TANZANIA JOINT HEALTH TECHNICAL REVIEW 2002

FINAL REPORT HIV/AIDS

February 2002

1. EXECUTIVE SUMMARY AND RECOMMENDATIONS

Please see chapter 6: Recommendations

2. INTRODUCTION

2.1. Background

Tanzania has a HIV epidemic at an estimated range of approximately 12% of the adult population (15-49 years) being infected. The epidemic is still increasing and there are few signs that the epidemic will level off in the near future. Until 2000 the response to the epidemic was the responsibility of NACP, the National AIDS Control Programme, within the MoH. As the epidemic and the insight of the impact of the epidemic on society progressed the health approach changed to a multi-sectoral response – still led by the MoH. However, as in other countries with a significant HIV epidemic it was decided to move the response of the epidemic to the highest level of government. The multi-sectoral approach thus underwent a transformation from a strategy of the MoH to a strategy of GOT by placing the responsibility under the Prime Ministers' Office. In this transition the TACAIDS was formed to provide the leadership of GOT's fight on HIV/AIDS in 2001. TACAIDS is placed within the PM's Office and has slowly started to become operational. In January 2002 the commissioners were appointed and the first meeting will take place in February. The NACP is undergoing a transformation from being the body for the national response of all sectors in society to be part of the response from the MoH. The new role of NACP is still being developed, but it has been decided that the NACP in the future will operate under the authority of the CMO in the MoH. The task within the health sector is huge since the health sector is the first to be impacted by the epidemic and many of the cost-effective preventive measures to combat the epidemic, such as STI treatment, and the care of an increasing number of people being sick and dying from HIV/AIDS, fall on this sector to be appropriately dealt with in partnership with civil society and other stakeholders.

The timing of the mission is appropriate as far as HIV/AIDS is concerned. Great expectations are attached to TACAIDS to ensure leadership and the MoH can now concentrate on improving the provision of services in the health sector where it has a comparative advantage. At the same time new money are being made available from the donors in the basket fund for district health services and new resources are soon going to be available for HIV/AIDS activities: the Global Fund for AIDS, the HIPC money, and the TMAP – perhaps effective from 2003. The opportunity to consolidate the achievements in the health sector has never been greater.

2.2. Objectives and scope of work

It is the objectives of the review to assess the performance of the health sector's response to HIV/AIDS; main challenges regarding the consequences and combat of HIV/AIDS; and based on this recommend actions in the short and medium term.

The scope of work includes a review the performance of the National Aids Control Programme and the opportunities lying ahead for TACAIDS. Further the review on HIV/AIDS will assess constraints and opportunities within the health sector with regard to both preventive and care interventions including MTCT and HAART treatment. The response is assessed with regard to the capacity of the health care sector. In all these areas the following should be considered:

- Experience within Tanzania with a view to possible best practices and lessons learned.
- Cost implications should be considered, with a particular view to opportunity cost in areas where there would be a choice.
- Private sector possible contribution and specific problems.

3. METHOD OF WORK

The team, Adeline Kimambo, medical doctor and Anita Alban, health economist, hold international and national experience in the field of HIV/AIDS. The team carried out a review of existing documentation, including policies and guidelines, and interviews were carried out with key people within MOH, PORALG, TACAIDS and civil society (NGOs for PLWHA). Further a field trip was undertaken to a district that is part of the health sector reform process.

3.1. Approach

For the Health District Reform to succeed it needs an effective facilitated response from the MoH and cooperation from all stakeholders in the process – not least PRORALG. The report reflects this approach by reviewing and assessing both the new opportunities and obstacles of the MoH in the transition from a multi-sectoral response to a consolidated health sector response and the progress of the decentralisation process at district level. Further the team has made a strategic choice in focusing on the HIV/AIDS interventions that can make a significant difference if scaled up. In the time available for the team a choice also had to be made between assessing MTCT interventions and the introduction of anti-retroviral drugs into the care agenda. We chose the latter since it is the greatest investment challenge to the MoH.

4. FINDINGS

4.1. HIV/AIDS in Tanzania

The epidemic in Tanzania is approximately 12 % on average (with wide variations geographically and between the sexes and different age groups). The surveillance system in Tanzania is weak and some uncertainties are attached to the figure. However, the trend is less uncertain: The epidemic is on the increase and 2/3 of new cases are among young people. Those who are sick today and in need for care were infected 5-10 years ago when the overall prevalence was half of what it is today. For the health care sector it means that the resource burden is going to expand – at least double. A recent study on the resource burden revealed that 35% of the health

resources might be used for HIV related diseases. But this figure is hardly reliable and great inefficiencies in the system are flouring the data. Health staff is already decimated from HIV/AIDS and replacements not planned for; ever-decreasing health professionals are required to cope with increasing demand from PLWHA and at the same time falling ill themselves.

4.2. Assessment of the response

The HIV/AIDS response in Tanzania started as a health sector response. The Second medium Term Plan (MTPII), 1992-96 adopted a multi-sectoral approach, but a review in 1997 revealed that the focus was still on the health sector. The third plan, MTPIII, covering 1998/2002 was developed to ensure an expanded multi-sectoral and multi-level response involving all stakeholders. The GOT allocated about Tshs 4.8 billion in the budget for 2000/2001 but the funds were never disbursed. In 2001/2002 Tshs 8 billion was budgeted and disbursement has started.

HIV/AIDS is part of the recent Poverty Reduction Strategy Paper (PRSP). Health is ranked as third priority next to education and agriculture. The concerns expressed on the health sector include the poor level of health education and weak service provision. Underlying these concerns was a sense of alarm in regard to the HIV/AIDS epidemic. The objective for HIV/AIDS in PRSP reflects a modest hope since the GOT is aiming at containing sero-prevalence among pregnant women in 2010. There is no objective for reducing the risk of young people as agreed in the Programme of Action for the International Conference on Population Development, 1999. The strategies lined out are:

- Introduce HIV/AIDS, public health and peer education in schools
- Ensure quality health services are available and accessible to all
- Strengthen the national support systems for personnel management, drugs and supplies
- Promote and coordinate private sector and civil society activities

The indicator proposed to measure progress is 75% of districts covered by an active AIDS awareness campaign.

The GOT budgets for 2002/03-2004/05 reveals the following picture within priority diseases in Tanzania:

Public Health Programme	**Budget 2002/03 -bn TShs-**	**Budget 2003/04 -bn TShs-**	**Budget 2004/05 -bn TShs-**
TB and Leprosy	4.2	6.3	7.3
Malaria	5.0	5.2	5.4
HIV/AIDS	9.0	9.1	9.1

Source: Public Expenditure Update, Draft Report, 2002

The interesting point is that all three diseases will be able to apply for funding in the Global Fund, but HIV/AIDS has the lowest budget growth rate. If the fight against HIV/AIDS is going to be intensified the money will have to come from other sources than GOT.

Within the health services Tanzania has established relevant health services for HIV prevention (STI services, condom distribution, IEC campaigns, blood screening, VCT and MTCT has been introduced with extensive support from the donor agencies) and home-based care (HBC) is being introduced to ease the burden of the hospital system and support the families in the communities to cope. However, the main finding of this mission is that specific priorities costed and budgeted for have not been introduced and pursued and many effective strategies per se have never reached a scale and a quality to make an impact on the epidemic. With an epidemic of the scale as the one in Tanzania everything possible must be done to settle the account and scale up the right interventions to a level and a quality that will bring the epidemic under control. All the resources to cover everything will not be available and the absorption capacity of new flows of money will challenge the health system. It is therefore essential that the number of priority prevention interventions is focusing to the most relative cost-effective strategies and that cost-effective care strategies are widely made available in cooperation with private providers and civil society. It is proposed – based on evidence from cost-effectiveness studies in Africa – that the two top prevention priorities in the coming years become STI management (including syphilis screening of pregnant women) and VCT as an entry point for prevention and care. By top priority is meant allocation of funds to HIV/AIDS intervention with the budget of MoH. Both interventions need to improve their quality of service and go to scale. If the health care system succeeds in this strategy it will have a significant impact on the epidemic. Scaling-up does not mean achieving 100% coverage; it means going to scale within the existing capacity and infrastructure in a planned, coordinated and systematic manner, including monitoring the coverage and quality reached and sustained. The following observations have been made for the services proposed:

- VCT: the model chosen today is inefficient, not sustainable and will take a very long time to reach an acceptable coverage. Today health staff is trained at a very high cost (TSh: 1.500 000). The problem is not only the high cost attached to training of staff but the fact that some of the staff will not bring their newly acquired skills to best use – they will only counsel a limited number of persons per month as part time counsellors. Other and more efficient models must be developed and implemented. One strategy is to increase the involvement of CBOs and NGOs in counselling and find new ways of getting the testing solved for NGOs without health staff through effective cooperation with the health services. It is important that a strategic approach is taken to the implementation of future VCT services as far as training, coverage of services; service providers and resource input are concerned. First counselling must be included in the curriculum of training health staff. Second, there is a need to train health staff – some perhaps in a shorter period of time than the present training programme suggest, e.g. if the person has experience in treating STIs. But these well-trained counsellors could then act as supervisors. The approach developed by AMREF in cooperation with NACP is recommendable for the incorporation of a quality assurance system. Since some of the

trained health staff is themselves HIV positive the training of supervisors must take into account the morbidity and mortality among staff. There is a great need for the health system to assist in training counsellors in communities, but curriculum matching their need must be developed. A sufficiently number of staff and NGOs must be trained to maintain a reasonable coverage. The districts play an important role in ensuring that VCT gets a high profile in the community and the training need is accommodated/planned for.

- STD: If a person has a STD the susceptibility for being infected by HIV/AIDS increases significantly. The importance of establishing effective STD programmes cannot be overemphasised. In Tanzania the STD programme has had substantial donor funding especially from EU over the last years, and has achieved coverage of 12 regions. Extra donor funding has recently been secured for scaling up STD services to five of the remaining 8 regions. The programme needs to be scaled up within each region and quality of the services leaves much to be desired. The programme in place and being implemented will not cover all with appropriate services and even within this important prevention service supplies was a problem. Last year it was not possible for six month to have test kits for screening for syphilis of pregnant women. In Tanzania the syphilis rate is 7% in this group – and in certain places going as high as 32%. Drugs for STDs are still not delivered regularly to the clinics and condoms are often out of stock – although they are available in the FP clinic next door. In 1994 a survey of the quality of the STD services was carried out in Tanzania. It showed that 51% of the patients had a correct examination and only 6.2% of the patients had the correct treatments. The cure rate of STI services today is not available, but the number of new cases treated is collected.

- HBC: The NACP had at the end of 2000 trained 83 HBC TOTs in 19 districts. A strategy has been developed from 2 pilot districts with the volunteers ultimately training the affected family members. HBC training manuals, course plans for training at district, health facility and community level and supervision tools and guidelines have been developed. However, some of the trained health staff is visiting homes after day duties and thus the investment in training is not brought to best use. The coverage of HBC is already thinly staffed (sometimes the staff do not even get overtime or allowances – although they expect it) and there is no way that this approach will be able to cope with the burden of sick people in the communities in the coming year. It is urgency that NGOs and CBOs, especially church organisations, are mobilised to assist with this task. Health workers could then act as supervisors and capacity builders for the community services and the district health services could provide an essential package of disinfections, pain relief, gloves, and soap. From 1996-2001 8,657 PLWHA received HBC services in19 districts according to NACP. The need is obviously much bigger and trained health staff will become a scarce commodity in the coming years. There is great need of recruiting volunteers for the HBC services from communities to relieve the health workers from the dual purpose of providing hospital care and HBC. These facts need to be considered in the future planning of up-scaling HBC services.

If the proposed strategy to focus on selected cost-effective HIV interventions is implemented, indicators to monitor the strategy need to be introduced. Below some indicators are proposed:

Activity	Proposed strategy	Proposed indicators
STI management	Consolidating : • increase coverage • increase quality	• Proportion of pregnant women tested for syphilis • No of new STIs treated and cured (situation analysis) • No of health facilities covered at hospital and health sector level • Amount of tracer drugs and tracer supplies delivered
VCT services	Scaling-up: • Incorporation of counselling in the health staff curriculum • Training of counsellors (supervision) • TOT of counsellors • Cooperation with CBO/NGO	• No of people counselled • No of people tested (incl. diagnosis and blood screening) • % of resources from basket funding to NGOs/CBOs and private organisations including no covered
Home based care	Scaling-up: • Training of health staff and NGO/CBOs (supervisors) • TOT • Provision of a HBC package	• No of chronically ill persons reached/district • No of HBC packages distributed • No of NGOs/CBOs operating per district

The greatest threat for the intensified multi-sectoral response to fail is the widespread stigma in Tanzania. A strategy to break the silence effectively at community level is badly needed. Ministry of Health has an important role to play within its own institutions and staff. There is strong stigma by the health workers towards HIV positive patients who are not receiving appropriate treatment. The awareness and knowledge among health staff on HIV/AIDS continues to be very low. The MoH has a number of best practice strategies at hand. They include:

- Introduction of workplace policies at all levels of provision of services

- Enforcement of Medical Ethics
- Strengthening of health systems including providing protective gears
- Changing the attitude of staff to PLWHA through health education
- Promotion of openness
- Developing basic counselling skills into the curriculum of health staff training
- Increasing the cooperation with private health organisations and civil society.

The re-organisation of the national leadership in the fight against HIV/AIDS provides the MoH with a unique opportunity to rethink its strategy for health. The MoH will need a coordinating mechanism at the highest level of decision making to ensure this. It has already been decided that the NACP will be placed under the CMO. The work of the management team on HIV/AIDS will include development of priorities, strategies of implementation, policy guidelines, surveillance strengthening, monitoring and evaluation. As one of the urgent issues the team needs to deal with is how best HIV/AIDS can be streamlined into the comprehensive district planning – and when it is feasible, e.g. will it be possible to streamline STI and TB services into the district without compromising the up-scaling of the services within the next three years? The limited implementing capacity at district level and below is today a bottleneck for community-based activities. The MoH needs to reflect on how it can partner with local and regional NGOs to strengthen its capacities at community level.

4.3. Progress made

4.3.1. MoH/NACP achievements

NACP has over the years managed to implement a number of HIV prevention and care interventions the new structure can build on. These include the provision of IEC material, a supply system of condoms and drugs, introduction of VCT and HBC, and screening of blood. Furthermore the NACP has been successful in organising a smoothly allocation of resources from donor funds (e.g. NORAD resources in 2001) to district level (district accounts). It is of the utmost importance that gains won in the past are not weakened because of integration into a new organisation not yet fully operational. Especially the funding of effective health based prevention interventions call for attention such as STI treatment. If districts do not perceive HIV/AIDS and the prevention of HIV/AIDS as a high priority, the costs of decentralisation will be very high.

The ongoing HIV/AIDS interventions are based on priority areas that were formulated by NACP in the MTP III but resource requirements for the response were never developed to facilitate resource mobilisation. The MTPIII included the following priorities within health care: Maintain safe blood transfusion services, reduce vulnerability of youth to HIV/AIDS/STDs*, provide

appropriate STD case management services, reduce unsafe sexual behaviour among highly mobile population groups*, Reduce HIV transmission among commercial sex workers*, reduce unprotected sex among men with multiple partners*, promote acceptance of persons living with HIV/AIDS*.

(indicates that health has a role to play but other stakeholders also play important roles such as civil society).*

Since the last Joint Health Review a year ago the maintenance of safe blood has experienced lack of test kits. As a consequence the health services have had to turn people away from giving blood at the facilities. The test kits were available from the donors but for unidentified reasons the applications were not forwarded in time.

During the last year training of counsellors have been carried out by NACP in 29 districts, test kits have been procured, training of HBC carers have taken place in 11 districts (both health care providers as well as private organisations), and VCT guidelines have been disseminated. For the STI management programme funding has been secured for up-scaling to the remaining 8 regions and both MOH staff as well as NGO staff have been trained. However, problems with test kits, drugs and condoms occurred)

Tanzania has at present no comprehensive strategy to target the youth including specific programmes such as youth friendly STD and VCT services in the communities but a number of small-scaled programmes are being implemented. Teenage births are common in Tanzania and young girls are vulnerable to HIV/AIDS. Programmes to address these issues are most needed. Tanzania has committed itself to achieve the goals of ICDP+5 including exactly this activities but no concerted action has been taken during the last year. (A youth programme is part of the framework of TACAIDS strategy presented in January 2002).

Since 1993 the EU has in cooperation with GOT carried out an extensively STD management programme in Tanzania. The programme was scheduled to end in 2001, but has been extended another two years. Further the Japanese Government is prepared to provide STI drugs for 2-3 years, starting in late 2002.

4.3.2.TACAIDS

Since the last review TACAIDS has been established in October 2001 to effectively transform the National response to HIV/AIDS from a National AIDS Control Programme under the Ministry of Health to a strategic and coordinating mechanism under the Prime Minister's Office. A recent consultancy report carried out for TACAIDS on district systems capacity concluded that ***there is little sense of urgency about HIV/AIDS at national, regional, district or community levels.*** To turn this attitude around will become a major challenge for TACAIDS which main objective is to intensify interventions to reduce the rate of HIV infections through well coordinated national response programmes that ensure comprehensive community based HIV/AIDS interventions by:

1. Creating conducive environment for effective evidence based and well coordinated responses at national, district and community level

2. Developing effective prevention programmes to reduce new HIV infections

3. Providing an enabling environment for effective care and support programmes to reduce the suffering caused by the epidemic

4. Developing plans that target, identify and facilitate programmes to provide support for the survivors of HIV/AIDS.

There are great expectations to TACAIDS to implement an intensified response and in the short run (during 2002) to formulate, cost and prioritise a strategic plan. This challenge is intensified by the fact that new resources are made available. These include the Global Health Fund, the HIPC share for HIV/AIDS and perhaps at the beginning of 2003 a TMAP (Tanzania Multi-Country AIDS Programme, the World Bank) with partly grant money and partly loan of a substantial size – perhaps as much as US$ 60 million. TACAIDS recognizes the expectations and is prepared to move fast to ensure that opportunities are not lost. Further TACAIDS is determined to involve all stakeholders including NGOs that will play a more prominent role in the fight against HIV/AIDS in the future. However, this still have to emerge and the NGO/CBO environment in the field of HIV/AIDS is fragile and needs a lot of support and strengthening to play its role.

4.3.3.Health Sector Reform, the basket funding and HIV/AIDS

The Health Sector Reform provides an excellent opportunity to do the right things right. If the delivery of health services at district level for HIV/AIDS were strengthened to comprise awareness raising involving local communities, quality STI services, quality VCT services and HBC for the chronically ill, a lot would be achieved. It is the responsibility of the MoH to ensure that the priorities are set to achieve the best results for money in a balance between prevention and care activities provided by the services. Resources to HIV/AIDS are scarce and it is essential that the services provided are the most cost-effective ones for the purpose be it prevention or care. The basket funding can fill gaps and assist the district in implementing efficient services at an acceptable quality.

From a small random sample of the approved district plans it appears that the basket funding for HIV/AIDS activities at district level has been within the range of 0.5 – 7.0 % of the total sum available. This raises a number of issues for consideration:

- Is this part of the general under-spending of the basket funding last year and is the problem associated to the implementation or planning process
- Is HIV/AIDS not a priority at district level because the disease burden is “invisible” – diagnosis not established and/or need stigma to be effectively addressed
- Is it because the districts need guidance in what works and how to implement

The planning process at district level is still in its infancy. However, it must be stressed that the planning process needs to include all stakeholders in the district – not only the public health

service as seems to be the present trend. The system thinking appears to be strong and is dominating the planning of HIV/AIDS activities. The DMO with the council, the private health services and the CBOs/ NGOs must plan together. The planning guide prescribe cross-sectoral planning. However a report on district systems capacities found that the collaboration is low (A NGO staff commented: "We bring our plans to the DMO but we do not feel welcome"). It is also important that the DMO ensures that the health centers and dispensaries receive sufficient support. Stigma is still very high among staff and the lack of supplies such as gloves and test kits at peripheral services does not create an enabling environment. This is not acceptable and needs to be effectively addressed by the district management team, DHMT. Money from the basket funding could be used to improve the communication process among all stakeholders to be involved in the planning process to make it a comprehensive plan in practice. PRORALG could facilitate this process. Stigma also needs to be addressed among the health staff to ensure that the PLWHA in the communities is treated in a non-discriminatory way. This could happen through sensitising the staff and basket funding could be used to assist in this process (development of material etc).

The greatest obstacle to overcome will arise if the council does not perceive HIV/AIDS as a priority. The PER, 2000/2001 makes the following observation: "The spending on health services raises some concerns about whether there are funds allocated to health at a council level, which are not spent on the sector". This is worrying because HIV/AIDS is not just another disease: the impact on community is grave and poverty will increase not only for the individual families but also for the community at large. It may not be sufficient for the basket funding process to ask the districts to consider "the burden of disease". The resource burden will be more appropriate from a planning perspective. The extreme underreporting of HIV/AIDS does not help to make the burden of disease on health service resources transparent. The underreporting must be addressed at MoH level as well as at district level by encouraging VCT and ensuring data is collected on HIV-related diseases treated to get a more accurate picture of the impact of HIV/AIDS. But the sensitising of communities goes further and the community must be made aware what HIV does to the community. To use a district prevalence rate is helpful. However, the prevalence rate quoted in the district plans is based on blood screening which is a biased example and the procedure is not always carried out in a systematic manner – and test kits are not always available. Further the MoH must ensure that the logistics around important HIV/AIDS supplies work. The basket funding could provide money to assist in this process, but basket funding should not pay for irregular or insufficient supplies of test kits. To strengthen the planning of HIV/AIDS and eventually the response at the council level the district could be assisted in mapping out all resources available for HIV/AIDS (public, private institutions and community involvement) and incorporate areas where there are many young people (secondary schools, vocational training centres, bars etc), many chronically sick people and other indicators of prevention and care needs to be covered. This could be done in a simple GIS system already in use for malaria in Tanzania. PRORALG could facilitate such a process in cooperation with the MoH.

The thinking on HIV/AIDS and community cooperation is dominated by system approaches – not partnership. The decentralisation is an opportunity to find new ways of working together in the communities that Tanzania cannot afford to forgo. Two major activity areas within HIV/AIDS have great potential for strengthening efficiency, equity/access and community involvement:

VCT and HBC. The funding for CBOs/NGOs needs re-worked and the civil organisations need encouragement to organise themselves around HBC and VCT (capacity building and supervision to be provided from the health system).

The accounting rules for minor CBOs must be adapted to the situation or national or regional NGOs must support the CBOs on management issues to make them concentrate on supporting the communities instead of trying to adapt to rules made for much larger companies/systems.

The MoH with other key partners such as the councils and PRORALG need to discuss how the balance between integrating health programmes into the local government plans and at the same time ensuring that a critical area such as STI management services are not deteriorated because it gets lower attention by the district. The MoH could provide more guidance and direction to the districts on the priorities of HIV/AIDS services to be available at the district level and how this could be implemented. From the plans it seems to be the case that much of the funding has been used for training of counsellors and building capacity for HBC. However the plans also reflect the finding from the recent PER: During 2000/01 almost 30% of central basket fund was on employment allowances which was more than allocated for medical supplies and services (27%). The budget estimates for 2001/02 do show a change in this, with employment allowances down to 13% and funds for drugs and medical supplies rises to 57%.

It is important that all health services providers in the community are included into the district planning process. This includes traditional healers who treat many PLWHA. Cooperation with this group of health service providers might also offer information on chronically ill patients in the community that never present themselves in the health services – because they cannot afford the fees or do not trust the system to treat them well.

An overview of problems identified at district levels and proposed solutions is provided below:

Problem identified	Consequences	Proposed solution	Management issues
STI management needs strengthening in the district	The effectiveness of STI management as a cost-effective HIV prevention activity is low and many lives are lost	Feasible performance targets to be introduced for each district based on capacity and monitored by MoH. Irregularities in supplies to be managed by DMO	The DMO is responsible for the quality of services (private as well as public) and timely reporting to MoH. The MoH to ensure the organisational framework for regular supplies
People with HIV-related diseases are not getting appropriate treatment for opportunistic infections	PLWHA spend many days in the health facilities without improving their health status. This leads to inefficient use of resources	People with HIV-related diseases must be encouraged to be counselled and tested and getting appropriate treatment for their infections before they are referred home for continuous care	The DMO to be made accountable to the RMO that this strategy is being pursued by reporting no of patients being treated for HIV-related diseases and no being counselled
The districts do not perceive HIV/AIDS as a priority or/and do not know how to respond at community level	Under-spending is widespread and money are not allocated to CBOs and NGOs working in the communities	Include the community in planning of health service delivery in the communities. Indicator: allocation of resources outside the MoH facilities	Ensuring that instructions in the HSR are carried out and relevant stakeholders are included in a participatory planning process
Under-spending on supplies and overspending on training\workshops	Staff cannot protect themselves and stigma prevails. Patients receive inefficient treatment because of lack of drugs	The DMO to be made accountable for sufficient supplies for all health services and for the protection of staff	MoH to ensure that the supply system is functioning optimally The DMO to report to the RMO
The allocation of funds to the district is not optimal (PER)	Allocation of resources based on per capita adds to the problem	The allocation of resources needs to include performance and need to work effectively in general and for HIV/AIDS in particular	This needs to be addressed at the highest level of MoH and the basket funding could revise its allocation principle per capita in the future

5. THE INTRODUCTION OF ANTI-RETROVIRAL DRUGS (ARVS)

Tanzania has decided to establish a programme for care and drug access for PLWHA and is at present negotiating with an Indian drug company to deliver ARV drugs at a reduced price of US$ 1 per day – this excludes manpower, equipment for monitoring and drugs for opportunistic infections. The price is the lowest ever negotiated. Until now the cheapest price negotiated for Senegal was almost US$ 3 per day.

The Drug Access Initiative will strive to meet basic requirements that are essential for ensuring availability; rational prescription and safe use of HIV related drugs. The major issues that are addressed by the programme include the following: Patient management guidelines and levels of health care facilities to be involved. Strengthening of health care infrastructure including human resources development and improvement of diagnostic facilities. Establishment of an efficient, responsive and flexible drug procurement, storage and delivery system is a necessity. To empower the health system in Tanzania to cope with safe and effective use of antiretroviral will require extensive upgrading of staff and laboratory capacities. The cost to upgrade the system to administer ARV is estimated by the NACP (Programme for Care and Drug Access for People Living with HIV/AIDS) to be US$ 14 million for four referral centres. In another proposed strategy for Muhimbili National Hospital (February 2002), the cost is estimated to US$ 6 million for 2002/03 and US$ 5 million for 2003/2004. (The budget for health care in 2000/2001 was approximately US$ 120 million). The initiative(s) will no doubt has a number of positive externalities, e.g. improved management of opportunistic infections, improved support system for the MTCT programme and general improvements of the drug delivery system. However, the initiative raises a number of issues that will have to be dealt with in collaboration with TACAIDS:

- The opportunity cost is high even for relatively low price costs
- Sustainable funding of drugs to ensure continuous drug supply
- Funding of up-grading the capacities to meet the requirements is uncertain
- Equity concerns
- Unknown survival effect in Africa. In USA it has been estimated to 1.38 years
- ARV contradicts the present national health policy of providing free access to drugs for treatment of conditions related to HIV/AIDS.

The ARVs are already being imported and used in Tanzania although the amount is very limited. Today the appropriate monitoring of the treatment takes place outside Tanzania (Uganda and Kenya) if it takes place at all. A USA based NGO has started to cooperate with a number of NGOs for PLWHA, e.g. WAMATA, in order to provide a small selection of their members with "free" drugs. There is obviously the question of resistance from the ARV drugs that creates a public health threat – although limited because of the small number to be included. But a strategy is badly needed for what happens to people who cannot tolerate the "free" drugs after some time. Will new more advanced drugs follow? However, at present time the financial threat is far more serious. The investment to be able to monitor a proportion of the HIV infected people far below 1% of the total number infected is beyond the governments' total investment in HIV/AIDS for one year ($US 8 mill). To achieve economics of scale of such a vast investment in a poor country will take many people, but as it is the government will not be able to pay for the

drugs – even at a very low price. Since the decision to introduce a monitoring system for ARVs in Tanzania has already been taken and proposals for its implementation is in the pipeline, it is proposed that the MoH ensure that a very modest monitoring programme for a limited ARV programme (the Kenya model) is put in place and money to invest in this activity does not forgo the much needed strengthening of prioritised prevention activities. The approach to ARV should be phased starting with one referral hospital and the present budget proposals must be slimmed considerably.

The situation might change in the future if a low tech is marketed that suits developing countries. The drugs need to come down to a DOTS approach and not present itself as up to 20 pills per day with many meals the poor cannot afford. The monitoring system also needs developed to suit affordable systems in developing countries. The push for such technologies will hardly come from the drug- and laboratory industry – but funding for research into such low-tech solutions should be pushed by government – perhaps in the SADC or African region context.

6. RECOMMENDATIONS

A proposed outline of the health sector response to HIV/AIDS and priorities for the immediate term and medium term is provided below.

Proposed activity	Objective	Next steps	Milestones
TACAIDS to finalise Strategic Plan, 2002 - 2006	To intensify the response to HIV/AIDS	1. Costed and prioritised plan 2. Funding of plan	Plan available October 2002 50% funding achieved by the end of 2003
TACAIDS to increase the overall GOT funding to HIV/AIDS	To demonstrate commitment To fund an intensified response and decrease HIV/AIDS over time	1. Present a costed workplan 2. Hold negotiation with the GOT	Increase of the budget for 2003/04 with min. US$ 2 million (from proposed TSh 9 billion to 11 billion)

Proposed activity	Objective	Next steps	Milestones
TACAIDS to establish a funding mechanism for CBO/NGOs	To intensify the response To reduce stigma	1. Assign consultant to propose models 2. Decide model 3. Implement model	Model implemented in September 2002 5% of resources allocated to CBO/NGOs at the end of 2003
MoH to up-scale and improve quality of VCT service	To prevent HIV infections To provide support for infected people To reduce stigma To strengthen the MTCT programmes	1. Incorporate basic counselling into the curriculum 2. Introduce a cost-effective VCT approach 3. Train health staff as well as private organisations 4. Cooperate with private organisations and communities 5. Introduce a supervision system	VCT incorporated into all health staff curriculum at the end of 2002 MoH to develop a strategic plan for addressing efficiency and quality issues of VCT at the end of 2002 VCT available in every district and cooperation with NGOs established by end of 2003 All pregnant mothers at ANC centres to be offered VCT at the end of 2003

Proposed activity	Objective	Next steps	Milestones
MoH to Implement cost-effective HBC services	To ensure access to basic care for the chronically ill	1. Develop policy guidelines 2. Develop a basic HBC package 3. Develop comprehensive district plans for HBC services	HBC established in all districts at the end of 2003 Cooperation with CBOs established in all districts by the end of 2002 4000 “new” PLWHA to receive HBC services at the end of 2002 6000 “new” PLWHA to receive HBC services at the end of 2002
MoH to improve data collection of HIV/AIDS cases in the health services	To assist in breaking the silence and improve care To improve planning at all levels of services	1. Develop a plan for data collection	Plan developed at the end of 2002
MoH to establish a coordinating mechanism within the highest level of MoH	To ensure that HIV/AIDS is managed as an urgency at the highest level of decision making	1. Finalise reorganisation and put management in place	The coordinating mechanism and its mandate to be announced in May 2002
MoH to develop a strategic plan for the health services	To ensure an efficient provision of the health services To provide guidance to the service providers	1. Identify consultants 2. Establish a task force 3. Develop the plan	The Strategic Plan to be developed along the TACAIDS frame work at the end of October 2002

Proposed activity	Objective	Next steps	Milestones
MoH to introduce workplace policies	To improve HR policies To decrease stigma within the health services To demonstrate leadership	1. Develop plan 2. Fund the plan 3. Implement the plan	Workplace policy fully implemented at all hospitals and health centres at the end of 2003 Workplace policy disseminated at the end of 2002 Workplace policy fully implemented at all levels of services at the end of 2004
MoH to strengthen surveillance, monitoring and evaluation of HIV/AIDS activities	To strengthen advocacy To support planning and policies	1. Identify partners 2. Develop a plan 3. Fund the plan	Surveillance system strengthened at the end of 2003 A minimum set of Performance Indicators implemented for key activities (STD, HBC, VCT) at the end of 2002.

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Appendix 1

TOR

Joint Technical Review of Critical Issues:

HIV/AIDS

Tanzania Health Sector Programme

1 BACKGROUND

2 OBJECTIVE

- Review the performance of the health sector's response to HIV/AIDS
- Assess main challenges regarding the consequences and combat of HIV/AIDS
- Based on this recommend actions in the short and medium term

3 SCOPE OF WORK

Generally the work will be guided by the guidelines provided in the general TOR for the Tanzania Joint Health Sector Review. The work will comprise but not necessarily be limited to:

- Review the performance of the National Aids Control Programme
- Review the potential of the framework for the TACAIDS strategy within the health sector as well as actions implied by the MAP.
- Assess constraints and opportunities within the health sector with regard to:
  - IEC aiming at change in sexual behaviour and general awareness
  - Condom promotion, including supply
  - Voluntary counselling and testing
  - STD management, including diagnostic facilities and drug supply

- TB treatment
- Treatment of opportunistic infections and pain relief
- Home based care

- Assess implications and response with regard to:

- Capacity for clinical care, e.g. hospital beds
- Attrition rate for staff and need for increased training capacity

- Assess the current situation and possible future scenarios regarding:

- Mother to Child Transmission
- HAART

In all these areas the following should be considered:

- Experience within Tanzania with a view to possible best practices and lessons learned.
- Cost implications should be considered, with a particular view to opportunity cost in areas where there would be a choice.
- Private sector possible contribution and specific problems.

4 METHOD OF WORK

The team should be familiar with relevant international experience.

Review existing documentation, including policies and guidelines

Interview key people within MOH, PORALG and civil society

Field Trip to selected Districts

5 OUTPUT

Technical Review Report

Condensed contribution to the overall Technical Review Report

6 TEAM & TIMING

Public Health Doctor

Health Economist

Appendix 2

List of abbreviations

AMREF	African Medical and Research Foundation
ARV	Anti-Retroviral (drug)
CBO	Community Based Organisation
DHMT	District Health Management Tem
DMO	District Medical Officer
EU	European Union
FP	Family Planning
GIS	Geographical Information System
GOT	Government of Tanzania
HAART	Highly Active Anti-Retroviral Therapy
HBC	Home Based Care
HIPC	Highly Indebted
IEC	Information Education Communication
MoH	Ministry of Health
MTCT	Mother to Child Transmission
MTPII	Medium Term Programme, II Phase
NACP	National AIDS Control Programme
NGO	Non-Government Organisation
NORAD	Norwegian Agency for International Development
PER	Public Expenditure Review
PLWHA	People Living With HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TACAIDS	Tanzania Commission for HIV/AIDS
TMAP	Multi-Country AIDS Programme for Tanzania (The World Bank)
TOT	Training of Trainers
VCT	Voluntary Counselling and Testing
WAMATA	Walio Katika Mapambano na UKIMWI Tanzania (NGO)

APPENDIX 3

PEOPLE MET WITH

Date	Organisation	Persons met
5 February	USAID	Robert Cunnane, DAC coordinator
6 February	NACP	L.J. Kikuli, manager
6 February	interview	Natasha XXX
6 February	MoH	Nicolas Eseko, director, DPS
6 February	MoH	Zacharia Berege, director, DHS
6 February	MoH	Evarist Manumbu, director, DPP
6 February	MoH	Gilbert Mliga, director, DHR
7 February	Field trip/Bagamayo	S A mmari, DH Pharmacist
	Field trip/Bagamayo	E J Kiria, DH. HBC coordinator
	Field trip/Bagamayo	J Shishira, NGO/CBO rep.
	Field trip/Bagamayo	S Mmanyi, Lab. Ass.
	Field trip/Bagamayo	C Wambura, DH Secretary
	Field trip/Bagamayo	A P Mwenda DH Dental Officer
	Field trip/Bagamayo	N A Hamisi, DMO
	Field trip/Bagamayo	A O Dihenga, Ass. DMO
8 February	SHDEPHA +	A Jacob, Deputy and co-founder
	SHDEPHA +	J Karo, director and co-founder
8 February	The World Bank	E Malangalila, task manager
	The World Bank	D Habte, health specialist
	The World Bank	Bertboetbery
	The World Bank	A Follmer, operations officer
8 February	Danida	F Schleimann, RTA on health
	Danida	L Jespersen, Counsellor
8 February	TACAIDS	J M V Temba, Coordinator
9 February	UNAIDS	Hilde Basstanie
10 February	PROLARC	J P Dybdal
11 February	WAMATA	Z G Ssebuyoya
	UNICEF	B Lindquist, Country Representative
	AMREF	D Bukenya, Country Director
13 February	NACP	B Fimbo, acting director
	NACP	K Hassan, Lab. Officer
	NACP	Z Msumi, Coordinator, HBC and VCT
	NACP	G R Somi, Surveillance specialist
	NACP	S Hanson, STD/STI advisor