	15	ALL
10	12.30–13.15	<b>Health sector response to HIV/AIDS</b>	45	MOH & SW
11	13.15-13.30	Comments/clarification	15	ALL
<b>12</b>	<b>13.30-14.30</b>	<b>LUNCH BREAK</b>	<b>60</b>	<b>ALL</b>
13	14.30-15.00	<b>National response to OVC</b>	30	MOH&SW
14	15.00-15.15	Comments /Clarification	15	ALL
15	15.15–15.45	<b>Public Expenditure Review 2005 Highlights</b>	30	TACAIDS
16	15.45-16.00	Comments/Clarification	15	ALL
17	16.00-16.30	<b>PMO-RALG Local Government HIV/AIDS Perspectives for MTEF 2006/07</b>	30	PMO-RALG
18	16-30-16.45	Comments and Clarification	15	ALL
19	16.45–17.15	TEA BREAK	30	ALL
		END OF DAY ONE		

<i>Thursday 9 March 2006</i>				
No	Time	Session		Responsible
20	08.30-09.00	Recap of points from Day 1	30	
21	09.00-09.30	Groups Formation and Tasks allocation	30	
22	09.30–13,00	Group work	3.30hrs	
<b>23</b>	<b>13.00-14.00</b>	<b>LUNCH BREAK</b>	<b>60</b>	
24	14.00-14.30	<b>Presentations: Group 1: Finance, Resource mobilization, Budget and Administration</b>	30	Group Representative
25	14.30-15.00	Discussion	30	ALL
26	15.00-15.30	<b>Group 2: Policy and Planning including Coordination and overall TACAIDS Capacity and set up of TACAIDS</b>	30	Group Representative
27	15.30-16.00	Discussion	30	ALL
<b>28</b>	<b>16.00-16.30</b>	<b>TEA BREAK</b>	<b>30</b>	<b>ALL</b>
		END OF DAY TWO		

<i>Friday 10 March 2006</i>				
29	08.30-0900	Recap of Day 2	30	Facilitator
30	09.00-09.30	<b>Presentation: Group 3: District and Community Response</b>	30	Group Representative
31	09.30-10.00	Discussion	30	ALL
32	10.00-10.30	<b>Presentation: Group 4: Advocacy and IEC</b>	30	Group Representative
33	10.30-11.00	Discussion	30	ALL
34	11.00-11.30	<b>Presentation: Group 5: Monitoring and Evaluation</b>	30	Group Representative
35	11.30-12.00	Discussion	30	ALL
36	12.00-12.30	<b>Presentation: Group 6: Private sector response</b>	30	
37	12.30 -1300	Discussion	30	ALL
38	13.00 -1400	<b>LUNCH BREAK</b>	<b>60</b>	<b>ALL</b>
39.	14.00-16.00	<b>Main Observations, Conclusions and Recommendations</b>	2 hrs	Facilitator

	<b>END OF DAY THREE</b>		
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